TECHNICAL & FINANCIAL FILE

ESTABLISHING A FINANCIAL MECHANISM FOR STRATEGIC PURCHASING OF HEALTH SERVICES IN UGANDA (SPHU)

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THE BELGIAN DEVELOPMENT COOPERATION .be

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ABBREVIATIONS

ANC	Antenatal Care
ART	Anti-retroviral treatment
BOG	Board Of Governors
BS	Budget Support
BTC	Belgian Development Agency
CBO	Community Based Organization
CC	Coordination Committee
CDC	Centre of Disease Control
CHD	Community Health Department
CS	Caesarean Section
CSO	Civil Society Organization
DFID	Department for International Development
DGD	Directorate General for Development Cooperation and Humanitarian Aid
DHO	District Health Officer
DHMT	District Health Management Team
EMHS	Essential Medicines and Health Supplies
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
eMTCT	Elimination of HIV transmission from mother to child
ENT	Ear, nose and throat (Otorhinolaryngology)
EUR	Euro
FY	Fiscal Year
GHI	Global Health Initiative
GIS	Geographical Information System
GoU	Government of Uganda
HC	Health Centre
HDI	Human Development Index
HDP	Health Development Partner
HIV	Human Immunodeficiency Virus
HMDC	Health Manpower Development Centre
HMIS	Health Management Information System
HNP	Health National Plan
HPAC	Health Policy Advisory Committee
HPLM	Health Planning Leadership and Management
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System

HSBWG	Health Sector Budget Working Group
HSD	Health Sub-District
HSDP	Health Sector Development Plan
HTI	Health Training Institute
ICB	Institutional Capacity Building
ICP	Indicative Cooperation Programme
ICT	Information and Communication Technology
IEC	Information Education Communication
IFMS	Integrated Financial Management System
IHP+	International Health Partnership and related initiatives
IPC	Indicative Programme of Cooperation
IST	In-Service Training
ITA	International Technical Assistant
JICA	Japanese International Cooperation Agency
JMS	Joint Medical Store
LIC	Low Income Country
LG	Local Government
MB	Medical Bureau
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MMR	Maternal Mortality Ratio
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoFPED	Ministry of Finance, Planning and Economic Development
MoLG	Ministry of Local Government
MoU	Memorandum of Understanding
MoPS	Ministry of Public Service
MTCT	Mother-To-Child Transmission
NCD	Non Communicable Disease
NDA	National Drug Agency
NDP	National Development Plan
NGO	Non-Governmental Organization
NHP	National Health Policy
NMS	National Medical Stores
NRH	National Referral Hospital
NSDS	National Service Delivery Survey
NTA	National Technical Assistant
OPD	Out-Patient Department

PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PHP	Private Health Providers
PME	Participatory Monitoring and Evaluation
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNFP	Private Non For Profit
PNFPCB	Private Non For Profit Coordinating Bodies
PPP	Public Private Partnership
PS	Permanent Secretary
QA	Quality assurance
R	Result
RBF	Results-Based Financing
RRH	Regional Referral Hospital
SDG	Sustainable Development Goal
SDHR	Support to Beneficiary Institutes for the Skills Development of their Human Resources”
SDMT	Sub-District Management Team
SF	Strategic Financing
SIDA	Swedish International Development Agency
SPHU	Strategic Purchasing of Health Services in Uganda
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SURE	Securing Ugandan Rights to Essential Medicines
SWAp	Sector Wide Approach
SWG	Sub-technical Working Group
SWOT	Strengths, Weaknesses, Opportunities and Threats
TA	Technical Assistant
TCMP	Traditional and Complementary Medicine Practitioners
TF	Trust Fund
TFF	Technical and Financial File
TFR	Total Fertility Rate
ToC	Theory of Change
TWG	Technical Working Group
UAIS	Uganda AIDS Indicator Survey
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Service
UCMB	Ugandan Catholic Medical Bureau
UDHS	Uganda Demographic and Health Survey
UGA	Uganda

UGX	Ugandan Shilling
UHC	Universal Health Coverage
UMMB	Ugandan Muslim Medical Bureau
UNHCO	Uganda National Health Consumer Organization
UNHRO	Uganda National Health Research Organization
UNMHCP	Uganda National Minimal Health Care Package
UOMB	Ugandan Orthodox Medical Bureau
UPHIAS	Uganda Population HIV/AIDS Impact Assessment Survey
UPMB	Ugandan Protestant Medical Bureau
USAID	United States Agency for International Development
USD	United States Dollar
VHT	Village Health Team
WB	World Bank
WHO	World Health Organisation

EXECUTIVE SUMMARY

This Strategic Purchasing of Health Services in Uganda (SPHU) programme is part of the Indicative Programme of Cooperation (ICP) 2012-2016 negotiated between Uganda and Belgium. The Belgian contribution is 6,000,000 €. The Specific Agreement will be for a duration of 42 months. The duration of the actual implementation phase is set at 30 months. This SPHU will, through a programme approach, integrate the current interventions of the bilateral Belgian Cooperation in the health sector (ICB II and PNFP) and consolidate them. This will be done in view of supporting the scaling up the Result Based Financing (RBF) experience in the Rwenzori and West-Nile regions towards a sustainable national RBF strategy, rolled out in other regions of the country, under Ministry of Health (MoH) leadership and in collaboration with other Development Partners supporting RBF. This experience will also feed the longer-term reflection on strategic health financing and more specifically the development of National Health Insurance Scheme (NHIS).

The general objective of this programme is “Contribute to Universal Health Coverage (UHC) in Uganda following a Rights Based Approach’.

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

There are 4 results that should contribute to the specific objective of this programme. Result 1 and 2 will essentially pilot the RBF approach in selected Health Centres (HC) III and IV and general hospitals in the 2 regions. Direct support to health care facilities will be offered. Results 3 and 4 will cover essential support to i) selected districts, ii) the 2 regions and iii) the MoH authorities and will provide an important input to organize the continuous training of health staff in the country.

The results (R) are:

- R1: The equitable access to quality health care at public and PNFP HC IIIs in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.
- R2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.
- R3: The capacity of Districts to manage the quality of care, the right to health and the integrated local health system is strengthened.
- R4: The capacity of MoH to steer the implementation of the Health Financing Strategy is strengthened.

Specific attention will be given to important crosscutting issues (environment, gender, Sexual and Reproductive Health & Rights (SRHR) / HIV/AIDS, Human Rights, inclusive growth and digitalisation). These themes are integrated in each of the results.

To accompany the implementation of the programme, the programme foresees a mix of i) long-term international and National Technical Assistants (NTA) with expertise in strategic health financing and/or public health ii) punctual national and international expertise for specific issues. A Programme Change Manager from the MoH and a programme co-manager from Belgian Development Agency (BTC) will steer the overall programme with the support of a Financial & Administrative team.

ANALYTICAL RECORD OF THE INTERVENTION

Title of the intervention	Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (FSPH)
Intervention number	NN
Navision Code BTC	UGA 1603611
Partner Institution	Ministry of Health
Duration of Specific agreement	42 months
Duration execution	30 months
Estimated start-up date	2017
Contribution of the Partner Country	1,500,000 EUR (on top of in kind contribution)
Belgian Contribution	6,000,000 EUR
Sector (CAD codes)	12110 Health policy and administrative management
Global Objective	Contribute to Universal Health Coverage in Uganda following a Rights Based Approach.
Specific Objective	Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups.
Results	• R1: The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point. • R2: The equitable access to quality health care at public and private non-for-profit General Hospitals & Health Centres 4 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point. • R3: The capacity of Districts to manage the quality of care, the right to health and the integrated local health system is strengthened. • R4: The capacity of MoH to steer the implementation of the Health Financing Strategy is strengthened.

1 SITUATION ANALYSIS

1.1 Demographic and Health Context

Uganda has an area of 241,000 km² and has seen extreme population growth from 9.5 million in 1969 to 34.9 million in 2014[1]. Eighty eight percent of the population lives in rural areas. With an annual growth rate of about 3.2 % translating into an annual increase of approximately 1 million people, the population is projected to reach 47 million inhabitants by 2025.² Rapid population growth is fuelled by a high fertility rate (5.4 live births per woman) and a low contraceptive prevalence rate (39%). Fertility levels are higher in the rural areas compared to the urban areas (5.9 and 4.0 respectively).

The rapid population growth puts severe strains on the Ugandan health system. In spite of an overall improvement in the national health indicators over the last ten years, they remain unsatisfactory and disparities continue to exist across the country[2] (UDHS 2011). Life expectancy increased from 45 years in 2003 to 52 years in 2008 and to 64 and 62 for females and males respectively in 2016 (Uganda Census Report). The prevalence of vaccine preventable diseases has declined sharply. Between 1995 and 2016, under-five mortality rate declined from 156 in 1995 to 64 deaths per 1,000 live births; infant mortality rate decreased from 85 to 43 deaths per 1,000 live births; and Maternal Mortality Ratio (MMR) reduced from 527 to 336 per 100,000 live births. Teenage pregnancy rate at 24% in 2011 and up to 25% in 2016 significantly contributes to the overall MMR in Uganda. The new-born mortality rate was 26 per 1,000 live births in 2011 and increased to 27 in 2016. In spite of earlier successes in the fight against HIV and AIDS - HIV prevalence has been reduced from 27% to 7.3% between 2000/01 and 2010/11 - the national HIV prevalence in the age group of 15-49 years is on the rise again and increased from 6.4% in 2004 to 7.3% in 2011. HIV prevalence among women aged 15-49 (8.3%) is higher than among men of the same age group (6.1%). The percentage of people eligible for ART treatment has increased from 56% in 2014/15 to 86% in 2015/16. This is as a result of the change to Test and Treat Policy.

Malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis and perinatal and neonatal conditions remain the leading causes of morbidity and mortality. Seventy percent of overall child mortality is due to malaria (32%), perinatal and neonatal conditions (18%), meningitis (10%), pneumonia (8%), HIV/AIDS (5.6%) and malnutrition (4.6%). Non-Communicable Diseases (NCD) are an emerging problem due to multiple factors such as adoption of unhealthy lifestyles, increasing life expectancy and metabolic side effects resulting from lifelong antiretroviral treatment. Gender inequalities including sexual and gender-based violence (UBOS, 2007) remain a major hindrance to improvement of health outcomes.

Seventy five percent of the disease burden in Uganda however is still preventable through health promotion and disease prevention. These problems call for intensive focused and well-coordinated collaboration between the health sector and other stakeholders.

The major determinants of health in Uganda include levels of income and education housing conditions, access to sanitation and safe water, cultural beliefs, social behaviours and access to quality health services. While the proportion of people living below the poverty line has significantly decreased from 31% in 2005 and 24.4% in 2009 to 19.7% in 2013 (World Bank), Uganda is still a low income developing country with income disparities spread across the country. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea as they are more prevalent among the poor than the rich households (UDHS 2011). Notwithstanding Uganda's high economic growth rate with an average of 7% per annum, the country is still classified amongst the countries with the lowest human development index (HDI value 0.483, ranking 169 in 2014).

[1] Uganda Bureau of Statistics. 2014. Provisional Census Results, 18 November 2014.
[2] Uganda Demographic and Health Survey 2011.

1.2 Political and Administrative Factors

Administratively, Uganda is divided into districts which are sub-divided into lower administrative units namely counties, sub-counties and parishes. Overtime, the numbers of districts and lower level administrative units have increased with the aim of making administration and delivery of social services easier and closer to the people. This has however placed increased strain on delivery of health services, as numbers of management and administrative units and functions increase.

As a way of improving the efficiency and effectiveness of service delivery, the Government of Uganda (GoU) decentralized delivery of services guided by the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997). Each level of the decentralized health delivery system has specific roles and responsibilities. With changing leadership and creation of new districts, the district leadership needs to be periodically oriented in the roles and responsibilities. Supervision both from central level to districts and districts to lower levels is inadequate; inadequate funding and weak logistics management constrain the delivery of quality health services. Over the period of the Health Sector Development Plan (HSDP) 2015/16 – 2019/20, the sector shall continue reviewing the strategies and adopt the ones that will give optimum outcomes.

Although, the HSDP envisages establishment of a regional structure to support the national functions, there is no intermediate regional administration, neither is there a standard definition of what a region should be.

1.3 National Health Policies and Strategies

The 1995 Constitution of the Republic of Uganda provides for all people in Uganda to enjoy equal rights and opportunities, to have access to health services, clean and safe water and education, among many other things. Investing in the promotion of people's health and nutrition ensures that they remain productive and contribute to national development. The GoU recognizes this obligation to provide basic health services to its people and to promote proper nutrition and healthy lifestyles. National Development Plan (NDP) for the period 2015/16 - 2019/20 places emphasis on these fundamental human rights, and human capital development is one of the priority areas with focus on increasing the stock of a skilled and healthy workforce towards the production of human capital to accelerate the realization of the demographic dividend. In the chapter on health and nutrition the NDP prioritises the prioritizing preventive health care which is expected to have an impact on reducing costs for other services like curative health care. According to the NDP the health service focus during the 5 year period should give priority to mass malaria treatment; National Health Insurance scheme; universal access to family planning services; health infrastructure development; reducing maternal, neonatal and child morbidity and mortality; scaling up HIV prevention and treatment; and developing a centre of excellence in cancer treatment and related services.. The ultimate aim is to ensure that Uganda achieves the health related SDG targets by 2030.

1.3.1 National Health Policy II (2011-2020)

The second National Health Policy 2011-2020 (NHP II) is based upon the 1995 Constitution of the Republic of Uganda, the NDP 2010/2011-2014/2015, and current global dynamics to achieve its vision of "A healthy and productive population that contributes to socio-economic growth and national development". The Uganda health policy emphasizes the achievement of the health related SDGs and more particularly SDG 3 (Ensure healthy lives and promote well-being for all at all ages).

The NHP II mission is to provide the highest possible level of health services to all people in Uganda through delivery of promotional, preventive, curative, palliative and rehabilitative health services at all levels. The NPH II is based on a series of social values, embedded in the Constitution and detailed in the Uganda's Patient Charter that will guide its implementation, i.e.: the right to the highest attainable standard of health; solidarity, equity, respect of cultures and traditions, professionalism and ethics, clients' responsibilities; and accountability.

The NHP II is inspired by ten guiding principles, nine of which are of importance for this new project:

- Primary Health Care (PHC): PHC shall remain the major strategy for the delivery of health services in Uganda, based on the district health system, and recognizing the role of hospitals as an essential part in a national health system.
- Decentralisation: Health services shall be delivered within the framework of decentralization and any future reforms therein.
- Evidence-based and forward looking strategy: taking into account emerging trends.
- Gender-sensitive and responsive health care: a gender-sensitive and responsive national health system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health Programmes.
- Pro-poor and sustainability: NHP II provides a framework to support sustainable development. In order to address the burden of disease in a cost effective way, GoU, Private Health Providers (PHP) and PNFP organizations shall provide services included in the Uganda National Minimal Health Care Package (UNMHCP) with special attention to under-served parts of the country. The GoU shall also explore alternative, equitable and sustainable options for health financing and health service organization targeting vulnerable groups.
- Partnerships: the private sector is seen as complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.
- UNMHCP: in order to address the burden of disease in a cost-effective way, public and private providers shall offer services that are included in the UNMHCP.
- Integrated health care delivery: curative, preventive and promotional services shall be provided in an integrated manner.
- Alignment with international development policies: The NHP follows the principles of the Sector wide Approach, the Paris Declaration and the Accra Agenda for Action through the International Health Partnership Plus (IHP+) on aid effectiveness in the interaction and collaboration with national and international development partners.

1.3.2 Health Sector Development Plan 2015/16-2019/20

The HSDP provides the strategic focus of the sector in the medium term and guides the participation of all stakeholders in health development in Uganda. The HSDP goal is ‘To accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life’. The HSDP is based upon four strategic objectives:

1. To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.
2. To address the key determinants of health.
3. To increase financial risk protection of households against impoverishment due to health expenditures.
4. To enhance the health sector competitiveness in the region and globally.

To achieve these, the health sector development priorities are defined around strengthening the national health system including governance; disease prevention, mitigation and control; health education and promotion, curative services; rehabilitation services; palliative services; and health infrastructure development.

1.4 Organisation and Management of the Health System

1.4.1 Organisational Structure of the Health System

The National Health System is made up of the public and the private sector. The public sector includes all GoU health facilities under the MoH, health services of the Ministries of Defence (Army), Education, Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of PNFPs providers, PHPs, and the Traditional and Complementary Medicine Practitioners. The provision of health services in Uganda is decentralised with districts and health sub-districts (HSDs) playing a key role in the delivery and management of health services at those levels.

The health services are structured into National Referral Hospitals (NRHs) and Regional Referral Hospitals (RRHs), General Hospitals, HCs IV, HCs IIIs, HCs IIs and Village Health Teams (VHTs). Hospitals provide technical back up for referral and support functions to district health services. Hospital services are provided by the public, PHPs and PNFPs.

HCs IV are considered to be functional if they can carry out caesarean section (CS) and blood transfusion. In 2015/16 FY, 36% of all HCs IV were providing Comprehensive Emergency Obstetric Care (CEmO), i.e. C/S and blood transfusion. In the same period, 62% HC IVs were conducting C/S and 40% offering blood transfusion services. Ideally all HC IVs should be able to provide both C/S and blood transfusion with the aim of reducing maternal deaths. Overall, about 3% of health care facilities are hospitals, 4% HC IV and 70% HC III. Most facilities are owned by government (54%) while 29% are owned by PHPs. The government owns and operates a tiered structure of 2867 facilities of which 64 are hospitals (2 national referral hospitals, 13 RRHs, 47 general hospitals, and 4 military and police hospitals).

Over the past years the MoH has invested a lot in the expansion of the health infrastructure, including rehabilitation and upgrading of some existing facilities, in order to achieve greater coverage. According to the Health Facility Inventory 2011, there are a total of 5,073 health care facilities. According to the National Service Delivery Survey (NSDS), 2015 at national level, the median distance to the Government health facility where treatment was first sought was 3 Km compared to only 1.2 Km for other health facilities (PHP or PNFP).

Seeking treatment from a Government health facility has progressively increased since 2004. The majority of persons who fell sick first sought treatment from a Government health facility which has persistently increased from 33% to 51%; followed by private health facilities which has also increased from 29% to 36% between 2004 and 2015 (NSDS 2015).

The government also provides non-facility based services through national Programmes such as Maternal and Child Health, Environmental Health and Sanitation, and Communicable Diseases Control using the VHTs.

The Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15 and the current HSDP provided for the institutionalization of a regional health level, but so far intentions “to regionalise” or “to zonalise” the health sector has not come to materialize. This explains why many stakeholders (such as the Global Fund, UNICEF, Intrahealth but also the Belgian Cooperation) tend to support Programme specific regional structures and mechanisms in order to facilitate Programme management as well as the coordination between the district and the central level.

A recent 'regional mapping study' exercise has been financed by Belgian Cooperation in order to document existing practices with strengths and weaknesses. This will be presented to the MoH and other stakeholders for consensus building. A 'feasibility study' on the chosen model will follow if needed / possible.

1.4.2 Roles and Responsibilities

1.4.2.1 At the central level: the MoH and National Institutions

The core functions of the MoH at central level are as follows:

- Policy analysis, formulation and dialogue;
- Strategic planning;
- Setting standards and quality assurance;
- Resource mobilization;
- Advising other ministries, departments and agencies on health-related matters;
- Capacity development and technical support supervision;
- Provision of nationally coordinated services including health emergency preparedness and response and epidemic prevention and control;
- Coordination of health research;
- Monitoring and evaluation (M&E) of the overall health sector performance.

Several functions have been delegated to national autonomous and semi-autonomous institutions including Uganda Cancer Institute, Uganda Heart Institute, Uganda Blood Transfusion Services, Uganda Virus Research Institute (UVRI), National Medical Stores (NMS), Central Public Health Laboratories, Professional Councils, National Drug Authority (NDA) and research institutions. The Uganda National Health Research Organisation (UNHRO) coordinates the national health research agenda, whilst research is conducted by several institutions including the Uganda Natural Chemotherapeutic Research Institute and UVRI. The Health Service Commission (HSC) is responsible for the recruitment, and deployment of Human Resources for Health (HRH) at Central and RRH levels. In the districts, this function is carried out by the District Service Commissions. The Uganda AIDS Commission (UAC) which falls under the Office of the President coordinates the multi-sectoral response to the HIV/AIDS pandemic in close collaboration with the MoH.

1.4.2.2 At the District Level

The Constitution (1995) and the Local Government Act (1997) mandate the Local Governments[3] (LGs) to plan, budget and implement health policies and health sector plans. The LGs have the responsibility for recruitment, deployment, development and management of HRH for district health services, HRH development, the passing of health related by-laws and the monitoring of overall district health sector performance. LGs also manage public general hospitals and HCs and also supervise and monitor all health activities (including those in the private sector) in their respective areas of responsibility.

The District Health Management Team (DHMT) is headed by the District Health Officer (DHO) who is responsible for the planning, monitoring and coordination of both public and private health service provision in the sub-HSDs under their responsibility. However, the public private partnership at district level is still weak.

1.4.2.3 At the Health Sub-District Level

The HSDs are mandated with planning, organization, budgeting and management of the health services at this and lower health centre levels. The HSDs carry an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities including those carried out by the PNFPs and PHPs in the HSD. The headquarters of a HSD are at HC IV or general hospital.

HCs IV provide preventive, promotive, curative, maternity, in-patient health services, emergency surgery, blood transfusion and basic laboratory services.

[3] Currently there are 137 Local governments -112 Districts and 25 Municipalities.

1.4.2.4 National, Regional and General Hospitals

Hospitals provide technical back up for referral and support functions to district health services. Hospital services are provided by public and private health providers. All RRHs are supposed to provide technical support supervision and mentorship to the general hospitals and HC IVs, and to maintain linkages with communities through the Community Health Departments (CHDs). The Regional Referral Hospitals have been granted self-accounting status but remain under the MoH oversight. The two National Referral Hospitals, Mulago and Butabika, are semi-autonomous. All PNFP hospitals are autonomous.

National Referral Hospitals provide comprehensive specialist services and are involved in health research and teaching in addition to providing services offered by general hospitals and RRHs.

Regional Referral Hospitals offer specialist clinical services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, higher level surgical and medical services, and clinical support services (laboratory, medical imaging and pathology). They are also involved in teaching and research. This is in addition to services provided by general hospitals.

General Hospitals provide preventive, promotive, curative, obstetric, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training, consultation and operational research in support of the community-based health care Programmes.

1.4.2.5 Health Centres II-III and VHTs (HC I)

HCs III provide basic preventive, promotive and curative care. They also provide support supervision of the community and HCs II are under their jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HCs II provide the first level of interaction between the formal health sector and the communities. HCs II only provide out-patient care, community outreach services and linkages with the VHTs. The VHTs are supposed to play an important role in health care promotion and provision but their coverage is limited and their actual capacities are quite limited.

The MoH has developed a Community Health Extension Workers (CHEW) policy and strategy to establish and strengthen the community health workers programme as part of the national health system in order to bring services closer to the community and ensure equitable distribution of community and household centered health care services. This will be rolled out in a phased manner with 2 CHEWs per parish.

1.4.3 Health Financing

1.4.3.1 Evolutions in Total Health Expenditure

The health sector in Uganda obtains varying levels of funding from public sources (central government, LGs and parastatals, private sources (households, firms and local NGO's) and external sources (donors, international NGOs and GHI). Total Health Expenditure (THE) in Uganda has decreased in %, especially since the financial year 2015/2016.

Table 1 TRENDS IN GOVERNMENT ALLOCATION TO THE HEALTH SECTOR 2010/11 TO 2015/16

Year	GoU Funding (Ushs bns)	Donor Projects and GHIs (Ushs bns)	Total (Ushs bns)	Per capita public health exp (Ushs)	Per capita public health exp (US $)	GoU health expenditure as % of total government expenditure
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.10	799.11	25,142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.8
2013/14	710.82	416.67	1,127.48	32,214	10	8.7
2014/15	748.64	532.50	1,281.14	37,130	13.5	8.5
2015/16	818.86	451.94	1,270.8	36,830	11	6.4

The figures above are MTEF figures and exclude Non-Tax revenue collected by the sector institutions and spent at source

This trend has important implications for service delivery as it will imply the need for further priority setting based on the UNMHCP. The current population growth rate will have an escalating effect on the total resource envelope required. Not less than 9% of household expenditure is spent on health care (out-of-pocket health expenditure). The GoU will need to explore alternative financing mechanism to increase resources for health sector, to reduce dependency on donors, to improve resource allocation criteria to address inequities to build a better link with the private sector and better coordination of partners to attain policy goals and improvement of accounting systems.

Recent figures (See table 2) confirm that still total general health expenditure (TGHE) is far below the Abuja Target of 15%.

Table 2: Government allocation to the health sector FY 2016/17 and 2017/18 compared with some other sectors

Sector	Approved Fiscal Year (FY) 2016/17			Proposed Fiscal Year (FY) 2017/18		
	Nominal allocation	% share of FY budget	% change from previous FY	Nominal allocation	% share of FY budget	% change from previous FY
Health	1,827.3	8.9%	43.8%	1,704,1	8.3%	-29.6%
Education	2,447.5	12.0%	20.6%	2,370.0	10.6%	-3.2%
Energy and mineral development	2,377.2	11.6%	-15.9%	2,999.6	13.4%	26.2%
Urban development	147.0	0.7%	-10.8%	217.7	1.0%	48.1%
Works and transport	3,823.8	18.7%	14.9%	4,867.5	21.7%	27.3%

From Table 2 can be deduced that the GoU is decreasing its support to the social sectors. This budget reduction must be interpreted with respect to the significant increase of the budget in the FY 2016/17. But it seems clear, when compared to the private sector related development areas, that the government is favouring national infrastructure like roads. Already the most important national budget increased 2 years consecutively with respectively 15 and 27%. The relative disengagement should be followed carefully to understand where these changes in budget allocation lead to.

Finally, social security is little developed so that the ability of government is limited in determining priority areas in which funds should be allocated in order to improve the country's health indicators.

1.4.3.2 End of budget support and renewed focus on project support

The budget of this project is a reoriented budget-support financing. Uganda has been benefitting from years of budget support, also from the Belgian cooperation, with in the beginning many positive outcomes for the system[4]. The positive environment did not last and though and for the past years, budget support outcome evaluations were rather negative. The Overseas Development Institute regretted that donors neglected the complementary tool of projects to budget support, an approach Belgium has followed for many years.

1.4.4 Health Information System, monitoring and evaluation

The GoU is investing heavily in the computerisation of its health information systems through the institution of several electronic systems, i.e.:

- a web-based District Health Information Software (DHIS2)**,** which has been rolled in all (112/112) the districts
- the Human Resource Information System (HRIS), which has been rolled out in 66% (74/112) of the districts
- m-Trac[5] for monitoring service delivery and medicines availability, which has been rolled out in all (112/112) the districts.

Both public and private health facilities are expected to report through the National HMIS, however there are still challenges in reporting from the PHPs A number of bottlenecks call for an adequate response in order to ensure optimal use of the system.

The MoH in Uganda developed a M&E Plan for the HSDP to facilitate the establishment of a country led platform for M&E in the health sector and is using the DHIS2 as the main source of health statistical data. M&E coordination and oversight in the health sector is embedded within the Directorate of Planning & Development. The M&E functions are divided between the Quality Assurance Department, responsible for organising quarterly sector performance reviews, and the Planning Department responsible for data management under the Resource Center, and preparation of annual sector performance reports. The various programmes and projects have TA support for their M&E functions. The MoH restructuring proposal was to have a fully established M&E unit to carry out this function.

1.4.5 Medical Equipment and Drug Supplies

Supply, procurement, and distribution of medicines and health supplies for the public sector are carried out by the NMS, a public semi-autonomous body. The Joint Medical Store (JMS), a PNFP entity co-owned by the Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau, procures for the PNFP subsector. US$1.60 per capita is needed to provide Essential Medicines and Health Supplies (EMHS) in all government and PNFP facilities. The funding gap to provide the EMHS required for the delivery of the UNMHCP is nearly 50%.

The GoU and the Health Development Partners (HDP) have recently undertaken a number of initiatives to improve efficiency, cost-effectiveness, and access to medicines, including developing a classification system to strengthen the selection of medicines and medical products, updating the essential medicines list to include laboratory supplies and introducing a kit-based push system to district-level HC IIs and IIIs, which has had a proven and positive impact on reducing stock-outs in the districts. In 2009/10, in a bid to improve efficiency, effectiveness, and compliance with expenditure guidelines, the MoH consolidated 50% of the PHC budget for medicines with a credit line and created

[4] ODI: “Budget support to Uganda 1998-2012. A review. Tim Williamson et all.
[5] M-Tracis a SMS-based disease surveillance and medicine tracking system. It provides real-time data for response while monitoring health service delivery performance. The initiative also integrates governance and accountability through citizen feedback, an anonymous hotline and public dialogue sessions.

a new single pool for financing medical products. Money for this consolidated fund is channelled to NMS to procure and distribute medical products to the public sector providers.

However, stock-outs in public sector facilities, informal payments in the public sector, and high prices in the private sector continue to pose challenges to equity and access – about 65% of households in the lowest socioeconomic bracket face monthly catastrophic expenditures on pharmaceuticals. A key challenge that exacerbates drug stock-outs and expiries is the lack of broad-based coordination between the public sector and HDPs on procurement and distribution. Moreover, the NMS makes use of different procedures for different lines of supplies (UNMHCP, ARV, family planning, etc.) depending on the criteria imposed by the respective donors.

1.4.6 Human Resources for Health

The HSC is responsible for the recruitment and deployment of public HRH at Central and RRHs. At district level, this function is carried out by the District Service Commission. Significant progress has been made in recent years in increasing the output of health professional and in producing a multi-purpose nursing cadre capable to perform both nursing and midwifery tasks. Availability of data on the public sector health workforce has also improved. A comprehensive HRH policy and strategy to address priority HRH constraints is in place, although its implementation needs to be improved. Another encouraging development is the recognition of the need for human resource management and leadership training. The wage bill limits the ability of the public sector to fill its vacant positions and to absorb the increasing numbers of health workers produced. New incentives have been created in 2012 to attract doctors to General Hospitals and HC IV.

In spite of the progress made, the health sector is still facing serious challenges in HRH. Uganda has an estimated health workforce of 45,598[6]. Although the percentage of filled public sector posts has increased from 56% in 2010 to 69% in 2014 and 71% in 2015/16, the vacancy rates especially for critical cadres remain high. Of the essential cadres required to deliver the RMNCAH (Reproductive, Maternal, Neonatal, Child & Adolescent Health) package, the cadres which are severely short in number include theatre assistants (57%), doctors (49%), pharmacists (40%), dispensers (40%) and anesthetic officers (27%). The target of the HSDP is to fill the current staffing norms in the public sector to at least 80% of the current staffing norms by 2019/20, by which time the structure of the whole health workforce should have been reviewed.

The rapid increase in the number of districts has likely contributed to these high vacancy rates, as the number of health facilities in the districts has increased without an increase in HRH. Ideally the health system should distribute health care workers to match geographic population and disease burden distributions. While 87% of the population lives in rural areas, HRH distribution, particularly among higher-level professional cadres, is skewed in the urban areas. This geographic mal-distribution is a result of the failure of the health system to attract health care workers to rural, remote, and hard-to-reach areas and to retain them once there. This poses major barriers for the rural population to have access to quality health care in these areas.

1.4.7 The Health Manpower Development Centre

The Health Manpower Development Centre (HMDC) was established in Mbale in 1982 as a national centre for continuing education of health workers, through the Uganda Health Training and Planning Project funded by the Canadian Development Agency (CIDA), and implemented by the MoH and the African Medical and Research Foundation (AMREF).

The Centre is located in the neighbourhood of Mbale RRH. HMDC is responsible for providing In-Service Training (IST) / Continuing Professional Development (CPD) to various cadres of health

[6] Midterm Review Report Health Sector Strategic and Investment Plan (HSSIP) 2010/11 - 2014/15

workers in Uganda. The purpose of these Programmes is to re-equip health workers with new knowledge and skills required to cope with the rapidly changing health sector environment. In recent years HMDC has started investing in modern training methodologies such as e-learning and has created several regional hubs (at the premises of the RRHs) in order to facilitate access of the trainees. Training courses are not accredited by the Ministry of Education and Sports (MoES), which is responsible for all health and medical training in the country, but certificates are provided by the MoH. Official MoES accreditation is obtained through collaboration with accredited training institutions such as universities.

HMDC is highly donor dependent, however the MoH insists on keeping and strengthening HMDC as it is the only well-established IST institution under the MoH. In May 2013 a “Draft Strategic & Investment Plan for the Uganda Health Services Management Training Institute (UHSMTI)” was developed (with support of the Belgian Cooperation). In 2014 a memo about the Principles of the UHSMTI Bill was submitted to Cabinet which requested for clarification on some issues. The purpose of this regulation is to turn the HMDC into a self-governing and autonomous institution. The process, however, has taken time and the bill has not yet been passed. The autonomous status appears to be key for the institute to become really viable, to be able to develop a quality and needs responsive training offer and to make the necessary agreements with the MoES for the accreditations. There also appears to be a growing consensus among other major HDPs about the added value that a well-managed training institute for continuous and IST can have for improving the quality of health service delivery in Uganda.

1.4.8 Supervision, Monitoring and Evaluation

The MoH and other central level departments/agencies have the mandate to supervise the health sector. In line with the decentralization framework, District Health Teams (DHTs) are responsible for the supervision of the district health system. Technical supervision is provided at all levels of care with each level supervising the implementation of the NHP II. Monitoring relies on the HMIS and compilation of quarterly and annual reports which are verified during quarterly monitoring visits and reviewed by Joint Review Missions, the National Health Assembly and the Uganda Parliament. Periodic evaluations of the sector’s performance such as the mid-term review of the national strategy are also carried out. Health Professionals’ Councils and the NDA are autonomous bodies charged with ensuring maintenance of professional standards and safety of pharmaceuticals, equipment and procedures.

Challenges exist in terms of inadequate human, logistical and financial resources for supervision, M&E. Other additional challenges are limited mechanisms that incorporate private sub-sector performance into overall sector performance and lack of coordination of community/civil society organizations (CSO) and monitoring with mainstream health sector.

The transition from the first (2000/10) to the second (2010/20) National Health Policy (NHP) has seen an increased number of districts, from 39 to 112 in less than two decades, a great increase in number of health facilities. This situation has overstretched the already limited capacity of the MoH to effectively supervise and monitor all districts bringing to virtual collapse of the support supervision. There is an urgent need, to reorganize the services provided by the MoH through a regional approach to bridge the gap between the Centre and Districts and optimize inspection and supervision of health services delivery. The exercise is expected to decentralize important supervisory and inspection functions from the Centre to the Regional Level, bringing those functions closer to the service delivery level.

The Ministry is in the process to reform inspection, supervision and monitoring of health services delivery delegating such functions to a regional structure. However, the development of the supervision, inspection and monitoring strategy has been slow over the last 3 years.

1.5 Development Cooperation

1.5.1 The Indicative Cooperation Programme (ICP) 2012-2016

The Belgo-Ugandan Cooperation is present in the health sector since 2005 (ICP I, 2005-2007) and since 2008 the health sector is one of the two priority sectors besides education. Geographically the activities are mainly located in the Western part of the country, more particularly in Rwenzori and West Nile. This new SPHU programme will be supported under ICP 2012-2016.

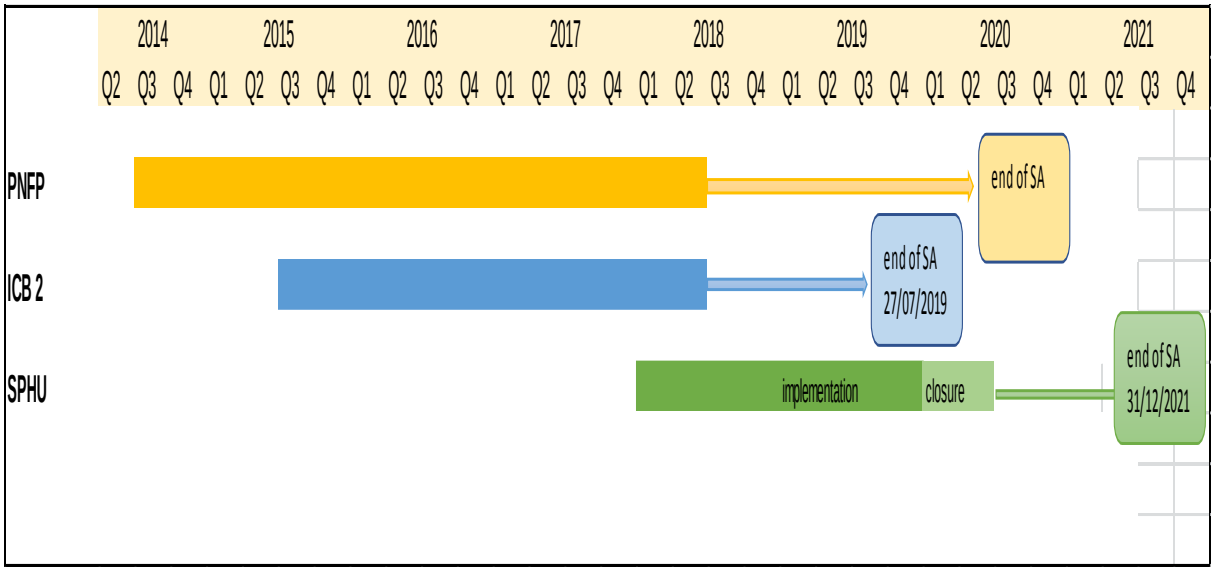
Since the Joint commission of 2008, Belgian health support in Uganda has opted for a "portfolio approach", aiming at one strategic objective while working through a mix of modalities (projects and budget support). As mentioned above, the international community estimated that the budget support conditions were not united any longer in Uganda and also the Belgian cooperation stopped sector budget support in 2016. Currently there are 3 ongoing interventions: the Institutional Capacity Building Project (ICB-II), the Private-non-for-Profit Project (PNFP) and the Skills for Human Resources Development Project (SHRD) which are designed to operate in a complementary and synergetic way.

- ICB-II/HPLM project: the *"ICB in Planning, Leadership and Management in the Uganda Health Sector"* (HPLM) project started effectively in 2016 only. Although ICB II is a second phase after ICB I project, the project is subscribing the new policies and demands of the national partner with regard to results-based financing. The aim is to improve the effective delivery of the integrated UNMHCP stimulated through an RBF approach. The project is anchored in the Department of Planning at the MoH and works in close collaboration with the PNFP project (see further). ICB II concentrates in the same regions as the PNFP project the public facilities, complementary to the private facilities of PNFP project.
- PNFP: the implementation of the *"Institutional Support for the Private-Non-For-Profit (PNFP) health sub-sector to promote universal health coverage in Uganda"* started in June 2014. The project aims to build stakeholders' capacities in order to strengthen and effectively implement the partnership with the PNFP sub-sector. It is embedded within the framework of the National Policy on Public Private Partnership in Health (PPPH) and will assist the MoH in testing the "Specific implementation guidelines" that have been developed for the PNFP subsector. It has the ambition to strengthen the respective roles of the MoH, the District Health Offices (and LGs), the Medical Bureaus (MB) and the PNFP health facilities. The project is anchored at the Directorate of the Planning and Development at the MoH and will also strengthen the Medical Bureaus, the Diocese Health Coordination (DHC) and other PNFP Coordination Bodies (PNFPCB) in their capacities of elaborating and maintaining partnerships with the MoH and the DHO. At regional level, the project will be implemented in synergy with ICB-II and strengthen the role of the DHO in planning, monitoring and supervision of the PNFP health units. The project will use two complementary strategies to structure the strengthening of the PPPH between the Ugandan government (GoU) and PNFP, i.e.: the design and use of a health coverage plan and the financing of PNFP health units through a Results-Based Financing (RBF) mechanism. The RBF mechanisms developed by PNFP project serve as basis for the implementation of the public facilities' RBF.
- SHRD (2014-2019): The project *"Support to Beneficiary Institutes for the Skills Development of their Human Resources"* is a scholarship programme aimed at strengthening the capacities of a selected number of institutions in the education, health and environment that play a key role in the development of their respective sector. As for the health component of the project, specific attention is paid to improving skills in the areas related to SRHR and child health. The project is implemented in synergy with the

ICB-II and PNFP projects. The SPHU programme will inform the supported health facilities about training opportunities offered by SHRD.

The ICB II and PNFP interventions will be integrated together with the new SPHU programme (described in this document) into one programme approach. The timeline of the health portfolio is displayed in the figure below.

Figure 1: Time-line contract-periods Health Portfolio



1.5.2 Health Development Partners

The HDPs in Uganda have a mandate to support the government and all public and private key stakeholders in health in their efforts to ensure universal access to a minimum package of health services, the equitable distribution of health services, the effective and efficient use of health resources and the promotion of sustainable health financing mechanisms. This partnership is based on a Memorandum of Understanding with the MoH, within the frame of a sector wide approach (SWAp) to the health sector. The Uganda Health SWAp is a sustained partnership aimed at improvement of people's health through a collaborative programme, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sector performance against jointly agreed milestones and targets. Uganda is signatory to the IHP+ and related initiatives. IHP+ seeks to ensure that all stakeholders rally around one result-focused country-led national health plan, one monitoring and evaluation framework, one review process focusing on results and mutual accountability in the joint effort towards the achievement of the health-related SDGs.

Currently, quite a number of HDPs are involved in leadership and management, health financing and M&E. In terms of RBF, only the World Bank (WB) and World Health Organisation (WHO) are really into it. The Swedish International Development Agency (SIDA) decided to support the RBF project of WB.

The Department for International Development (DFID)

DFID has been a budget support partner in Uganda but has been withdrawing from such support. DFID has since piloted a RBF initiative in Northern Uganda, on a limited scale and only at HC level. The piloting was very much inspired by an operations' research methodology and no complementary initiatives were taken. The official conclusions are not yet out, but they are mitigated. RBF by its own cannot regulate the entire care delivery system. RBF is potentially a strong corrective tool, but has to act in synergy with other measures in the system.

DFID is in principle interested in a national RBF approach and is supportive of the idea of creating a basket fund with other donors.

SIDA

The Swedish cooperation has decided to provide additional support to the WB project on RBF. It shows clearly the shared interest between donor agencies on the subject of RBF. They provide the budget under a project modus and will concentrate on mother and child health care including human and specifically women's rights. It will support NGOs and CSOs in areas that are underserved – or not served - by the public health sector, such as emergency contraception, abortion and services for the Lesbian, Gay, Bisexual, Transsexual and Intersexual (LGBTI) populations. Priority will be given to supporting the health sector in fragile settings and districts with high rates of maternal mortality. The regions of intervention correspond with those served by WB.

The World Bank (WB)

The WB is currently in the final stage of a 150 million US$ programme for Health System Strengthening of which 60 million US$ would be earmarked for RBF. The programme would start in the coming months and would take 4 years of implementation. The preparations of the new project take longer than foreseen and the start-up of the intervention is foreseen towards the end of the year.

World Health Organization (WHO)[7]

The WHO is supporting the MoH technically and politically and is interested in supporting an RBF approach. It intends to support UHC and health insurance in particular.

[7] WHO Country Cooperation Strategy, Uganda, 2016-2020

2 STRATEGIC ORIENTATIONS

2.1 A human rights and inclusive growth approach

First of all, the present programme subscribes the general position of the Belgian cooperation that health is part of the much larger field of interest of ***Human rights***. Health and more precisely the right to health care is indeed a human right. This principle is internationally recognized under the UHC concept, established by WHO some years ago (2010). Despite many efforts in Uganda, much remains to be done. The right to health care immediately has links with the rights of women and other vulnerable groups in society, with patients' rights, safety and regulation of health care, financial and geographical access to care. Many specific strategies and activities proposed in this programme have direct links with this human right.

Gorik Ooms of the London School of Hygiene and Tropical Medicine and expert in international law approaches the universal right for health care as an international legal obligation of richer countries to fill the financing and capacity gap through international aid in lower-income countries. *"In many low-income countries the health sector is heavily dependent on external assistance to fulfil the right to health of people thus it is vital that policies and tools for delivering reliable, long-term assistance are developed so that the right to health for all becomes more than a dream."* Ooms reasoning Ooms is based on the international conventions that most developed countries signed and therefore the contractual obligation of these countries to respect promises.

Inequity in society and therefore also inequitable access to health care is not just a moral injustice, but also contributes to the destabilization of countries. Populations that do not have access to general public goods like health care have less opportunities, get frustrated and mistrust their (political) authorities and elites. It can lead to violence and societal breakdown.

RBF is the major intake in this programme. It encourages MoH and Ministry of Finance Planning and Economic Development (MoFPED) to mobilise additional funds and to inject it more efficiently into the health production system by linking the subsidies to real performance. The motivation of health staff is boosted by the fact that they get more autonomy in (financial) management decisions and are able to influence their own performance. On top, they get a (small) salary bonus through the performance payments. The additional funding is for the larger part reinjected in the facilities and will make them more viable. For PNFP facilities already supported by the ongoing PNFP project, most facilities lowered the fees for the patients and accessibility (hence utilisation) increased significantly.

Secondly, development is not possible without ***inclusive economic growth***. Public goods like health care should be linked up and combined with inclusive economic growth to fully exercise their potential. In other words, (functional) health services contribute to inclusive growth, and inclusive growth contributes to health.

In 2008, the WB published a comprehensive study on Population Health and Economic Growth. The report describes the intimate relation between health status of a population and its economic growth. The causal relation typically runs in 2 directions. Economic growth contributes to the health status of people, but healthy people also become more wealthy thanks to their health status and contribute maximally to the economic growth of their country. WB states:

"Health is a direct source of human welfare and also an instrument for raising income levels. We discuss a number of mechanisms through which health can affect income, focusing on worker productivity, children's education, savings and investment, and demographic structure. As well as the impact of current illness, health may have large effects on prospective lifespans and life cycle behaviour. Studies suggest there may be a large effect of health and nutrition in utero, and in the first few years of life, on physical and cognitive development and economic success as an adult. Macroeconomic evidence for an effect on growth is mixed, with evidence of a large effect in some

studies. However, there is a possibility that gains from health may be outweighed by the effect of increased survival on population growth, until a fertility transition occurs. The low cost of some health interventions that have large scale effects on population health makes health investments a promising policy tool for growth in developing countries. In addition, higher priority could be given to tackling widespread "neglected" diseases—that is, diseases with low mortality burdens that are not priorities from a pure health perspective, but that do have substantial effects on productivity."

OECD (Figure 2) is showing the mutual interferences between economy and health status of a population. These relations are not just theoretical but all have proven impact on economic growth. Health is a condition for good economic growth because healthy populations produce better. Health also influences economic growth directly because the health sector represents an enormous market. On the other hand, economy is a condition for people accessing quality care and the economic status of a country will shape the quality of the health system performance for instance through the level of financing of the system.

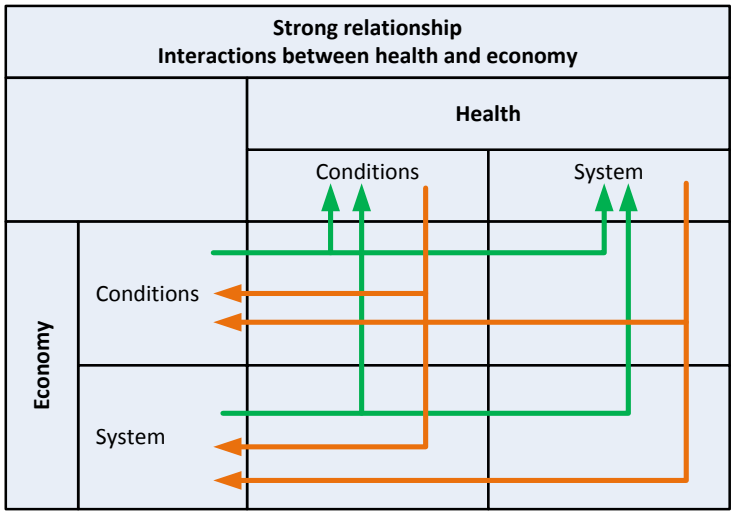


Figure 2: The strong relationship between health and economy (source Government of México)[8]

RBF is also in the forefront when it comes to Inclusive economic growth. RBF, together with health insurance are financing modalities so much more effective on the performance of the health system than simple 'input-based' financing. They give a real boost to the system, including to inclusive growth and equity in society.

[8] ©OECD Observer No 243, May 2004

2.2 A health system perspective to improve quality of care and of management through strategic financing

2.2.1 Definition of strategic financing mechanisms

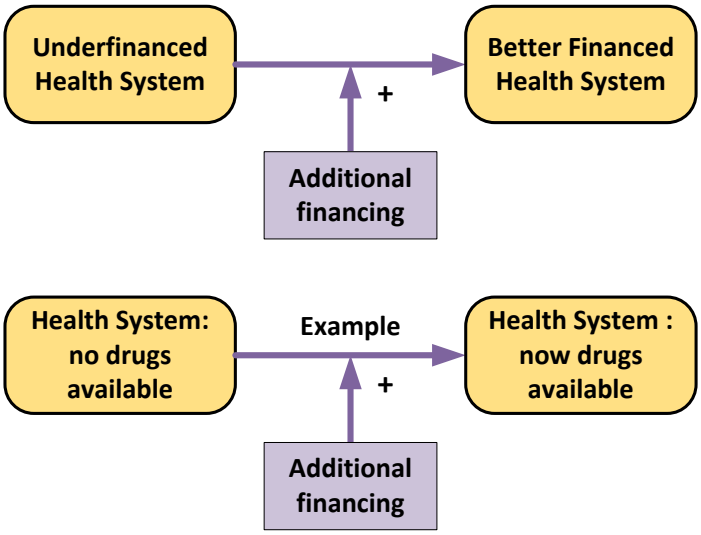


Figure 3: Simple, linear additional financing of the health system

In Figure 3 a linear logic of health financing interventions is represented. Increased financing, especially in heavily underfunded systems, should have an impact on the performance of the health system, as illustrated in the example with drugs: additional funds increase the availability of drugs in the system. It is the more traditional way of looking at the financial gap of the health sector in most Lower Income Countries.

But this does not mean the performance of the system as a whole will have improved as well. Much irrationality exists in most systems and additional financing might increase irrational use of resources. In the example of the drugs availability, increased drug availability might very well increase irrational prescriptions or illegal vending of drugs rather than improve the quality of care.

Strategic financing could mitigate this risk.

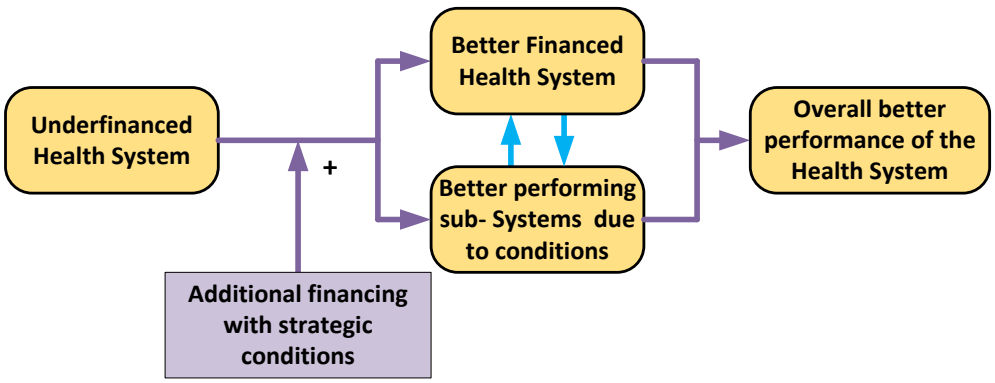


Figure 4: Strategic financing model

Strategic financing can be defined as the ***"conscious use of financing modalities to influence the health system beyond its financial viability"***. In other words, Strategic Financing (SF) refers to those effects that the financing system has on the global functioning or performance of the health

system as a whole due to conditions that the financing modality poses to the system. This is illustrated in Figure 4. Finances can only be accessed if the system fulfils quality conditions. It motivates the system to improve its performance intrinsically, contrary to externally demanded quality improvement initiatives.

SF surely is not a new concept in public health as such. The Bamako Initiative in its origin was essentially a strategy to boost community participation and to give voice to people. By paying for the care, people would have the right to influence the content of the package of care and the way this package would be delivered.

RBF as one of the building blocks for a rationalized health system (see chapter 3.1: Theory of Change) is but one example of how health financing mechanisms can discourage irrationalities in the functioning of the system. RBF is not just rendering the subsidized health facilities more viable but can stimulate health facilities to i) lower direct fees for patients (ex PNFP project), ii) introduce flat fees[9] where possible, iii) render health facilities more responsible for their own financial resources and management, etc. Universal health insurance is another strategic financing mechanism that may provide incentives towards a more rational health system.

2.2.2 System improvement

A health system strengthening approach means that the overall objective of the intervention(s) of the Belgian cooperation is to reinforce the performance of the entire system, not just to solve local problems. The Belgian interventions in the health sector aim for structural change in the system in such a way that health care facilities and support services like the District Health Office and the MoH work more effectively together and the internal functioning of each of those structures has significantly improved.

This means that the intervention aims at strategically strengthening structures at different levels of the health sector. Although it is impossible to cover the whole country geographically (see further) and not all structures within the sector will benefit from the intervention's support, it is feasible to contribute to strengthening the entire health system by improving specific essential structures in the system. Through lessons learned that are taken up by the health authorities dissemination of the strategy over the wider territory can be assured. The present intervention precisely aims at installing reform models (essentially on strategic financing mechanisms) that are sufficiently matured (experienced) for the health authorities to roll out for the country.

In order to reach this objective, the present programme will intervene at the 3 organisational-administrative levels of the health system and will cover essentially the 3 major dimensions that each organisational level needs to cover.

2.2.3 Three dimensions of capacity building at each level of the health care sector

At each level of the health sector, specific attention should go to the different aspects of health performance. Three dimensions, which are intrinsically linked, will be considered in particular:

For the **administrative and financial management aspects**, the organising bodies should be strengthened. Without a good management, support, supervision, control, appropriate monitoring and evaluation, planning and overall vision on the system at each organisational level, health facilities won't function properly. It encompasses financial support and control (auditing), but also HRH and asset management, priority setting, norms application, interpretation and contextualization (when needed).

[9] Flat fees instead of paying by act are known to be an important measure against commercialising health services by trying to increase (personal) income through over-prescription of drugs and médical diagnostics.

Quality of care is multidimensional and can be considered from a health services perspective (technical medical quality) or from a population-patients' perspective (perceived quality)[10]. Organisational aspects do influence quality of care, but also financial constraints, individual clinical capacity, drug procurement, the presence of a referral (evacuation) system, etc. Improving quality of care needs addressing problems at all 3 organisational- administrative levels. The promotion of patient centred care will be key for the promotion of gender equality and improving access of vulnerable populations to health services, and more particularly in the field of SRHR and HIV/AIDS This intervention pays special attention to women's and other vulnerable groups' care and the RBF incentives will strategically favour these aspects of the health care delivery (see further).

The **HR development** is another dimension when it comes to system capacity strengthening. This means more than just training individuals. It means also looking at the size of manpower (not too many, not too little number of personal according to the workload) and, looking at their (intrinsic and extrinsic) motivation determinants, including incentive structures (positive or negative). The gender aspects in HR management will also be addressed. An important point of discussion in the HRH management in Uganda is the point that HRH needs are defined in the Ugandan health system according to norms for each type of facility, instead of workload. Staff shortages therefore are sometimes claimed in settings where the workload for the existing staff is already very low.

2.3 A coherent Programme approach

All interventions of the Belgian cooperation in the health sector work together in a complementary and synergetic manner with the general objective of strengthening the national health system. Different interventions of the Belgian cooperation in the field of health are not regarded as independent interventions with separate and very specific objectives and results, but rather as different entry points to reinforce the national system. The same is true for the coordination and collaboration with other donor interventions. The international Programme coordinator will support the Belgian embassy in its efforts to coordinate the donor community.

The following aspects are crucial for a programmatic approach:

2.3.1 Building on the achievements and existing dynamics of ICB II, PNFP and SDHR projects

SPHU will build on the achievements and dynamics of the ICB I, PNFP and ICB II project. Some initiatives started already in the ICB I intervention are still continued in the new programme. The regional coordination meetings, the emergency evacuation (ambulance) system, the leadership and management courses are but some of the promising results within ICB I that was supported by the ICB II and PNFP project and will be further consolidated under SPHU. These aspects are described in more details in chapter 3.

2.3.1.1 Timing:

The SPHU project will have a life-time of 2 years of implementation and will end around the same time as the other interventions in order to enable to a maximum the synergistic aspects between the interventions. This will allow also for a more global and coherent planning for eventual future interventions in the sector.

2.3.1.2 Synergies and complementary activities:

Potential synergies and complementary actions with PNFP and ICB II are obvious and are rendered explicit in the table in annex 7.3.

[10] A technically correct prescription of drugs might be inacceptable for a patient because no injections are included. Another patient might be very satisfied with antibiotics whilst he might not need them.

2.3.1.3 Geographical scope:

The SPHU programme will intervene in the same geographical settings as the other interventions, namely in West Nile and Rwenzori regions. The budget does not allow however for covering all the eligible health facilities to benefit from RBF support through this intervention. Moreover, the experience of ICB II and PNFP intervening in all districts at the time shows enormous operational (logistic) constraints. SPHU programme will try to concentrate RBF support to those health facilities where ICB II and PNFP are already predominantly present.

If possible, implementing RBF covering a complete district would be very beneficial to complete the model that MoH with the support of the Belgian cooperation. It would for instance allow estimating more correctly recurrent costs and workload for the districts and the verification teams and would allow determining more precise norms for timely reporting and transmitting invoices.

2.3.1.4 Coordination and sharing competences

For the different interventions to maximise their potential synergies and complementary functions, a strong technical coordination and the sharing of available technical competences is necessary.

Therefore:

- The International Technical Assistant (ITA) responsible for the global Programme will also be responsible for the technical coordination of all existing interventions in the health sector. His profile is defined according to these particular duties. This implies that regular technical exchange meetings and joint planning meetings are organised. Strong coordination does not mean that individual interventions lose their autonomy of decision. It implies a hierarchical relation between the different international experts in place.
- There will be only one Steering Committee for the whole Programme. The different interventions will still successively report to the Steering Committee during the same meeting but difficulties and successes will be considered as programmatic, not individual.
- The existing National Technical Assistant (NTA) functions will be maintained. Although they might be paid on different budget lines of different interventions, they will be considered as collaborators in 1 Programme.
- All administrative staff is considered Programme staff and hence shared between the intervention units.

2.3.1.5 Joint evaluation

The evaluation of the 2 projects will be coordinated and integrated in one single exercise as much as possible. As Programme team members are pooling their expertise and are working intensively together, they will be collectively responsible for overall achievements of the Programme. In practice, the mid-term evaluation of the SPHU programme will be the occasion to realise the final evaluation of ICB II and PNFP project.

2.3.1.6 Support to Beneficiary Institutes for the Skills Development of their Human Resources (SDHR)

Capacity building needs should be addressed preferably by the SDHR project on demand or indication from the technical sector interventions (see table under annex 7.7). The SDHR project should be supported to identify opportunities, quality of existing courses and orientations on pertinence.

2.3.2 Complementarity and synergies with other Development Partners

The Programme staff will participate in technical working groups which concern their fields of interest and in other technical meetings in collaboration with other HDPs. Opportunities to exchange information and to build collaboration with other HDPs will be actively looked for. Without being

exhaustive, RBF, the PNFP approach and regional coordination & management are subjects that should be shared with other HDPs because their interest is already established.

Establishing a basket fund is another opportunity to contribute to a joint vision with other HDPs. The WB and MoH have expressed interest and recognise the need for a RBF basket fund in order to enable the Ministry to roll-out the initiative gradually in the whole country. Although necessary in a testing situation as for now, the project approach with its relatively heavy management structures will be quickly becoming counterproductive when the RBF Programme goes nation-wide. In a roll-out phase, MoH would have to deal with too many individual projects at a time.

Especially the WB is interested already in RBF and is ready to help the MoH to roll out the Programme in 60 out of 105 districts. SIDA would be co-financing this intervention. It is hoped that other donors will follow the example. The Programme will definitely keep the discussion among donor agencies going.

WB evoked also the potential of this initiative to evolve towards a NHIS, which represents a more comprehensive financing system than RBF. The Programme will follow discussions and eventual initiatives closely.

JICA is providing equipment to RRHs. This will contribute to strengthening the regional referral network.

Finally, in order to fulfil the commitments towards the Compact, a Partnership funding with the HDPs will be set-up. BTC has been asked to financially contribute to this fund as well as to manage it.

2.4 The strategic advantages of RBF

2.4.1 Transparency and other preconditions

As for the PNFP facilities, public facilities will have to go through a certification and accreditation system to be eligible for RBF support. For HCs, this implies that they have to be part of a coverage plan, that they have the basic infrastructure, the minimal staff and the necessary equipment for them to function correctly. They must show that they have a sufficient initial stock of medicines and the management tools and forms in place to deliver good quality. The intervention has a limited fund to support the facilities in fulfilling these preconditions.

To fulfil the preconditions for funding, HC IV and hospitals will need to develop a business plan for the facility, allowing for the rational use of the RBF income; this plan includes:

- a long-term vision for the facility (with a clear definition of mandate / role of the institution, including the scope of cure and care), in line with the district coverage plans
- a HR development plan calculating stating the workload and division of labour (‘who does what’) within the different departments, the communication flows (e.g. between lab services and wards, between admin and wards, organisation of doctors’ rounds, etc.) as well as a definition of a general HR management system
- a proper stock management system for the pharmacy and the laboratory needs
- A transparent, analytical and performant accounting system, allowing planning for recurrent costs and investments in short and longer time perspective.

The hospitals should demonstrate to have the proper physical conditions, equipment and skilled staff for the departments for which they might be financially supported through RBF. The programme will technically support the individual facilities to develop these business plans and has a limited fund to support facilities in their initial needs for equipment and assets. It also will invest in disseminating the experiences and advantages of having these plans for the MoH, district authorities and PNFP institutions to profit maximally of this experience as well.

2.4.2 Strengthening the referral system

The support to the ambulance services that was introduced by the ICB I project will be discussed further. It might be that the viability of this life-saving activity will be covered through the RBF support to the districts, but these detailed calculations are not available at this moment and will depend on the decision and experiences of the district. RBF fees for referred pregnant women however do take already the costs of emergency evacuations in account.

The referral system does not only cover emergencies though. Cold referrals need to be properly guided, non-referred patients should in principle not be treated at higher levels and fee-paying systems should financially discourage patients of doing so. Cold referrals are part of quality of care. Patients should be sent timely to higher levels of care, on the other hand false positive referrals (especially in urban areas under pressure of patients who 'want to see the doctor') also exist and should be avoided. Much of irrational allocation of funds (efficiency in the system) is due to a weakly performing referral system. The relation with the RBF is obvious. RBF will not pay the HC IV and referral hospitals for their primary care activities. These activities should be oriented towards urban HCs which can deliver this care more efficiently. It would decongest overburdened hospitals and would rationalise referrals to much occupied doctors. The programme can support the concerned hospitals to look into local solutions, for instance by separating the primary care wing from the hospital activities or by creating a close-by HC. The latter is the preferred option but needs usually more initial investments.

RBF will not pay for non-referred patients at the hospital (or HC IV) neither. Outpatient department patients and inpatients should normally be referred when consulting at hospital level. Road Traffic Accidents and medical emergencies are the exception. Patients that consult directly the hospital should be paying. This rational approach will need discussions at central level and good communication within the population before it can be introduced.

The preparatory phase will last 1 year. Meanwhile, every hospital and HC IV can benefit from a fixed amount to invest in equipment and consumables in order to provide the correct conditions for RBF to be introduced.

2.4.3 National drug supply system

The drug supply system for public facilities is centralised and highly standardized in Uganda. The disadvantage of such a system is that the supplies do not always correspond to the needs (quantitatively or concerning the type of drugs). At this moment health facilities are not allowed to buy drugs even if they would be in need and would have the necessary resources to do so. This makes it difficult, especially for highly frequented facilities where deficits are the most important, to have adequate drug stocks and to increase their performance. An adequate and needs responsive drug supply system is also key for the improvement of the SRHR and HIV/AIDS indicators.

Consultations without delivering the care can hardly be accounted for as quality care as required under RBF. The programme will negotiate possible approaches to improve this situation.

2.4.4 The new role of MoH under RBF regime

The MoH takes new responsibilities when adopting a RBF strategy. Financing of health facilities becomes more equitable (bigger units get more resources), but demands a controlling role from the MoH. MoH will have the final check of the invoices in terms of finances but also verify quality of care before facilities are being paid. The new RBF unit that needs to be established at this level will have to initiate also independent audits. MoH increasingly plays in this a purely regulating and controlling role in terms of financing but also in terms of respect for clinical norms.

RBF will have also repercussions on the way HRH are managed (not norm-based recruitment but based on real workload), new norms and activities are introduced or how particular activities are being

stimulated (activities with higher margins of benefit for the facility are taken up more rigorously). Therefore, not just the RBF unit, but many other departments will be affected as well by the introduction of the RBF strategy.

2.4.5 RBF as one of the building blocks in the perspective of a NHIS

Annex 7.5 describes the general concept of RBF and the long-term vision of the RBF tool to evolve towards a National Trust Fund and a NHIS as was initially proposed in the PNFP project and applied also in the ICB II project. It covers the rational of RBF, it describes the possible perverse effects and the broad set-up of the piloting experience in Uganda. The Belgian cooperation still subscribes this long-term vision although this Programme will not actually contribute in a practical way to universal health insurance. But the WB and MoH picked up this possibility as well and are aware of the advantages. They are willing to invest in developing preliminary ideas on how RBF could evolve towards a national health insurance (NHI). NHI indeed shows the same advantages of RBF as a strategic financing mechanism such as the output-based financing principle, third-party payment, increased transparency, and decentralisation up to health facility level of management decisions.

With a NHIS, the population would be able to contribute financially in an equitable way, protected from catastrophic health expenditure and would boost the viability of the system considerably. The RBF part would remain the subsidy part from the national government, supported by the donor community, to complement the financial efforts of the population. The NHIS could, as an independent body from the MoH, not only act as a complete third party financer of the health facilities, but could also manage the patient's and community complaints for the sector.

The MoH adopted a national RBF framework and the necessary contracting and monitoring tools for RBF implementation. The Belgian cooperation was an important partner in this achievement and PNFP and ICB II projects are actually applying the tools under field conditions. This will allow for fine-tuning of the procedures and the tools related to them. With the additional support of the present SPHU programme, this will result in a mature model, ready to be rolled out.

2.5 Complementary fields of interest

2.5.1 Regional coordination

Regional coordination is one of the promising initiatives of the Belgian cooperation already since ICB I. The initiative of regional coordination is continuing and has enlarged even by involving other local stakeholders such as LG and CSO in the coordination efforts. The regional Joint Review Meetings that were established on the initiative of MoH, were supported by PNFP and ICB II and will be continued.

The SPHU programme will continue accompanying the MoH in the development of the vision and its operationalisation of a regional coordination. The RBF strategy foresees a regional verification level that in future should be embedded in more formal structures.

2.5.2 A functional emergency evacuation system (integrated in a more comprehensive referral system)

ICB II and PNFP projects invested already in an emergency evacuation system. Ambulances were provided, communication systems were established between lower level HCs and HC IV and hospitals and several experiences with cost-containing measures are underway. Correctly so, MoH considers emergency evacuation as an important part of the health care system and showed a lot of interest in the ongoing experience.

The Programme will continue investing in and monitoring of the ambulance system which will feed the reflection on the organisation of the referrals from general hospitals to regional or national hospitals. The programme will in particular have to concentrate on how to render the system sustainable. Local experiences need endorsement through a national policy. The Programme will invest in conceptualisation, organise broad consultation and workshops and finally will help the ministry to come up with a nation-wide policy. The organisation of an operational and sustainable referral system is key for the reduction of maternal mortality and morbidity.

The referral system does not only cover emergencies though. Cold referrals[11] need to be properly guided, non-referred patients should in principle not be treated at higher levels and fee-paying systems should financially discourage patients of doing so. Cold referrals are part of quality of care. Patients should be sent timely to higher levels of care, on the other hand false positive referrals (especially in urban areas under pressure of patients who 'want to see the doctor') also exist and should be avoided. Much of irrational allocation of funds (efficiency in the system) is due to a weakly performing referral system. The relation with the RBF is obvious. RBF will strengthen the referral system by stimulating the referral consultations at HC IV and Hospital level. RBF fees for referred pregnant women take already the costs of emergency evacuations in account.

2.5.3 Coverage plans

Coverage plans are an important tool for health service planning and organisation. PNFP and ICB II are about to finish the plans which are very important to make decisions on which HC II should be upgraded to HC III and which HC IV should be upgraded with surgery and other hospital services. This will serve the RBF scheme to make decisions on which facility to support to work towards an accreditation, hence an enrolment into the RBF financing. The coverage plans will be part of the policy dialogue with the MoH and all DP in order to rationalise the location of new health facilities, to objectify the need for new health personnel or its reallocation, and to calculate the practical and theoretical workload of each health facility and even individual cadre.

2.5.4 Revising the packages of health care in line with needs of vulnerable groups

This programme will work on quality of care and will revisit the respective roles of HC and general hospitals in order to come up with a more optimal division of labour between the facilities, regulated by a rational referral system.

But there exist also gaps in the health care system, e.g. important health care needs that are not addressed by either health facility close-enough to the population. They are important in several domains and the ICB project thinks of piloting low-cost initiatives in:

- Integration of epilepsy and schizophrenia in the health care packages of HC II and III and in general hospitals. Complementarity between the 2 levels is key. International experiences in

[11] Patients transferred from a lower to a higher level for advise, further investigation and/or treatment without this being an emergency

Africa show that at very low cost, such chronic patients can be dealt with close to the community. Interested district will be allowed to pilot.

- Integration of HIV care at HC II and III. Although this type of care is officially provided, many HC are under-performing in this matter. An effective integration into other activities is another important challenge.
- Integration of family planning (FP) services in the curative care, under-fives clinics and antenatal care sessions. Most HC do provide FP services, but have a rather passive approach to the matter and simply respond to explicit demand. It is known that soliciting women actively does provoke an otherwise unexpressed demand for such services.
- Basic ophthalmological care and specifically the provision of glasses is a highly neglected area in many health care settings. Nevertheless, WHO correctly indicates that the provision of glasses for instance for children is one of the most cost-effective health acts in the world. It is cheap, provides quality of life and simply the ability to function in society for another 50 to 70 years. One general hospital per region will be chosen to pilot such an ophthalmological workshop.

2.6 Guiding principles for implementation

The following guiding principles will be respected for the implementation of the programme:

- The programme will align entirely with the long term strategic vision for the health sector as laid out in the NDP II and the NHP II, whereby particular attention will be given to gender and human rights.
- The programme will support the implementation of the HSDP 2015/16 - 2019/20. Hereby specific attention is given to the achievement of the health related SDGs.
- The programme will be implemented according to the principles as laid down in the Memorandum of Understanding (MoU) signed by the GoU and HDPs in 2005.
- The programme will aim at concentrating the support to specific (sub)districts as much as possible in order to have a coherent approach and to come up sufficient evidence regarding the changes related to RBF in the HSDs and in the health facilities (both public and private) supported.
- The programme will be fully integrated into the planning procedures of the facilities or institutions that will be supported. No specific programme activities will be planned for. The programme will stimulate targeted facilities and institutions to integrate in their year plans activities eligible for programme financing. Only under this condition, the programme will intervene and support initiatives. The programme's year plans will be extracted from the plans of the respective institutions that will be supported that year.
- The programme will build synergies with other initiatives in the field of capacity building and health system strengthening initiatives in the country. It will develop a programmatic approach in synergy with the existing Belgian health interventions (ICB II and PNFP).
- The programme will draw on existing capacities, initiatives and structures as much as possible, as well as learning from best practices elsewhere, regionally and internationally.
- The programme will be implemented through a highly collaborative arrangement.
- Collaboration with universities and other training institutions will be developed.

2.7 Monitoring and evaluation

2.7.1 'Realistic evaluation theory' approach

The type of support of the Belgian cooperation to the MoH is one of systemic strengthening and support to development processes. This implies the capacities of continuous analysis of a situation based on visions / models and policies. Those evolve and are adapted on the base of lessons learned through their operationalization.

Figure 5 shows how a complex situation like a health system can evolve from an initial situation to a more favourable situation. The development pathway is in the first place influenced by a broader and more powerful context, that can act positively on change efforts, but can also show to be resistant to change.

For the MoH to pass from an initial situation to a desired change, there is need to develop a vision in the first place. The vision, translated in a concrete model in which all elements or structures in the system get specific roles and conditions and translated in a change mechanism (e.g. RBF), will guide and orient the change pathway or process.

Figure 5: The Realistic Evaluation – Action Research approach for institutional capacity building

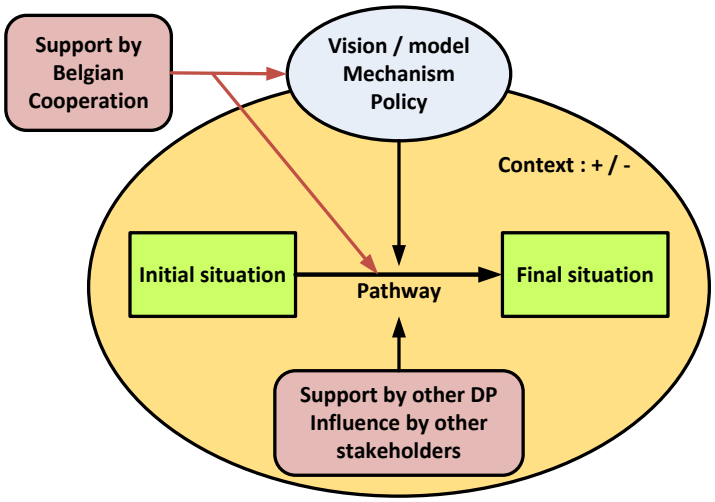


Figure 5 also shows the 2 levels of intervention for the Belgian cooperation and the Programme in particular. The Programme will support the MoH to develop its vision concerning several strategic aspects in the health system. Concrete examples are RBF, the emergency evacuation system, the regional coordination. For each of those strategic topics a vision needs to be developed and constantly refined as experience grows and new information emerges from the field experience.

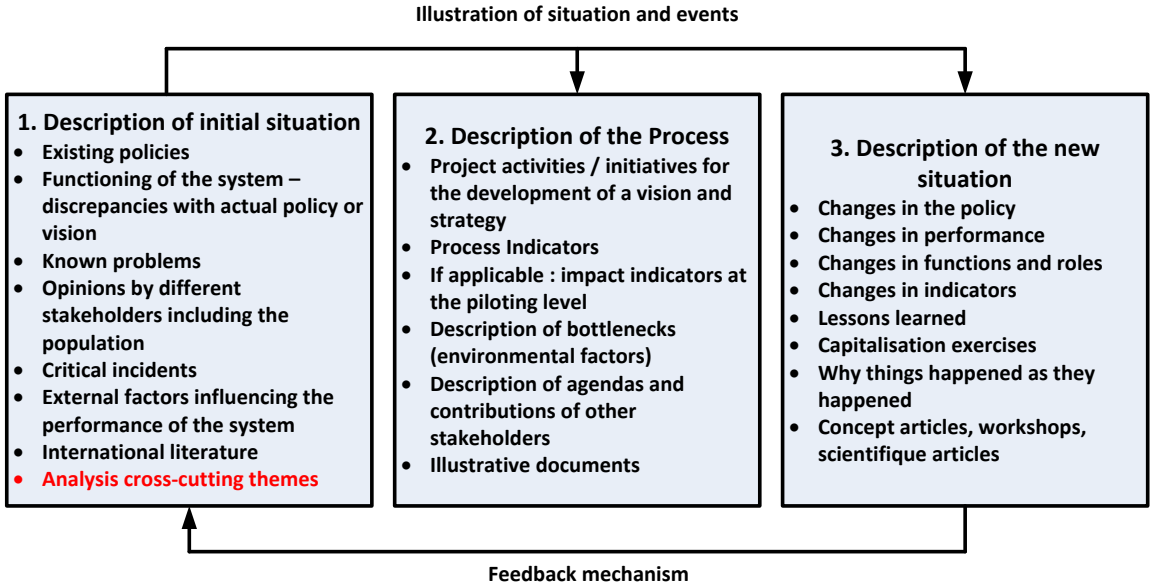
A second level of support to the MoH is the implementation of new initiatives, often on a limited scale (piloting), in order for the Ministry to gain experience in the matter. Illustrated experience (see further link with M&E) will help the ministry to understand the mechanisms of progress or defeat and to subsequently adjust its policy where needed.

2.7.2 Monitoring

The monitoring of change in complex systems demands a systematic documentation of a complex (and changing) situation, documentation of efforts, of initial working hypotheses based on the vision and strategy defined by MoH. This is illustrated by Figure 6.

As the SPHU component of the Programme is completely in line with the other 2 components (PNFP and ICB II) the Programme will, beside some exceptions, not follow different indicators than what PNFP and ICB II are already using. At the start of the programme the existing indicators will be valued as the starting point for the SPHU part of the Programme. ICB II invested already in describing situations on various specific subjects – including the crosscutting issues - on which the Programme as a whole will intervene further and have an impact. This initial documentation can be completed later during the Programme lifespan when new information pops up (Figure 6, box ***1***).

Figure 6: Systematic monitoring of changes in a complex system



All decisions, monitoring of indicators and observations (critical incidents) need to be illustrated systematically when events occur (Figure 6, box ***2***). This second data-base allows all stakeholders of the Programme to follow decisions, institutional and organisational evolutions on several strategic topics (points of interest) for the Programme. The description of the processes and efforts delivered by the programme are at this stage more important than the hard results or impact that the Programme aims to support. Concrete results or highly unpredictable in the short period because they depend on many other factors than the isolated actions of a project (Figure 5).

Yearly internal evaluations (reflexion on efforts and intermediary results, qualitative and quantitative process indicators) and MTR / ETR allow balancing the programme's efforts with its goals (objectives). This is represented in Figure 6. Such reflexions will allow feedback to previous stages of reflexion and action, creating an iterative process of action and reflection (action research). Obviously, this approach also applies for giving more visibility and improving the impact of the crosscutting issues, which often tend to "disappear" as they are integrated in the various aspects of the project set-up.

2.7.3 Identification of Strategic Topics for the Programme

The present document already highlighted several strategic topics for ICB II, derived directly from the important achievements of ICB I that need continuation of efforts and from the specific objective and results of the project proposal. They are summarized in Table 3.

Other topics can pop-up during the lifespan of the programme as opportunities or new MoH initiatives or policies that need programme attention. These constitute new broad opportunities for the intervention. New topics need to go through the same process of describing a baseline, a vision (model), qualitative and quantitative process indicators, etc.

Obviously a priority will have to be decided in the documentation process so as to give feasible targets.

At this stage, PBF, creation of a regional health zone, referral system with ambulance service, coverage plans, human resource management and planning (Local, national) appear particularly important. However, this may evolve and review by the programme team.

Table 3: Topics of particular attention for the programme[12]

Topics identified in this TFF	
• Performance based financing • Universal health insurance • Referral system general • Referral system – ambulance service • Coverage plans • Free health care and drug availability • Human resource management and planning (Local, national) • Continuous training organisation • Role of DHO • Creation of regional health zones	• Role of HC IV • HIV care decentralisation and global performance • Chronic patient care (?) • Integration of mental health care • Reproductive health and family planning organisation and performance • Quality of care • Hospital business plans • Patient-centred care (?) • Improved understanding and application of a gender and human rights based approach to health

[12] (?) = not sure that the project will influence but may have insufficient opportunities to consider the theme as a topic of special attention with formal capitalisation.

2.7.4 Realistic evaluation[13]

The monitoring system of the programme has been described before. The proposal is based on the realistic evaluation theory in complex environments. The difference with more traditional intervention evaluations is that the consequences of complexity are taken into account:

- Programmes are part of the system. It may influence indirectly system's performance. System's effectiveness should be assessed mainly through its capacity of adaptation to achieve relevant outputs. Capacity to take relevant decision and adapt it after ongoing monitoring should be therefore at the centre of performance evaluation
- Targets are difficult to identify because there is much uncertainty on how far progress can be achieved.
- The coherence in decision-making and the process are more important than the concrete (temporary) results. Therefore, illustration of processes, contributions and decisions are important to describe and understand.
- Quantitative indicators are important but qualitative descriptions have equal value (not everything can be measured, what is measured is not necessarily true or objective)

In this context, evaluations should concentrate more on how decisions led to or contributed to change and why progress was made (or not). Understanding is more important than judging. Recommendations should deal with what has been learned and what new decisions might further improve given situations. New strategic points of attention or opportunities for further systemic improvements should be indicated.

2.8 Sustainability

Sustainability is the final responsibility of the partner country, and in this Programme the MoH is responsible to maintain achievements, to make sure that dissemination of experiences in the field is realised and that financing remains accurate in a changing environment. At this point in time, RBF is not yet sustainable.

Sustainability should be regarded as a process to which all partners should contribute. As said earlier, MoH has in this a major responsibility. It gave already several signs for taking RBF serious:

- MoH signed a loan agreement of 150 million with WB to invest essentially in the RBF approach
- MoH is eager to create a RBF unit at central level that not only will be responsible for the overall financial management but that will also assure the correct articulation between RBF and other aspects of care delivery that will be affected through RBF and eventually corrected. In that respect, MoH showed for example already its willingness to give authority to public health facilities to buy additional drugs from the RBF resources. This is a new approach compared to the existing routine of drug supply in the country.

By the end of the intervention, the Programme will have contributed to the sustainability by delivering certain products to the MoH with regard to PBF:

- The Programme will be able to present a viable and rational RBF model for the country.
- The Programme will have reinforced capacities at both national, district and facility level concerning RBF and related matters. Some training will have taken place in districts outside the 2 intervention regions to prepare MoH for the roll-out of the Programme. Special attention goes to capacitating the MoH and specifically the cadres within the RBF unit.
- The Programme will be finalising (in concertation with MoH and other DPs involved in RBF) the

[13] Pawson and Tilley: "Realistic evaluation", 2003

RBF training modules on behalf of the MoH which can be adopted for use in the rest of the country. The modules will be officially approved by MoH and its HDPs. A minimum number of national trainers will be available at the end of the Programme.

2.9 The development priorities of the Belgian cooperation

Although many of the priority themes of our Ministry of Cooperation were already treated in the earlier paragraphs in chapter 2, it is worthwhile to look closer into some of them in a more explicit manner.

2.9.1 Gender aspects and human rights

Access to quality health care is a fundamental human right and especially women in childbearing age need access to health care to avoid dramatic human suffering like maternal deaths. This programme works specifically on financial access in PNFP and access to quality of care and geographical access for both public and private facilities. RBF is also creating the necessary transparency in fee-paying, which protects patients from misuse and excessive (informal) payments.

Gender aspects are addressed directly by favouring those health activities that directly benefit women and children. More than 60 % of the RBF subsidies go to mother and child health care. Both qualitative and quantitative indicators for which RBF pays are having a positive bias for maternal and child health.

2.9.2 Maternal and child health and family planning

Besides RBF, among the other results the Programme will address, a particular focus will be on i) the national ambulance system which is particularly live saving for pregnant women and ii) the FP services which are widespread in Uganda, at least in the public facilities, but which receive too little attention in practice. Fundable RBF indicators on FP services should motivate the personnel to improve their performance in this respect. For the PNFP institutions, the dialogue on this matter will be continued and even intensified further.

2.9.3 Digitalisation

This intervention is continuing the many digitalisation efforts the PNFP and ICB II are already exerting.

Much preparatory work has been done for developing e-patient files that will increase the administrative and financial management as well as the clinical management in the hospitals. The Ugandan health sector is developing its own software, which takes more time than if external software is bought, but the appropriation will be stronger. By the end of this intervention, selected hospitals, benefitting from the RBF should be running the software. It will improve drug and other supply chain management aspects, automate patient invoices and the accounting system.

The RBF monitoring and verification will be digitalised, reducing tremendously the running costs for RBF. This software will moreover communicate with the DHIS 2 system, which is international software for the health information system. RBF and health information system will mutually benefit from the efforts of the programme. The software development started already under ICB II and will be continued under the present intervention, including the preparation for roll-out to other regions by building capacity at central level and by handing over the software to other donors like WB.

The Programme will actively promote and accompany the roll-out of the DHIS 2 system.

PNFP and ICB II already invested in health coverage mapping. This software application development is in an advanced stage, and will be completed by ICB II. There will be need though for rolling-out the system nation-wide and the tool should be properly used for further planning both at local and at national level. Development of new infrastructure, coverage of certain equipment, coverage on specific Programmes such as family planning, personnel distribution, etc., can all be plotted on the maps and updated on a regular (yearly) basis, coverage indicators calculated automatically, etc. This information

base will be cross matched with the DHIS 2 system, will orient important investments by MoH (new infrastructure and personnel allocation). The programme will facilitate the roll out in the specific intervention areas but will also stimulate training and capacity at central level so that roll out beyond the Programme's intervention borders will be influenced.

2.9.4 Inclusive growth

Massive investment in health, as mentioned earlier, will have an impact on the growth of the health market as well. The coordination and mobilising efforts of the Programme to convince HDPs to join efforts to finance health services will give a major boost to the local economy. Healthy people will also be more productive and increased access to care protects people against catastrophic health expenditure by secondary prevention[14]. Catastrophic expenditure is known to be an important poverty trap in many Low Income Countries.

2.9.5 Environment

The contribution to a better environment will be very specific. It will focus on a more rational use of the ambulance network in the 2 regions, on supporting the introduction of e-patient files in the health facilities (as explained in one of the previous points) as well as on separate of waste in health facilities.

2.9.6 Monitoring of transversal themes

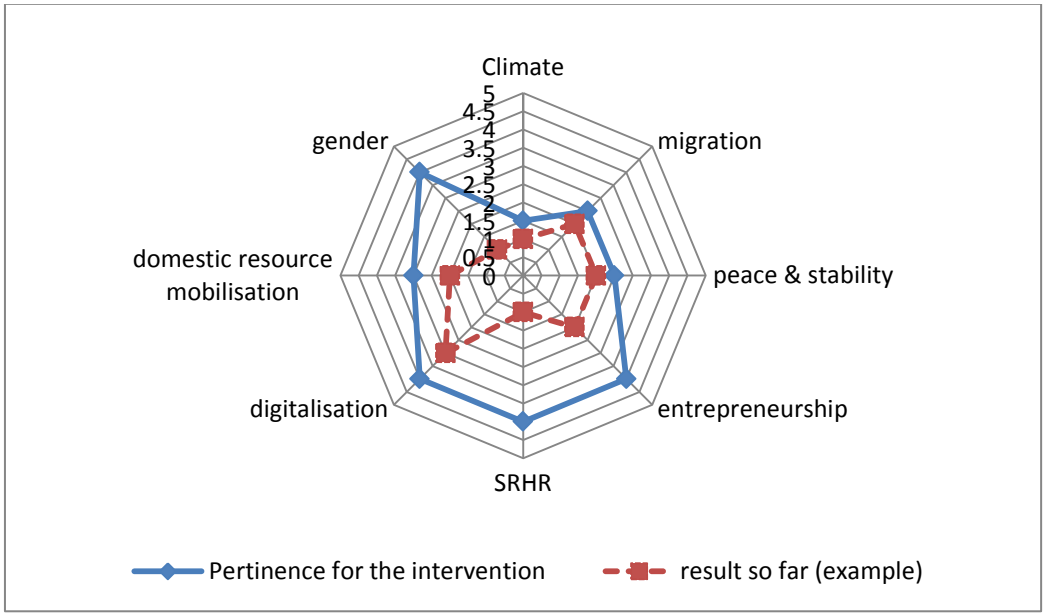


Figure 7: Baseline & expected results for tranversal themes

Figure 7 shows a spider diagram estimating the importance for this Programme of several transversal develoment themes. Each topic mentioned here will be discussed in more detail in chapter 6. Each theme will get the necessary attention, relative at their respective pertinence and will be monitored over time. In principle, at the end of the intervention the result should completely overlap with the pertinence values given to each theme in this TFF.

Although it concerns qualitative data, these pertinence values will be considered as baseline and will be monitored and reported on, on a yearly basis.

[14] Secondary prevention is the prevention of complicated diseases and high patients' expenses through early treatment of illnesses, before complications develop.

3 INTERVENTION FRAMEWORK

3.1 Theory of Change (ToC)

The ToC of this intervention is the same as for the 2 other health interventions of the Belgian cooperation combined. Through RBF as a strategic financing mechanism, fundamental and lasting changes are foreseen to be introduced in the system. Introducing RBF should not only revolutionise the way health services are financed, but should influence a series of other aspects in the system. These changes won't happen spontaneously, but the conditions linked to financing system will stimulate action. There is need for accompanying these initiatives, but their sustainability is better assured because, once change is established, the pressure generated from the health financing conditions to maintain the newly obtained standards will continue to exert its power (see Figure).

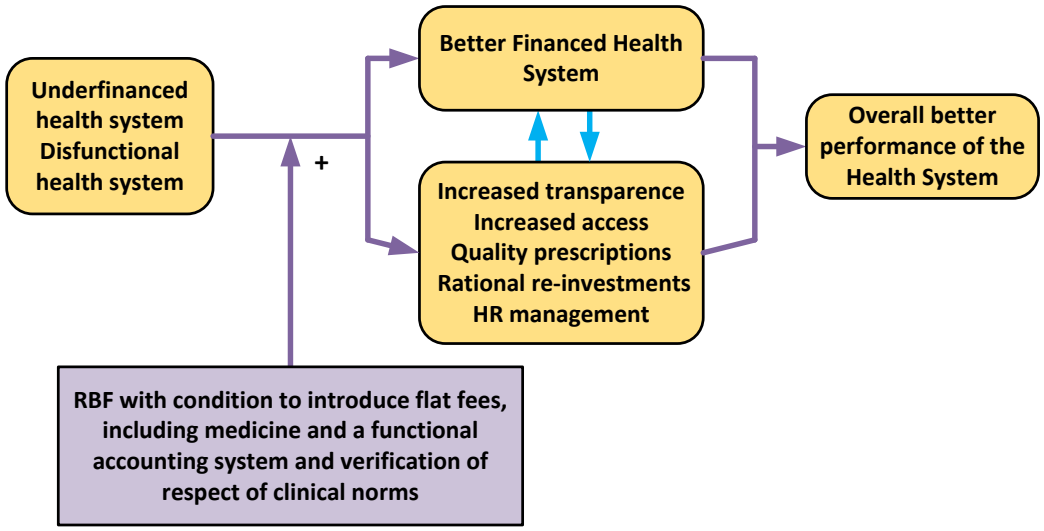


Figure 8: RBF as the motor for systemic change

Fields in which RBF will contribute to lasting solutions are:

° **Quality of care**: RBF should encourage quality of care through a system of valorisation for respect of quality norms. RBF is measuring specific aspects on quality of services and is providing separate financing for these aspects. Poor quality services will not be financed, and salary topping-ups are based on the quality score.

Improving quality of care is not just a matter of goodwill though. Personnel have to have the appropriate capacities and therefore the Programme will invest in training and motivation.

° **Drug supply system**: RBF has already put the existing drug supply system, at least for public services, under pressure. Health facilities are supposed to deliver quality care, including the provision of drugs, whilst they have no say in procuring the necessary drugs. The normal NMS supply continues as it is and RBF funds will be used to purchase medicines (provided they are of good quality[15]) on top of the existing NMS supply. If in future NMS supply will become sufficient and no more additional purchase is needed, the fees can be revised accordingly.

RBF introduction already under ICB II stimulated the dialogue on public health facilities buying their own medicines in contrast with the national procedure which is to send fixed quantities of drugs to each facility. Quantity and quality often mismatch with the real needs at the facility level. RBF makes individual health facilities responsible for the drug availability and therefore supports health facilities

[15] See www.quamed.org

procuring the needed essential drugs through their income, of course taking into account quality criteria[16] for drugs. .

° **Human Resource Management**: HR is actually hired by norms. Every type of facility has its automatic staffing norms irrespective of the workload in the facility. Hospitals or HC IV might indicate lack of medical doctors in a situation where 2 existing doctors each perform on average 5 consultations per day.

RBF is giving salary topping ups to teams, not to individual staff members. Health facilitates therefore would not like to share to big and underutilised team members. The Programme will support the national level of revising the norms for personnel and to define them in the first place through workload.

° **Working and planning through coverage plans and simplified referral rules**: The actual health system in Uganda foresees in theory several levels of referral, from HC II to III to IV to general hospital. This referral system does not function because far too complex (too many levels). RBF does not intend to invest in unnecessary health facilities and therefore the Programme invests in developing coverage plans. Mapping will visualise gaps and overlaps between facilities and will stimulate reflexion on where to invest in new facilities, which facilities need to be upgraded and which ones should not be further developed. Realising that building unnecessary health facilities introduced big systemic inefficiencies for at least 30 years, mapping has a high potential for rationalisation.

According to their pertinence RBF will enrol facilities in the financing scheme or not.

3.2 General objective

Contribute to Universal Health Coverage in Uganda following a Rights Based Approach.

3.3 Specific objective

Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups.

3.4 Expected results and proposed activities

There are 4 results that should contribute to the specific objective of this intervention. Result 1 and 2 will essentially pilot the RBF approach in respectively the HC and hospitals in the 2 regions. Direct support to health care facilities will be offered.

Results 3 and 4 cover important institutional support to the district and MoH authorities and provide an important input to organize the continuous training of health staff in the country.

- R1: The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.
- R2: The equitable access to quality health care at public and PNFP General Hospitals & HC IVs in the regions of West Nile and Rwenzori is strengthened using RBF as an entry-point.
- R3: The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened.
- R4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened.

[16] The technical checklist of Quamed for the purchase of drugs should serve as a guide (www.quamed.org)

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

Justification of the result:

Result 1 focuses on continue to assure RBF financing to selected first line health services (at HC III level) in Rwenzori and West Nile regions. Since the available budget does not allow covering all health facilities in selected districts in the two regions, specific HSDs will be targeted as much as possible for reasons of coherence, in order to demonstrate the functioning of an integrated local health system. The HCs will be selected based on the (digitalised) district health coverage plans developed in the current interventions (ICB II and PNFP). As a consequence, some HC IIIs actually supported may no longer be supported through RBF, and new HC IIIs (including some HC IIs which will be upgraded up to the HC III) might be integrated.

3.4.1.1 Prepare strategically selected first line services (HC III) according to the district coverage plan to meet the accreditation criteria for RBF enrollment

A.1.1 Select HC III on the basis of the district coverage plans

Using the district coverage plans, priority HSDs will as much as possible be identified taking into account equity and objective needs on the one hand and current level of functionality on the other hand. A rational choice of HC III (both public and PNFP) will be made. It concerns already supported HC III or new ones based on important geographical gaps in the coverage plan. The total number of HC III however, cannot exceed the number supported through the current interventions (ICB II and PNFP). District development plans will be updated before the introduction of RBF, particularly in relation to a rational allocation of human resources.

A special attention will be paid to the HCS in an urban environment and /or close to hospitals or HC-IV. Hospitals should outsource primary care activities to urban HCs to reduce their workload and to rationalise scarce resources. The coverage plans in urban environments should be based on the principle that HC should provide primary care with a restricted, personalized team of health workers for a maximum population of 7,000. If the agglomeration contains more population, more HC should be strategically distributed in the city quarters, instead of increasing the size of the centre and the number of health workers per centre. This is necessary for primary care provision that is patient-centred and personalised.

Outreach and mobile clinics can be planned where there is poor access to health facilities in the district. HCs should get the transport means and the organising capacity to plan and execute such outreach visits for preventive care (under-fives, vaccinations, antenatal and postnatal care and family planning.

Possible sub-activities will include:

- Organize a district (HSD) workshop to interpret the coverage plan. Community representatives and civil society should be implicated. Local politicians should understand the choices made for strategic implantation of new HC to avoid sub-optimal sites for new facilities. Training and tutorship to write proposals and bid for local or international financing for strengthening health facilities.
- Organize a district workshop to update district development plans and to explain the principles and decisions, specifically regarding HR
- Organize a workshop for planning outreach activities organised by the HC and develop a communication (community participation) and implementation strategy.

A.1.2 Provide investments for new HC IIIs and for priority needs of already enrolled HC III

Each selected HC III will need coaching to develop or update their health facility business plan. Based on that plan, the programme will, if indicated, finance some basic requirements for health facilities to provide minimum quality of care, with a particular attention to FP, MCH and HIV-related activities.

Possible sub-activities will include:

- Organise a workshop for the selected HC III staff to develop their business plan
- Provide initial (clinical and managerial) training according to identified needs
- Make sure that (all) staff is trained in patient-centred care including components of a gender and human rights approach to health.
- Procure a list of basic material needed, with a particular focus on child and reproductive health care (including contraceptives)

3.4.1.2 Implement the RBF approach at the level of the accredited HC III

This implies a continuation of the activities of the RBF strategy outlined in the current interventions (ICB II and PNFP). A summary of the activities is listed below. More details can be found in the TFF of ICB II and PNFP.

A.1.3 Sign new grant agreements to continue RBF financing

The grant agreements with the districts will be updated based on the lessons of the present agreements and the selection of the HC III to be supported by the RBF system. Funds will be used to cover recurrent costs and investments.

Possible sub-activities will include:

- Reinforce the HC M&E system through quarterly district meetings
- Strengthen capacities for M&E of gender and human rights based approaches to health;
- Finance HC III according to agreed mechanisms

A.1.4 Assure RBF verification and monitoring

The necessary capacities of the district to implement RBF verification and to analyse the results need to be kept at the required level.

Possible sub-activities will include:

- Assure continuous training and mentorship of districts regarding RBF implementation
- Assure a joint analysis at district level of the performance of health facilities enrolled in RBF together with the major stakeholders in relation to health (including civil society and local authorities)
- Install a regular verification system by independent external auditors with regard to the use of RBF funds by the health facilities

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

Justification of the result:

Result 2 will assure the continuity of the RBF for first level referral public and PNFP health facilities (HC IV and general hospital that have been retained in the district coverage plans at an initial stage)

supported by the current interventions (ICB II and PNFP). The pre-conditions[17] to continue to receive RBF funding remain the same: these facilities need to be part of an officially recognised coverage plan, to obtain a score of more than 85% according to the pre-qualification assessment tool, to have a business plan approved by DHO and the SFPH programme according to pre-defined quality norms and a proven sufficient capacity for financial management. This capacity will be jointly assessed by the MoH and the programme. Indicators to measure performance will be equivalent to the ones already adopted by MoH

Important principles of the RBF strategy currently implemented will prevail:

- Financing of health facilities should be according to the needs, i.e. according to quantity of activity.
- In order not to fall into the vicious circle of "increased opportunistic behaviour of provider – increased control of purchaser", a simple fee paying system (flat fee per type of pathology at hospital and flat fee per episode of patient at HC level) should be implemented in the PNFP facilities.
- Employees' incentives should not become too important as to make the basic salary obsolete, and should be based on quality measures rather than on quantitative indicators which are easily 'gamed'.
- Drugs and medical supply procedures (including family planning and ARV) should be improved in order to address the mal-distribution of drugs in health facilities.
- Money from the output financing may be leveraged for customized purchasing of quality essential drugs, other recurrent costs and small investments.

3.4.2.1 Prepare General Hospitals & HC IVs to receive RBF

The support will consolidate the efforts of the current interventions (ICB II and PNFP).

A.2.1 Support priority hospitals and HC-IV to update their business plan

The business plans for each priority hospital and HC-IV will be realized / updated, taking into account the actualized regional coverage plans. It will build on a proper definition of the role of the hospital within the local health care system. Specifically, the primary care services function will have to be separated from the referral functions (through the creation of a separated health centre (type III) close by the general hospital – HC IV. It will include an updated human resources development plan.

Possible sub-activities are:

- Assure necessary coaching to update the business plans
- Evaluate the quality of the updated business plans as one of eligible criteria for RBF

A.2.2 Complete basic requirements for quality of care

Once the health facility business plan has been updated, investment priorities will be defined. The programme will finance the basic requirements for health facilities to provide minimum quality of care and for the facilities to continue the RBF regime under optimal conditions.

Possible sub-activities will include:

- Make a list of basic material needed and purchase it with particular attention to the purchase of X-ray equipment for public General Hospitals (2).

[17] Based on the accreditation and certification process defined by MoH and used for PNFP so far

- Provide continuous (clinical and managerial) training according to identified needs including clinical trainings for ensuring SRH and HIV/AIDS related services as well as patient-centred care. For general management and clinical skills, activities will be implemented in liaison with the "skills for development in human resources project". For RBF implementation, training will be structured according to procedures already established in the current interventions. Drugs and medical supplies management will receive particular attention.
- Assure the functioning of ophthalmological workshops / clinics to provide reading glasses in at least 2 hospitals. Such workshops need 100 m², and an initial investment of 25,000 Euros per unit.

3.4.2.2 Implement the RBF approach at the level of all selected public and PNFP General Hospitals & HC IVs

A.2.3 This implies a continuation of the activities of the RBF strategy outlined in the current interventions (ICB II and PNFP). General hospitals and HC IV that have been identified as a priority through coverage plans, and that fulfil basic conditions, will benefit from RBF. They will use the same procedures and devices developed under the current interventions concerning quality preconditions, training, monitoring, controlling (including verification of the use of the RBF funds by independent external auditors), payments and follow-up of expenses.

More details on sub-activities can be found in the TFF of PNFP and ICBII.

3.4.2.3 Consolidate the implementation of a functional e-patient file system in all selected public and PNFP hospitals & HC IVs

A.2.4. Assure a functional system of e-patient files

Relevant and valid clinical data are a pre-requisite for any RBF system. E-patient files, in which the clinical diagnosis, treatment and clinical management are recorded in individual electronic patient files, provide the potential to generate in an automated manner hospital statistics, invoices, stock management, etc. The current interventions are actually identifying the most appropriated system and will set the requisite and procedures needed to implement e-patient files in (both public and private) general hospitals and HC IVs in Uganda. MoH has much internal capacity in its ICT department to accelerate the installation of e-patient files in public hospitals.

Possible sub-activities will include:

- Monitor the implementation of the e-patient files and assure follow-up of problems
- Train the hospital staff
- Install the hardware and network in case new health facilities are selected

3.4.3 Result 3: The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened

Justification of the result:

Result 3 uses RBF as a leverage for the DHO to further strengthen an integrated district health system (insisting on a rational coverage of health facilities, the complementarity between health facilities, smooth circulation of information / patients between facilities, and absence of functional gaps) and to the quality of health care.

The focus will be on strengthening the capacities of the health districts related to i) RBF verification, ii) supportive supervision, iii) continuous training of the health facilities, iv) district management and leadership, v) user rights. A constructive collaboration between the various actors within the district

concerned by health will be fostered, in line with the recommendations of the Declaration of Dakar (2013) with regard to the development of local health systems.

At a regional level, regional coordination and support to the districts will be further improved. This will be done in collaboration with other actors (HDPs, civil society and political leaders) in order to improve a common understanding of health sector challenges and to avoid the development of counterproductive initiatives. The aim is to better integrate the regional health system and improve quality of care at hospitals (and HC-IV). Expected gains are:

- A strengthened referral system, taking as an entry point the critical incidents met with ambulance evacuations.
- A more cost-effective division of labour (between regional and PNFP hospitals for example).
- A more effective support to quality district care through regional exchanges between specialists and their district peers. Clinical case discussions, support ward rounds, development of clinical guidelines are but some of the opportunities for specialist medical doctors to support their colleagues at district level. Telemedicine will be tested.
- Improved accountability, coordination and interaction between various stakeholders in the health sector (public, private, civil society and other donor funded interventions). Civil society uses to play a key role in holding the authorities accountable for the fulfilment of the right to health, their HIV response and the SRHR. The district gender focal points should also be actively involved.

3.4.3.1 Adjust the annual district plans based on the analysis of the coverage plans in line with the district development plan:

A.3.1 Support the bottom-up planning at district and HSD level

The annual integrated district plans need to be in line with the district coverage plan and the district development plan. The analysis of the RBF performance and the district referral system may already yield some interesting improvement initiatives to be included in the annual plan.

The process should be participative involving the different stakeholders related to health in the district. This also includes representatives from the other sectors in order to assure attention in the development plan is given to the social determinants of health.

Possible sub-activities will include:

- Support the organisation of annual, participative district (and/or HSD) planning workshops

3.4.3.2 Improve the management and quality of care of the health facilities through RBF verification, supportive supervision and in-service training by the DHMT

A.3.2 Assure Quality of care through RBF verification and supportive supervision and continuous training

Regular RBF verification will be done. Moreover, HCs supervision will be strengthened with specific focus on quality of care aspects (including gender and human rights aspects). Supervision will be an occasion to identify needs for continuous training. Continuous training activities will be delivered by the DHO, especially in the following areas of management and public health: drug & medical supplies, team management, business plan, financial planning, costing of services, ICT, maintenance & environment, client-centred care, right to health, FP, Maternal & Neonatal Health, gender, etc.

A selected number of HC will experiment with taking care of epileptic and schizophrenic patients, complete the package of HIV care for that level of care and will experiment with a more integrated delivery of family planning services.

Mentorship activities will be organised at the general hospital and HC IV levels to work on patient-centred care with the HC staff.

Regular meetings with representatives of all health facilities to discuss issues related to the integration of the district will be reinforced. Involvement of political representatives and eventually civil society organizations will be sought for.

Possible sub-activities will include:

- Provide training in supportive supervision
- Assure mentorship & training activities in relation to specific priorities
- Assure availability of clinical guidelines and procedure manuals to cover the whole of the package of care foreseen for a HC III.

A.3.3 Assure specific monitoring of the PNFP Health facilities by the Medical Bureaus and MoH

Although the DHMTs will be responsible for the RBF verification, supportive supervision and continuous training to the health facilities, the Medical Bureaus also have a role in complementary supportive supervision and continuous training specifically in relation to the PNFP health facilities. This can however be done jointly with the public health authorities at the district or higher levels.

Possible sub-activities will include:

- Hold regular (Joint) supportive supervision visits to PNFP health facilities
- Organise complementary/joint continuous training sessions for PNFP health facilities

3.4.3.3 Assure continuous training of Health Facilities by the (general/ regional) hospital staff

A.3.4. Support continuous training by regional hospital specialists

Specialists from regional or PNFP's hospitals will help in specific clinical trainings of clinical staff working in general hospitals and HC IVs for improving quality of health care. These training sessions will come up with clinical guidelines for General Hospital level care.

Possible sub-activities will include:

- Outreaches of regional hospital specialists to general hospital to run joint consultations with general medical doctors.
- Formal training sessions in the context of a national plan for continuous learning for clinical staff
- Development of clinical guidelines
- Teleconferences of RRH specialists with groups of medical doctors from different general hospitals / HC IV.

3.4.3.4 Implement a standardised system of independent Patient Satisfaction Surveys

A.3.5 Set-up a cost-effective, independent strategy for Patient Satisfaction Surveys

From a perspective of patient rights, it is important to systematically have a feedback from the users on the health services. This may also contribute to more patient-centred services. Some initiatives do already exist but are not yet analysed (in terms of feasibility, cost-effectiveness, independency…) nor scaled up.

Possible sub-activities will include:

- Make an inventory of existing initiatives to strengthen the demand-side (feedback of users to health providers,
- Analyse the various options on how to best organize this, at which level, whether there is a link with RBF etc,
- Scale-up up the strategy in the 2 regions

3.4.3.5 Assure a coordinated integrated referral system at district and regional level including a viable ambulance-service

A.3.6 Assure the set-up of a coordinated referral-system with functional ambulance-services at district and regional level

Ambulance systems make referrals possible between HC, general hospitals and RRHs. Over the 2 regions, 32 ambulances with trained staff are managed by the districts. Lessons will be drawn from the current functioning of ambulance-services in each of the 2 regions. Under the leadership of the RRH, the coordination of ambulance-service will be further strengthened in order to improve efficiency of referrals (avoid referrals in places where services are not available). This will include setting duty rosters (between hospitals, or clinical specialists in various hospitals), optimize use of ambulances between districts, and ensure an up-to-date information on available services in the various hospitals in the region. Referrals do not necessarily respect administrative borders and where hospitals are overlapping, night duties are not necessary in every hospital if well-coordinated.

Most districts have implemented community initiatives to cater for fuel. However, sustainability is at stake, particularly for maintenance and buying new vehicles when needed. Innovative financing mechanisms to cover recurrent costs will be tested as well.

Possible sub-activities will include:

- Set up a commission within the regional health forum to monitor this coordination body
- Organize regular meetings and a monitoring system to enable follow-up of the initiatives
- Organize at the emergency service of the regional hospital a coordinating body.
- Organize the reflection at district and/or regional level on existing local initiatives in relation to the maintenance sustainability of the ambulance-service and the responsibility of communities (e.g. experience in Uganda on referral organised using community transport through a voucher-system for maternal care), LGs and health facilities regarding this issue
- Implement in selected districts emergency systems for RTAs and other domestic health disasters in collaboration with Red Cross (volunteer network).

By running the ambulance system, other system weaknesses become apparent. The complementary package of care (availability of blood transfusion services, permanence of functional operating theatres, etc) is often deficient, which renders evacuation little effective. Furthermore, the closest or the most convenient place to refer a patient does not always correspond with the general hospital from the district (sometimes the closest general hospital is not the one of the concerned district).

Moreover, there are functional RRHs with sometimes superposition of functions with PNFP hospitals. For example, in Fort Portal, 3 hospitals (2 PNFP and 1 RRH) with a superposition of functions co-exist.

Possible sub-activities will include:

- Evaluate and discuss the performance and efficiency of the referral network at the regional health forum
- Follow-up the implementation of recommendations

A.3.7 Adapt the national guidelines on the referral system based on the experiences on West-Nile and Rwenzori

Using an action-research approach, lessons will be drawn from the existing referral system in the 2 regions. These need to be documented, conceptualized and scaled-up

Possible sub-activities will include:

- Systematically document the referral system experiences
- Develop a coherent strategy and share it with the national level
- Elaborate (at central level) a policy specifically on how to finance the ambulance-service (using domestic resources) and how to monitor it effectively
- Accompany the process of adapting the national guidelines on referral system

3.4.3.6 Support quarterly and annual regional health reviews in the Rwenzori and West-Nile regions

A.3.8 Reinforce the functioning of the quarterly Regional Fora and regional planning

The Regional Health Forum (RHF) will be further strengthened. It takes place quarterly for 2 days with all the DHO's, the Director of the RRH (chairperson), District LG officials, the Project Coordinator at MoH, the HDPs, (sometimes) experts from resource centres and other senior officers when needed. It discusses issues related to planning, budgeting, leadership, management, quality, M&E, among others. It is at the same time a space for discussion and for training. The coordination of an optimal emergency evacuation system is also a subject of discussion at this level.

Involvement of local politicians and civil society at regional level will be strengthened through the organization of a regional health assembly. Representatives of JMS and NMS as well as training schools may be invited to these meetings because drugs and staff are key-determinants in health service delivery and in RBF. This will allow for a dialogue between health providers and these representatives and may contribute to better govern interdependencies between different actors in the health system.

Once a year a Regional Joint Review Mission will be organised. During this meeting annual priorities for the region can be set based on an analysis of the performance of all districts in the region. This will guide the district annual plans. After the finalisation of the district plans, the region should consolidate these district plans in order to improve coherence and cost-effectiveness of the regional health system. The regional health assembly should ultimately validate the regional plan.

Important is the development of a national policy proposal, based on these experiences to formalise the approach country-wide.

Finally, a lot of data are generated within the region. Besides that, innovative initiatives are taken and several mechanisms of performance monitoring exist. Compiling and analysing these data and initiatives would generate interesting lessons for improving the quality of care and the functioning of the health system. Special attention will be given to MCH, FP, HIV/AIDS, the right to health and gender.

Possible sub-activities will include:

- Support the standardization of the regional review process based on existing experiences
- Produce & disseminate guidelines
- Acquire an office for a more official coordination organ might be delivered (if progress in this respect is substantial)
- Support the organisation of quarterly regional health fora and the 6-monthly regional health assembly

- Invite representatives from JMS, NMS and training schools to the review meetings
- Compile and analyse data at regional level
- Support the production and dissemination of regional reports

3.4.4 Result 4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened

Justification of the result:

This result will align with the existing national RBF framework and primarily focus on supporting the set-up and functioning of a RBF unit (RBF team) within the Budget & Finance division of the Planning Department of MoH. This unit may be composed of additional staff of MoH and mobilisation of existing MoH staff who could contribute to RBF. This RBF Unit is crucial for the sustainability of the assets (such as quality of care, user rights, protection of vulnerable groups, transparent management, strategic purchasing and other efficiency gains) of the RBF experience and for integrating them it into the longer term objective of the Ugandan government to move towards a nation-wide system of inclusive social protection. The Planning Department being also at the heart of the reflection on social protection and strategic financing in general, will facilitate this process. It's obvious that in such debate the collaboration between various MoH departments (particularly between the Planning, Q&A and finance departments) and various Ministries (in particular the MoFPED) will need to be enhanced as well.

To achieve an adequate capitalization of the RBF experience, the capacities of MoH to define and adapt policies according to lessons learned from the field and adapted to the field conditions will be strengthened. This is the exact conceptual work a ministry should be doing to regulate the sector. To facilitate this learning modus, the RBF implementation in the two regions should be approached with an action-research modality, allowing the systematic illustration of hypotheses, implementation, monitoring and adaptation of intermediary results and capitalization. MoH delegates should be visiting the field regularly to better understand the RBF mechanism and contribute to the reflection.

Finally, this result will also strengthen the stewardship role of the MoH, both at regional level (where the MoH should support the coordination amongst the regional actors concerned by health) and national level (where the creation of a Partnership Fund may help to fulfil the Compact commitments).

3.4.4.1 Support the setting-up an RBF unit in the Planning department of the MoH

A.4.1 Support the creation of the RBF Unit

The role of the RBF unit will be to i) validate the RBF invoices, ii) conduct counter-verification missions, iii) exploit the data generated through RBF, iv) take the lessons from the current RBF experiences in the regions, v) consolidate RBF tools, vi) contribute to the development of a national approach on RBF, vii) define the package of care, under RBF and viii) prepare a strategy for the nation-wide scale-up of RBF. Moreover, the unit will be involved in the reflection at national level regarding strategic financing and the development of a national model for social protection. This unit will be institutionalised within the MoH. The programme will provide complementary capacity building through training, exchange visits, field visits, consultancies and longer term technical assistance. The needs expressed at the time of formulation are an international RBF/Strategic financing expert and a database manager (which includes competences in data-analysis and M&E.

Possible sub-activities will include:

- Provide equipment & support operation costs
- Ensure coaching for the development of RBF tools and the roll-out of a comprehensive RBF strategy
- Support the institutionalisation of the RBF Unit within the MoH and support the process to assure sustainable domestic financing of the unit

A.4.2 Assure capacity building of the RBF teams

The programme will provide the necessary training and coaching of the RBF team in relation to RBF, strategic purchasing and related topics.

Possible sub-activities will include:

- Organise specific short-term trainings (preferably online)
- Make provisions for exchange visits
- Accompany field visits of staff of the RBF Unit to the regions where RBF is implemented

3.4.4.2 Enhance the capacities of the MoH to utilise the digitalised RBF information system for evidence-based decision making

A.4.3 Support the utilisation of the digitalised RBF information system

This activity involves the training of the RBF focal points to practically use the digitalised RBF system, to make analyses and to disseminate the information.

With the support of an IT expert[18] the digitalised RBF system can be adapted according to needs or upgraded if necessary.

Possible sub-activities will include:

- Provide on-the-job training and coaching on the use of the digitalised RBF information system
- Involve the RBF team in the action-research concerning RBF at the level of the regions
- Support the production and dissemination of the Periodic Performance Reports
- Mobilise the necessary IT-support to maintain/upgrade the system and solve problems
- Develop a user-friendly dashboard with key indicators on RBF

3.4.4.3 Refine the national RBF model based on the pilot experience in Rwenzori and West-Nile in collaboration with stake-holders concerned

A.4.4 Capitalise/consolidate the BTC-MoH experience in Rwenzori & West-Nile

Using an action-research and a Realistic Evaluation approach, the MoH will consolidate the capitalisation process of the RBF experience in the 2 regions with the support of the programme and a scientific guidance team. This is a form of scientific support at regular intervals centred on the major themes of this programme (principally RBF and strategic financing at large, but also the referral system, the regional approach, the integrated district health system involving public and PNFP actors, decentralised treatment of mental health, the ophthalmological workshops, and the coverage plans). This research and capitalisation process implies a collaborative effort between both the actors working on RBF in the regions and the MoH. Due attention will be given to the capitalisation of experiences in gender, SRHR and HIV/AIDS, and user rights.

Furthermore, based on a concept note on the RBF experience in the 2 regions and experiences of other actors and the data generated through the digitalised RBF information system, strategic reflection on the whole approach at national level will be organised at regular intervals at different levels: i) a national RBF steering committee under the leadership of the PS of MoFPED, ii) the health sector budget working group[19] under the leadership of the MoH Planning department, iii) an RBF implementation committee[20] at the level of the Planning department , iv) Forum[21] of stakeholders involved in Output financing 1-2/year facilitated by the RBF Unit. This Forum includes as well actors

[18] If required, the BTC framework contract on digitalisation might help to provide the necessary competence

[19] This group may include actors such as MoH, the PFNP bodies, demand-side actors, representatives from the districts/regions, health professionals, public health scientists, BTC, World Bank, other interested DPs, political analysts,…

[20] This committee may include as well the School of Public Health

[21] They already have a what's app group

from the regional and district level. This may boost a dynamic of continuous improvement of the strategy based on the field reality e.g. i) adjust payment of indicators regarding rational drug prescription, ambulance-services/referral system, FP, vulnerable groups (HIV,…); ii) clarify role of the demand-side actors in RBF from a right's perspective; iii) set-up a regional verification system; iv) reflect on systemic constraints (e.g. drug procurement and role of PNFP in that),……

Possible sub-activities will include:

- Facilitate the participation of MoH staff in the action-research process in the regions as an ongoing learning process
- Make an inventory of the successes, challenges, lessons learnt
- Support strategic meetings on RBF with all stake-holders concerned by health financing at regular intervals (regular meetings of the national RBF steering committee)
- Produce a concise, well-argued concept note on RBF based on evidence

3.4.4.4 Contribute to a sustainable, national scale-up of the Ugandan RBF model

A.4.5 Support the dissemination of a sustainable national RBF strategy to all regions

The RBF Unit will prepare a strategy for national scale-up and roll-out of RBF in close consultation with the key-stakeholders. This strategy will be submitted to senior management of MoH for validation.

Possible sub-activities will include:

- Support the preparation of the scaling-up strategy and roll-out
- Communicate the RBF policy and roll-out strategy to the regions through workshops at central and at decentralized level
- Support the set-up a proper national monitoring system for close follow-up in the initial years of implementation.
- Explore the set-up of a RBF pooled fund
- Organise the training of trainers at central level
- Support capacities of RBF teams in the Rwenzori & West-Nile regions specifically

3.4.4.5 Build the capacities of public and PNFP actors in relation to strategic financing

A.4.6 Assure capacity building in relation to strategic financing

RBF is not a goal in itself but fits into a dynamic of health financing reforms, as explained in the national strategic health financing strategy. This strategy foresees a combination of input-financing & output-financing mechanisms and the development of a NHIS. How the different pillars of a social health insurance get conceived and operationalized will have to be reflected upon at the same pace as the RBF model is evolving. In particular, sustainability of RBF or any other health financing strategy[22] requires also a reflection on how to finance these strategies, with an increasing domestic funding as a result. These reflections require the involvement not only of the RBF Unit and Planning Department within MoH but also other Ministries, in particular the MoFPED. The MoH should develop a consistent dialogue with the donor community and will have to come up with a proposal for piloting in the 2 years to come. RBF will have to be experienced at a sufficient scale and for a sufficient period of time before actual transition might be considered. But the preparatory work and reflection on this matter has to start now.

The programme will provide resources to help to prepare the key-actors for this larger reflection.

[22] A comprehensive health financing strategy with roadmap was developed in 2015 but the follow-up of this roadmap needs to be taken up again

Possible sub-activities will include:

- Identify and train on selected topics regarding strategic health financing (such as costing, mobilisation & pooling of resources, accreditation, strategic purchasing, Quality assurance, other health insurance related topics…)
- Support strategic meetings on RBF with all stake-holders concerned on the sustainability issue
- Liaise with the task force on social health insurance within the Planning department of MoH
- Support benchmarking visits / study tours (e.g. Ghana, Belgium, Rwanda…)
- Provide resources for consultancies
- Support the PNFP human capacity of the Medical Boards
- Create an inter-ministerial reflection forum on the matter
- Create communication opportunities with the donor community

3.4.4.6 Strengthen the MoH stewardship through the creation of a Partnership Fund:

A.4.7 Contribute to the Partnership Funding

This Partnership Funding will finance the operational plan related to the Compact commitments at national and regional level. Several HDPs have expressed their interest to support this Fund: USAID, UNPFA, UNICEF, WHO, CDC, SIDA, Belgium through BTC and eventually World Bank.

Possible sub-activities will include:

- Contribute financially to the Partnership Funding
- Coordinate the contribution of HDPs to the SWAp roadmap
- Explore opportunities for pooled funding in future

3.5 Indicators and means of verification

The indicators of this programme will align with the already existing indicators from the 2 current interventions. Its baseline will start where the other interventions will have stopped. The updated baseline values and targets will therefore be determined at the closure of each component. They will be gender-disaggregated where possible.

The indicators (using as much as possible indicators of the national system) will focus on the WHAT. Progress-markers will particularly focus on the HOW.

The baseline figures are mostly drawn from the 2016 Annual Health Sector Performance Review (AHSPR).

3.5.1 Indicators for General Objective

Indicator TFF (with 2016 baseline)	Comments
Maternal Mortality Ratio (336 per 100,000 live birth)	These are the impact indicators from the HSDP 2015/16 – 2019/20. Although the TFF doesn't foresee the monitoring of indicators at impact level, the programme will follow these indicators at 2 levels: national and regional (numbers are too small to monitor at district or facility level)
Neonatal Mortality Rate (27 per 1,000)	
Infant Mortality Rate (43 per 1000)	
Under 5 Mortality rate (64 per 1000)	
Total Fertility Rate (5.4 live births per woman)	
Adolescent Pregnancy Rate (25%)	

3.5.2 Indicators for Specific Objective

SO: Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups		
Indicator	**Baseline value**	**Target Value**
Tested and updated RBF model, accepted by MoH and GoU as the national model, available	0 (Model available but not tested and updated)	1 (Tested and updated model)
% of the national health budget which is output-based	0%	> 25%
Utilisation rate for curative consultation at HC III level (gender-disaggregated)	1.2 (national average)	+20%
Hospitalisation rate for GH and HC IV for supported facilities (gender-disaggregated)[23]	7.2/1000 (national average)	8.0/1000 (= increase with 10%)
Template and directives regarding performance Improvement Plans for hospitals and HC IV are institutionalised at national level	baseline 2016: only for hospitals selected for BTC RBF	Template accepted by MoH to be used in all health facilities in Uganda

3.5.3 Inventory of 'evidence-for-policy notes' (based on action-research) presented to the national level Indicators for results

The indicators for the results are all part of the indicators that will be dealt with in the treatment of strategic topics and the context of a realistic approach as described in chapter 2. In dealing with topics and progress markers, the result indicators are not repeated although they all fit in one or another topic. It is in the context of these strategic topics of influence for the programme that the indicators will be fully relevant.

R1: The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point		
Indicator	**Baseline value**	**Target Value**
HC III obtain a score of at least 4 stars to the Quality of Care Assessment of MoH	To be determined by exhaustive baseline at start of programme	> 75%
Institutional based deliveries according to MoH quality standards in supported HCIII have increased	73%	80%
FP services, including access to modern contraceptives, are integrated and all public HC III provide the service	93 %	100%
HIV/AIDS care and treatment services, including PMTCT, are integrated and functioning conform MoH quality norms in supported HCIII	88% for ART 68% for eMTCT	Minimum 95% for ART 85% for eMTCT

[23] Gender-disagregated information will be developed during the intervention

R2: The equitable access to quality health care at public and private non-for-profit General Hospitals & Health Centres 4 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.		
Indicator	**Baseline value**	**Target Value**
Supported HC IV and General Hospitals obtain a score of at least 4 stars to the Quality of Care Assessment of MoH	To be determined by exhaustive baseline at start of programme	> 85%
Essential drugs out-of-stock during > 1 week for 6 tracer medicines	52 %	< 5 %
Supported HC IVs and general hospitals with a functional e-patient file	0 %	100 %

R3: The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened		
Indicator	**Baseline value**	**Target Value**
% of health facilities with a training plan	To be determined by exhaustive baseline at start of programme	75 %
% of health facilities with a completion of the training plan	To be determined by exhaustive baseline at start of programme	50%
Health facilities receive a support supervision visit at least 3 times per year	To be determined by exhaustive baseline at start of programme	100 %
Number of referred pregnant women using the ambulance system	To be determined by exhaustive baseline	Minimum 20% increase
% of visits to the hospital facilities by the Medical Bureaus completed as per plan on a yearly basis	66%	75 %
The District strategic plans are compliant with the National Health Planning Guidelines in 15 districts	0 districts	15 districts
Reduction of total amount of debt of PNFP HCIV and General Hospitals	Amount at start of programme will be taken as baseline	Reduction with 25%
% of RBF enrolled health institutions with a functional Patient Satisfaction Survey system	0 %	25 %
Regional coordination for ambulance services is functional in the 2 regions	only at district level in supported districts)	100% at regional level
A Regional Joint Review Mission is organised in the 14 the regions before the end of the programme	2	at least 5

Supported health facilities (both public and PNFP) with a gender activity plan	0 %	75 %
R4: The capacity of MoH to steer the implementation of the health financing strategy is strengthened		
Indicator	**Baseline value**	**Target Value**
National RBF Unit institutionalised (in organigram of MoH and financed by the national budget)	0	1
Percentage of Periodic (quarterly) Performance Reports produced by the RBF	To be determined by exhaustive baseline at start of programme	100%
Strategic topics of attention of the programme that have been subject of a national reflection exercise (workshop, reflection paper, policy note) taking into account cross-cutting issues such as gender, HIV and SRHR..	1	At least 5

3.5.4 Progress-markers

Complex situations cannot be captured in a few quantitative indicators. Where indicators rather focus on the WHAT, progress markers rather focus on the HOW, in particular in relation to interesting or strategic topics for sector development as described in chapter 2 under 'Monitoring'. Each pre-identified topic is attributed some (qualitative) progress markers and classical quantitative indicators. Progress markers contribute to the explanation why the principle indicators in the Log frame are moving in a specific direction. They will concentrate on policy notes, quantitative indicators, strategic notes and operational instructions and organization This is already happening in the current interventions and will be continued in this programme. The results of the current interventions at the start of this new programme will serve as a baseline. So no new, specific baseline exercice will be necessary.

Progress markers are not organized by activity, because institutional capacity building is about processes and contribution rather than about attribution, outcome and impact. Several activities, even under different 'results' can contribute to processes and institutional strengthening of policies and policy implementation. The strategic topics of attention of the programme should be regarded as the broad fields that the programme would like to influence. The list is not exhaustive. New opportunities or necessities might pop up during the lifespan of the programme. The same initial assessment and monitoring strategy can be initiated at that moment.

Table 4 : List of strategic topics and their progress markers (QL = quality indicator)

TOPICS OF INTEREST	PROGRESS MARKERS
Performance based financing	• RBF: national policy defined
Universal health insurance	• National Policy and vision written
Referral system general	• Number of hospitals that has dislocated the first line care • Policy on urban HC proposed • DHO training module on referral system available • % of new cases referred from HC to hospital (HC IV) level
Referral system – ambulance service	• Number of evacuations + % of new cases evacuated from HC II and III. • Maternal evacuations per district

TOPICS OF INTEREST	PROGRESS MARKERS
Coverage plans	• 100 % of coverage plans of districts in 2 regions available • National workshop on coverage plan principles held • Coverage plans integrated in national policy on the health district concept
Free health care	• Perverse effects of free health care demonstrated • Vision on alternative financing system written • National medical and drug supply system (including ARV and FP) for public facilities studied and under discussion
Human resource management and planning (Local, national)	• HC IV and GH have a HR development plan based on objective needs of staff (workload estimations) • The MoH has developed staffing norms for GH and HC III and IV based on workload estimates • Norms for HC staffing levels are made dependent from workload and for HC II depending on the upgrading intention according the coverage plan.
Continuous training organisation	• Health personnel in the intervention zones receive a maximum hours of continuous training hours according to accreditation norms • National policy proposal available including functions, quality assurance, M&E and business plan (budgeting) • Clearer and shared vision (among DP) on the HMDC Training centre
Role of DHO	• Role of DHO, division of labour, norms defined and adjusted if needed
Creation of regional health zones	• Official vision developed
Redefined role of HC IV	• Role of HC IV redefined in terms of mandate, management tools, staffing norms and financing mechanisms
Redefined role of HC II	• Policy on long-term vision on HC II: transformation, staffing, mandate
HIV care decentralisation and global performance	• Number of HC III providing HIV care according to norms (RBF-based)
Integration of mental health care / Chronic patient care	• Number of patients (per type) under chronic treatment • Piloting reports
Reproductive health and family planning organisation and performance	• HMIS indicators on FP, C-sections, maternal mortality, blood transfusion, number of deliveries, neonatal reanimation
Quality of care	• Quality of care indicators to be developed by RBF • Hospital hygiene score (cleanliness, maintenance of toilets, needles and blood product treatment, etc.), • maternity care score (drugs and equipment for 0^2 treatment, blood transfusion, general hygiene, reanimation protocols for mother and newborn available as well as the necessary equipment (reanimation masks for adults and babies, emergency drugs, functional theatre for C-sections, etc.)
Hospital business plans	• 75 % of GH and HC IV have a business plan conform quality norms
Patient-centred care	• 75% of clinical and administrative staff at all levels is trained in patient-centred care including gender and human rights aspects

3.6 Description of beneficiaries

MoH is the first beneficiary of this programme, not in financial terms but because this intervention will contribute to the realization of its public health mandate to assure that the population of Uganda has geographical and financial access to quality health care. It is the MoH that is in charge of the intervention.

The most important beneficiary of the programme in terms of financial resources and increased capacity are the health facilities and institutions (health districts and PNFP Medical Bureaus) though, particularly those in rural areas. The financial and technical support will be invested at their level in the first place.

The indirect beneficiaries of this intervention are the rural population and specifically the poorest and most vulnerable. Services will be organized close to their homes (rural HCs and hospitals) in a more affordable manner. Although public health care is free of charge in Uganda, out of pocket payment and other barriers for using the services remain important. Maternal and child care as well as HIV/AIDS patients will be discriminated positively because they can be considered as generally most vulnerable in society, especially concerning health. The population of Western Nile and Rwenzori is estimated at roughly 5.250 million people.

3.7 Risk Analysis

3.7.1 Implementation risks

The programme is complex, especially regarding results 1 and 2 regarding the support of numerous hospitals and HC over a vast territory. The DHO responsible for these institutions have been strengthened significantly over the past years and many have reached the necessary quality to implement the grant agreements signed with BTC. Other DHO will have to fulfil the minimal quality requirements before being eligible for BTC support. DHO that receive support will be monitored closely in order to avoid any fiduciary risk. As the grant agreements work with a maximum budget which can be replenished only if financial justification is accepted from previous expenses, the risk will always be low.

Because the Programme is executed over a vast territory of 2 regions, covering a population of 5 million, 15 Districts, about 35 HSDs, and numerous health facilities scattered all over the territory, the programme will aim at concentrating the support to specific HSDs in order to come with a coherent RBF strategy. I will continue to work with NTA besides the ITA in order to absorb the workload. Two of the NTA will be based in the regions to create proximity.

The ministry and its staff are not yet sufficiently familiar with the new RBF approach despite the efforts already undertaken by the PNFP project. As the RBF is an ambitious innovation on demand of the ministry, timely decision-making is crucial for the programme to keep track. The establishment of a RBF Unit will facilitate this process, stimulate coordination of the donors and will assure that individual interventions and initiatives are absorbed by 1 national approach and policy in the matter.

Implementation risks	Risk Level	Alleviation measure
Specific objecitve: Large scope, MoH understaffed with high competency profiles, vision on RBF underdeveloped	Medium	Support through specific, additional consultancies to increase understanding and capacities in relation to PBF and strategic financing Support the execution through an international administrative and financial officer
Result 1: Support to HC III is scattered over too many districts	Medium	Further concentration within the 2 regions to specific HSDs if possible
Vertical HIV and SRH Programmes limit DHO capacity to develop a sustainable approach.	Medium	Actions to be taken through the policy dialogue with the MoH, the Ugandan AIDS Commission and other HDP as well as with the AIDS Development Partners
Result 2: HC IV and GH do not develop or respect business plans	Low	Specific joint supervision visits MoH and/or Medical Bureaus together with the programme staff Specific consultancies on businessplan development
Result 3: Delays in paying RBF because of administrative rules related to grants	Medium	Take lessons from present grants before signing the new agreements
Political sensitivity to decentralise technical ministries before political consensus	Low	All decisions will be supported by MoH Coordination and information meetings foreseen with local politicians Regional support will remain restricted to technical aspects
Result 4: Political instability within the ministry	Medium	Good relations and regular exchange with senior authorities on the results, added value and challenges within the context of the programme

3.7.2 Management risks

Management risks	Risk Level	Alleviation measure
Specific Objective: Insufficient management capacity within MoH, multitude of stakeholders	Low	Support of International administrative and financial officer
Result 1 Subsidies from RBF are used for other purposes	Low	Specific follow-up of use of funds by DHO and programme staff
Result 2 Subsidies from RBF are used for other purposes	Low	
Result 3 -	-	-
Result 4 Implementation of the commitments of the Compact hampered	Low	Support of the Belgian Embassy for the policuy dialogue

3.7.3 Effectiveness risks

The effectiveness risk for this intervention is considered in general as low. The great majority of the budget will directly reach the health facilities that are obliged to reinvest the additional resources into the system. This will automatically render them more viable. The major limit is the budget, which prevents more health facilities to be supported by RBF in the two regions. Another challenge is also the organisation of the demand-side in order to claim more effectively their rights with regard to with regard to access and quality of care within the RBF framework.

There are also some system's challenges like the free health care, interference of vertical programmes, inadequate maintenance of medical equipment and the national drug supply system that might render the possible impact of the programme on facility performance difficult. Free health care prevents communities' participation and increases hidden payments. The national drug supply system based on fixed amounts of drugs per quarter is not only ineffective because never optimal for a specific health facility, but it also takes away responsibility from health facility managers. They are passive victims of an irrational system. The autonomous status of the national drug stores prevents the MoH to easily take corrective measures. The donor community carries a high responsibility in this matter. These structural problems need careful efforts in the policy dialogue and good donor coordination with technical inputs on alternatives. Time will be needed to overcome such performance barriers and sub-optimal impact on quality of care is never completely avoidable.

Effectiveness risks	Risk Level	Alleviation measure
Result 1 & 2 False reporting on RBF figures	Medium	Ad hoc additional RBF verification Simplify the RBF control mechanism by introducing a flat fee
Drug supply system, vertical programmes and free health care make health facilities dependent from others to improve their performance	Medium	Structure donor coordination and policy dialogue Discuss the problems in national workshops to demonstrate the drawbacks in the system Use PNFP facilities to demonstrate alternatives in terms of (quality) drug supply and user fee policies
Bad maintenance of medical equipment	Medium	Link maintenance to RBF performance
Insufficient medical equipments to assure necessary quality of care	Medium	Synergy with other development partners such as JICA to complement medical equipments in health facilities supported with RBF
Result 1, 2 & 3 Restricted and basically theoretical understanding of gender and human rights based approach to health (deficit at the level of the demand-side)	Medium	Collaboration with national and international gender and right to health experts Development of specific strategies to strengthen the demand-side
Result 3 Insufficient coordination at regional (especially regarding referral system)	Medium	Coordination body at regional level Development of integrated referral framework at regional level Regional health fora and health assembly
Result 4 Insufficient coordination at national level	Medium	Policy dialogue concerning the respect of the commitments as agreed upon in the Compact

3.7.4 Sustainability risks

This Programme intervenes with a long-term vision on social protection and an alternative financing system. Some of the objectives can only find a sustainable solution in 5 to 10 years to come. The programme is very much in line with MoH policy and the president's Programme and therefore has the political commitment. There exist short and medium-term sustainability problems and long-term sustainability problems. Short and medium-term, are the degree of engagement of the MoH in its political willingness to progress in the conception and financing of RBF and the Ministries' ability to unite the donor community around the ideas. The programme definitely will support the ministry in developing this common vision in the technical aspects, but it is the MoH and MoFPED that will have to create the political credibility at national level, also towards the donor community. MoH by itself will

never be able to finance RBF or a universal health insurance system by its own in the short run. The support by the programme will definitely help the ministry to find its way in the many technical and political aspects of these matters.

The donor community has shown interest and the Belgian embassy subscribes the joint efforts to coordinate the donor community and the MoH in these matters. This reflects a joint concern for financial sustainability over a period beyond the strict programme's lifetime. Belgian Embassy and BTC are already making efforts to discuss with other DP the creation of a common fund that would subscribe to RBF. It would represent an important step to sustain the innovations in the longer run.

The gradual introduction of the Programme, the efforts at the level of capacity building for all stakeholders, as well as the institutionalisation, the conceptualisation and scaling-up of RBF should create a technically sound environment for sustaining the Programme's goals beyond the duration of the programme. But MoH will have to show signs of commitment with concrete financial engagements as well. This is not purely new funding. Many national budgets, now still oriented through input-based financing could be gradually reoriented to RBF efforts (output-based financing). It is for the moment too early to be sure how the MoH will be able to tackle these new orientations.

Sustainability risks	**Risk Level**	**Alleviation measure**
Specific Objective: The national government does not fulfil its long-term engagements due to political or economic developments	Low	Donor coordination and policy dialogue
Result 1 & 2 Budget for RBF support too limited in volume and time to demonstrate a coherent RBF experience in the 2 regions	Medium	Focus if possible on specific subdistricts in order to make the support more coherent and more effective Encourage other donors to support RBF Adocacy at the level fo the Ugandan government to increase domestic funding in health and to shift funds from input to output financing mechanisms Work on the pre-conditions to allow preparations for the next PIC to start in order to assure the continuity/consolidation of the RBF programme
Result 3: Fragmented, donor dependent referral framework (with fragmented ambulance network)	Medium	Support by regional and national authorities to validate a comprehensive referral policy note and scale-up Donor coordination at regional level

Result 4: The MoH is not capable to increase domestic funding and to shift from input towards more output funding	Medium	Donor coordination and policy dialogue at the level of MoH and Ministry of Finances Organisation of a (inter)national strategic debate Exchange visits to other settings where that shift has been made
Gap in support of DP to use more the mechanism of output financing	Medium	Advocacy through donor coordination ansd policy dialogue

3.7.5 Fiduciary risks

Fiduciary risks	Risk Level	Alleviation measure
Multiple actors, sometimes in remote areas and outside the MoH, concerned by the programme,	Low	Support of Technical Assistants and Financial Officers at Regional level Payments only after verification of achievement of activities
Misuse of funds, wrong accounting information, false reporting, different user fees for patients	Medium	Strong follow-up by Finance and Technical team at programme level (ITA & RAFI at national level; and regional antennes Control mechanisms (control missions, audit)
High transaction costs	Low	Optimize cost-sharing between programmes
Low capacity of HC III (especially public) in financial management to absorp RBF funds	Medium	Specific financial management trainings Control missions and strong follow up by Finance team at programme level

4 RESOURCES

4.1 Financial resources

4.1.1 Ugandan Contribution

There will be a contribution “in kind” to the Programme(See point 4.2 & 4.3), Among other things, the MoH will provide an office space at the national level for the RBF Unit and the programme team as well as for the regional programme team (in particular in West-Nile).

Apart from that a 25% local contribution to the Programme has been agreed upon during the Special Partner Committee between GoU and the Government of Belgium (April 2017) for sustainability reasons. This contribution can be planned for starting with the annual budget exercise 2018-2019. It preferably will focus on:

- upgrading of selected HCIII, HCIV and General Hospitals in Rwenzori and West-Nile regions (especially in the poorest areas) so they become eligible for RBF
- contributing to the RBF for the newly selected health facilities.
- support to the set-up of the national RBF Unit.

4.1.2 Belgian Contribution

The Belgian contribution amounts to 6,000,000 EUR.

The summary programme budget is provided below. In annex 7.2 the detailed budget is included.

TOTAL BUDGET UGA 16 036 11				**Amount in Euro**	**%**
A		**OS**	**Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups**	**5,282,140**	**88%**
A	*01*		*The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point*	*1,755,000*	*29%*
A	*02*		*The equitable access to quality health care at public and private non-for-profit General Hospitals & Health Centres 4 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.*	*1,746,500*	*29%*
A	*03*		*The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened*	*558,340*	*9%*
A	*04*		*The capacity of MoH to steer the implementation of the health financing strategy is strengthened*	*1,222,300*	*20%*
X	01		**Contingency**	**120,000**	**2%**
Z			**General means**	**597,860**	**10%**
Z	*01*		*Personnel costs*	*353,460*	*6%*
Z	*02*		*Investments*	*70,000*	*1%*
Z	*03*		*Functional costs*	*39,400*	*1%*
Z	*04*		*Audit, monitoring and evaluation*	*135,000*	*2%*
TOTAL				**6,000,000**	**100%**

4.2 Human Resources

The Programme will be implemented in continuity with ICB II and PNFP interventions. The majority of staff positions responsible for the implementation of the programme will remain under contract and will be shared (See table 5) between ICB II, PNFP and SPHU interventions. Their job-descriptions and profiles are already described in the ICB II and PNFP interventions. In this document, only the ToR for the new international long-term staff will be described (See annex7.4).

4.2.1 Overall main positions

Within the MoH Directorate of Planning and Development:

- 1 Programme Change Manager (decision: Director Planning department)
- 1 International Technical Assistant (ITA) with Public Health expertise who will function as the Programme Co-Manager (for more details: See profile in annex 7.4)
- 1 National Technical Assistant (NTA) responsible for policy design and general monitoring and evaluation, in particular for the PNFP part
- Support staff (1 International Administrative & Financial Responsible (RAFI), 1 Financial project controller, 1 financial officer, 1 logistics and procurement officer, 1 administrative assistant, 2 drivers)

For support the RBF Unit in particular:

- 1 ITA, RBF/Strategic Financing expert (for more details: See profile in annex 7.4)
- 1 NTA Database manager

Within the regions (West Nile and Rwenzori):

- 2 NTA per supported region, responsible for supporting the implementation of RBF and of capacity building activities in selected health facilities and districts. One of them in each region will be the regional team-leader.
- 2 administration & finance officers (one per region), under direct supervision of the NTA team leader, however with a functional support and oversight from the RAFI.
- 2 drivers per region

Human resources represent 22.6% of the total budget. The table below summarises the different staff positions funded by the different interventions (ICB II, PNFP, SPHU) and the duration of their contract.

Table 5: Programme Financing Human Resources under BTC contract

Overview of Program financing Human Resources							
Position	**Status**	**Jan18-Jun18**	**Jul18-Dec18**	**Jan19-Jun19**	**Jul19-Dec19**	**Jan20-Feb20**	**Mar-June20**
Programme co-manager	new function	SPHU (30 months)					
ITA Intervention Manager	existing	ICB 2(100%)					
NTA Kampala	existing	PNFP (100%)		SPHU (12 months)			
NTA team leader Rwenzori	existing	PNFP (100%)		SPHU (12 months)			
NTA team leader W. Nile	existing	PNFP (100%)		SPHU (12 months)			
NTA in Rwenzori	existing	ICB 2(100%)		SPHU (12 months)			
NTA in West Nile	existing	ICB 2(100%)		SPHU (12 months)			
Financial Officer Rwenzori	existing	PNFP (100%)		SPHU (13 months)			
Financial Officer W. Nile	existing	PNFP (100%)		SPHU (13 months)			
Driver 1 in Rwenzori	existing	ICB 2(100%)		SPHU (13 months)			
Driver 2 in Rwenzori	existing	PNFP (100%)		SPHU (12 months)			
Driver 1 in West Nile	existing	ICB 2(100%)		SPHU (13 months)			
Driver 2 in West Nile	existing	PNFP (100%)		SPHU (12 months)			
RAFI	existing	ICB 2(50%) PNFP (50%)		SPHU (13 months)			
Financial Controller	existing	ICB 2(50%) PNFP (50%)		SPHU (18 months)			
Financial Officer	existing	ICB 2(50%) PNFP (50%)					
Financial Officer	new	SPHU (24 months)					
Logistic & procurement officer	existing	ICB 2(50%) PNFP (50%)		SPHU (12 months)			
Administrative Assistant	existing	ICB 2(50%) PNFP (50%)		SPHU (12 months)			
Driver 1 Kampala	existing	ICB 2(100%)		SPHU (18 months)			
Driver 2 Kampala	existing	PNFP (100%)		SPHU (12 months)			
ITA RBF/Strategicfinancing expert	new		SPHU (21 months)				
NTA Database manager	new		SPHU (18months)				
[1] Possibly the same person as intervention manager							

Some financial staff (regional financial officers, RAFI) will stay at least 1 month longer as well as the financial controller (6 month longer) in order to assure an appropriate closure of the intervention.

4.2.2 The RBF Unit

Capacity building to the RBF Unit will be provided by the ITA RBC/Strategic financing expert who will work very closely with the MOH RBF team leader, in particular regarding the following tasks:

- Exploit the data generated through RBF
- Exert the national control function regarding the RBF procedure (check invoices, verification control)
- Take the lessons from the current RBF experiences in the regions
- Consolidate RBF tools
- Contribute to the development of a national approach on RBF and the definition of the package of care under RBF
- Support the preparation a strategy for the nation-wide scale-up & dissemination of RBF and

capacity building

- Be involved in the reflection at national level regarding strategic financing and the development of a national model for social protection. Possible sub-activities will include:

There is also a need to have a RBF Data manager in support, to enhance the capacities of the MoH to utilise the digitalised RBF information system for evidence-based decision-making:

- Provide on-the-job training and coaching on the use of the digitalised RBF information system
- Support the RBF team in the action-research concerning RBF at the level of the regions
- Support the production and dissemination of the Periodic Performance Reports
- Mobilise the necessary IT-support to maintain/upgrade the system and solve problems
- Develop a user-friendly dashboard with key indicators on RBF

4.3 Other Resources

4.3.1 Services

This represents 22.3% of the total budget

Belgian contribution (Programme Budget):

- Consultancies represent 3% of the total
- Vehicle maintenance, fuel for car: the new RBF Unit will make use of the existing pool of cars at central level (see table 6)
- Communication costs
- Trainings
- Dialogue
- Partnership Fund

4.3.2 Investments

This represents 9.5 % of the total budget

Belgian contribution (programme Budget):

- Purchase of equipment for the health facilities
- Purchase of equipment needed for the programme team at national and regional level and the RBF Unit

Investments made under PNFP and ICB 2 interventions will be transferred to the SPHU programme.

Table 6: Overview situation of vehicles in current interventions and SPHU

	Year	CURRENT SITUATION		2018	Staff using the car
9		ICB II	PNFP	SPHU	23
Prado Toyota	2010	Project manager MoH Kampala		Project manager MoH Kampala	1
Landcruizer Toyota	2014		Kampala project team	Kampala project team	5/4
Vitara Suzuki	2016	Kampala project team		Kampala project team	
Landcruizer Toyota	2014		PPH unit MoH	PPH unit MoH	2
Vitara Suzuki	2017	Kampala project team		RBF Unit MoH	4
Pick up Toyota	2015	Rwenzori regional projec team		Rwenzori regional projec team	3
Landcruizer Toyota	2014		Rwenzori regional projec tear	Rwenzori regional projec team	
Pick up Toyota	2015	West-Nile regional project team		West-Nile regional project team	3
Landcruizer Toyota	2014		West-Nile regional project te	West-Nile regional project team	

4.3.3 Others

This represents 45.6 % of the total budget

Belgian contribution (programme Budget)

- Support to RBF implementation for public health facilities, DHO and regional coordination development.

In relation to the purchase of drugs in particular, it would boost the quality of the service delivery, if health facilities would be allowed to purchase with RBF funds drugs at JMS, in case of a (threatening) rupture of stock.

5 IMPLEMENTATION MODALITIES

5.1 Contractual Framework and Administrative Responsibilities

The legal Framework of the Programme is governed by:

- the General Agreement between the Belgian Government and the Ugandan Government that was signed on the 23rd of March 1995
- the Indicative Cooperation Programme (2013 – 2016) between the Government of Uganda and the Government of Belgium that was signed on the 5th of April 2012
- The Specific Agreement – of which this TFF is part - signed between the Government of Uganda and the Government of Belgium.

There is a joint administrative responsibility for the execution of this Programme.

The Ugandan party designates the Ministry of Finance, Planning and Economic Development (MOFPED) as the administrative entity responsible for the Programme.

The MOFPED designates the Ministry of Health (MoH) as the responsible entity for the implementation of the intervention.

The Belgian party designates the Directorate General for Development Cooperation and Humanitarian Aid (DGD) represented by the Head of Cooperation at the Embassy of Belgium in Kampala as the Belgian entity responsible for the Belgian contribution.

DGD delegates the fulfilment of its obligations to the Belgian Development Agency (BTC) represented by the BTC Resident Representative in Uganda as the Belgian entity responsible for the implementation and follow-up of the Programme. To that effect an “Implementation Agreement” (CMO) is signed between BTC and the Belgian Government.

5.2 Institutional Anchorage

The institutional anchorage of the Programme remains similar to the ongoing interventions in Health (ICB II and PNFP). The Programme is institutionally anchored in the MoH in the Planning and Development Directorate.

The Programme will continue to have field antennas in West Nile and Rwenzori regions.

5.3 Technical and Financial responsibilities

There is a joint Belgian (BTC) and Ugandan (MoH Directorate of Planning and Development) technical and operational responsibility for the execution and achievement of the results to reach the specific objective of the Programme, both at the level of the Steering Committee (chaired by MoH Permanent Secretary and co-chaired by BTC Resident Representative) and at the level of the Programme Management Unit (MoH Directorate of Planning and Development, and BTC). (See point 5.5.1 and 5.5.2)

The financial responsibilities linked to the execution of the Programme are also joint to the two parties. The Permanent Secretary of the MOH is the Authorizing officer for the Programme and the Resident Representative of BTC is the Programme Co-Authorizing officer.

5.4 Intervention Life cycle

The Specific Agreement has a total duration of 42 months, as from the date of its signature. The intervention execution period is planned for 30 months. The intervention life cycle entails the 3 phases.

5.4.1 Preparation phase

Activities to be carried out during the preparatory phase by the BTC representation Office and MoH are the following:

- Launch of international and national HR recruitment processes
- Opening of main bank account
- Start launching procurement of additional material & logistics needed
- Preparation of necessary procurements in case of outsourced parts of the baseline

The table below provides an estimation of costs during the preparatory phase.

HR costs	
Recruitment costs for the staff to be financed by the intervention	€ 10,000

5.4.2 Execution phase

Intervention Effective Start-up phase

The start-up is effective from the notification of the CMO.

The incoming Programme team assumes start-up duties (recruitments, share understanding of TFF among the team members and stakeholders, baseline, operational manuals, accounts opened and mandates defined, initial planning…), first cash call.

The end of the start-up phase is formalised with the start-up report after the first SC meeting.

The start-up report comprises:

- Signed minutes of the first PSC meeting since the effective start up
- Approval of the team recruited
- Programme operation manual (including the function of Regional Offices)
- Baseline study work plan
- Operational and financial planning of the 1st year

Given the link and synergy between the new (SPHU) and ongoing interventions (ICB II and PNFP), the start-up phase will serve as a period of smooth transition towards a Programme approach.

Operational implementation phase will be 2 years.

Both MTR and ETR will happen during this phase. At the end of this phase a planning of the operational closure is validated by the SC.

Operational Closure

The execution ends with an operational closure phase to ensure proper technical and administrative closing and hand-over.

This operational closure period starts at the latest 6 months before the end of the Specific Agreement.

The Programme final report is produced after the end of the execution period using the BTC template for intervention final reports. It comprises administrative, financial and operational information, as well as information on results with inclusion of indicators and progress markers as foreseen in the logical framework. The final report is presented to the Steering Committee (SC) for approval.

After Discharge of the Programme team, the Representation and partner can still proceed to the liquidation of last commitments.

At the end of the Specific Agreement, expenses are not authorised except if related to commitments

taken before the end of the Specific Agreement and if mentioned in the minutes of the SC. After the financial closure of the intervention, unused funds are managed following the modality foreseen in the Specific Agreement.

5.4.3 Administrative Closure phase

The final report is sent to DGD and the intervention is administratively closed.

5.5 Steering and implementation structures

The current interventions, PNFP and ICB II, focusing on the health sector and more specifically on the development of a result based financing mechanism for PNFP and public health facilities in Uganda, are complex interventions. With the addition of the SPHU intervention, BTC proposes to move towards a Programme approach. This Programme will ensure coordination between the ongoing interventions in health and ensure the delivery of expected and desired development changes for the purchasing of health services through RBF in Uganda. It will strengthen coherence between interventions and increase efficient use of resources. It will improve the coordination between complex interventions implemented in several regions and at national level, dealing with several components (capacity building, RBF, etc…) and multiple actors (PNFP and public health care facilities). The strategy, scope and expected results of ICB II, PNFP and SPHU are inter-dependent and complementary. Expected results of SPHU are defined in a way to enhance the expected results of ongoing interventions of ICB II and PNFP.

Although the coordination of PNFP and ICB II interventions functions already following a number of principles of a Programme approach, the addition of SPHU calls for formalising this approach (one Steering committee, Programme Change Manager and co-manager). This will be beneficial to satisfy strategic objectives of the three interventions by focusing on one hand on the bigger picture of the model or mechanism of strategic purchasing of health services in Uganda, and on the other hand by positioning BTC with its strong and coherent experience in the health sector in Uganda.

Figure 9 presents the suggested Programme set up.

Figure 9: Purchasing of Health Services Programme set-up

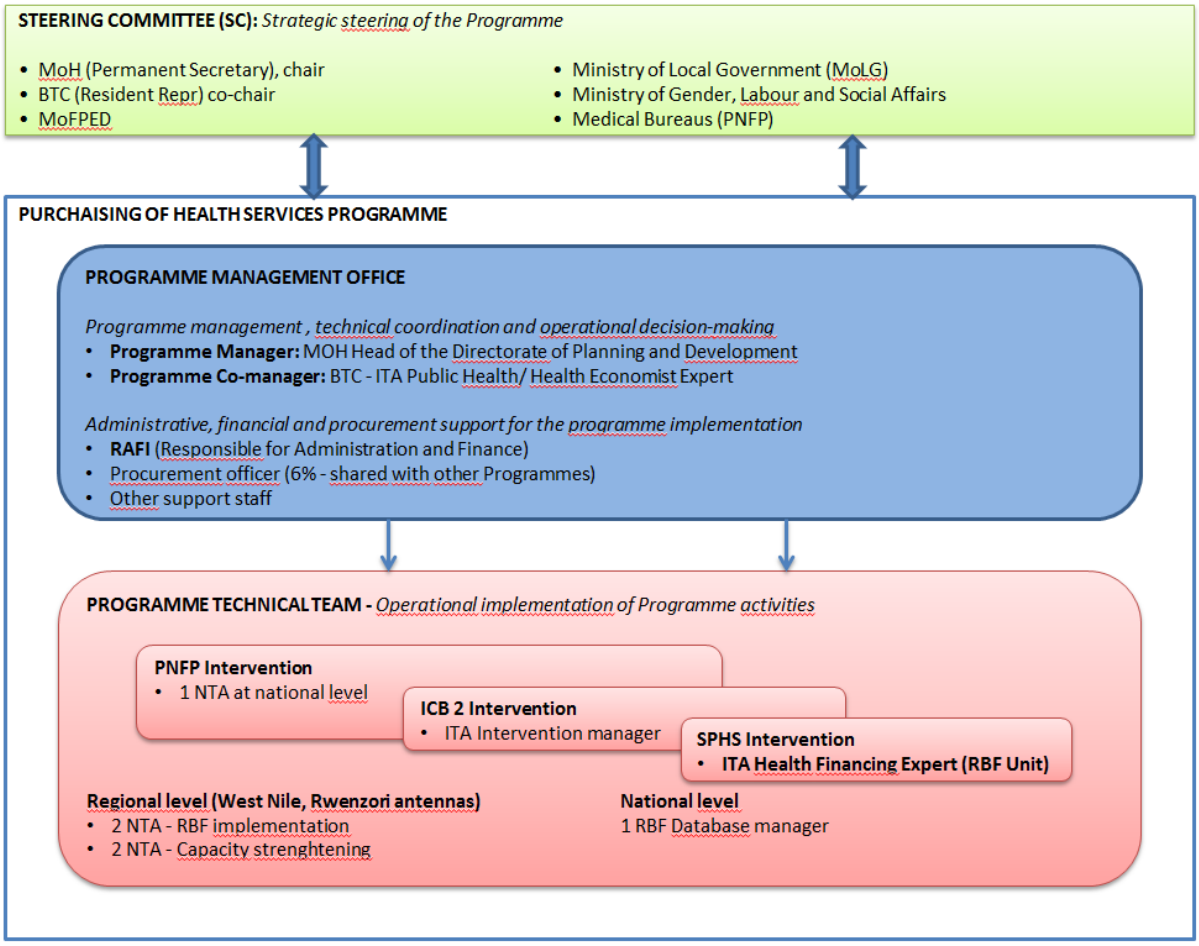
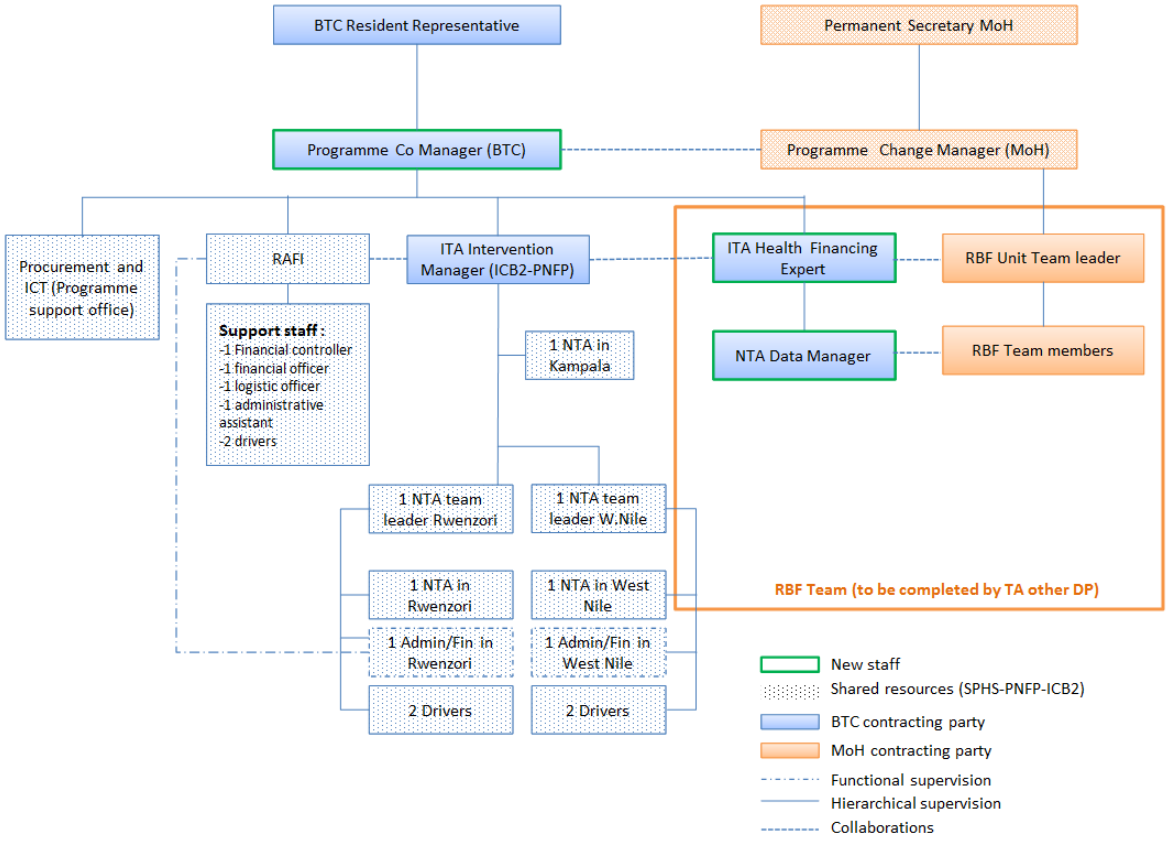


Figure 10: Organogram with supervision links



The MoH, through the Director of Planning and Development (Programme Change Manager) remains the overall technical responsible for the Programme's content and orientations. The Director of Planning (or person appointed by the Director) and the BTC Programme Co-Manager form **the Programme management team**, central decision making organ responsible for Programme management, technical coordination and strategic orientations.

The Programme Management team works closely with the Programme Technical team, providing following the overall coherence of Programme implementation and coherence with strategic orientations provided. A more detailed description of responsibilities of the Programme management team is presented in section 5.5.2.

The Programme Technical team is responsible for the operational implementation of Programme activities. This team is composed by technical staff shared between ICB II, PNFP and SPHU interventions. Distribution of tasks between the team members at national and at regional level is going to be planned in an efficient and coordinated way, to ensure full coverage of the Programme activities to be implemented, and avoid duplications. This will need support and specific attention from the coordination of the Programme. The section 5.5.3 presents main responsibilities of the Programme technical team.

Administrative, financial and procurement support to the technical team will be provided by the **Programme Support team**, headed by an International Administrative and financial coordinator (RAFI). The RAFI will contribute to capacity building in his field of competence and will also contribute to the conception and adaptations of the RBF mechanism from an administrative and financial perspective. At regional level, the administrative and financial officers will equally assist PNFP, ICB II and SPHU in both West-Nile and Rwenzori regions.

5.5.1 Programme Steering Committee (PSC)

The Programme Steering Committee is the highest level of decision in the Programme and will strategically steer the Programme. Given the Programme approach used for coherence and synergy between the three interventions (ICB II, PNFP, and SPHU), there will be one unique Steering Committee for the three interventions.

Composition:

The Steering Committee will be composed of the representatives of the following institutions:

- MoH (Permanent Secretary), chair
- Ministry of Finance, Planning and Economic Development (MoFPED)
- Ministry of Local Government (MoLG)
- Medical Bureaus (PNFP)
- A representative of the Ministry of Gender, Labour and Social Affairs
- BTC (Resident Representative) co-chair.

The PSC may invite external experts or other stakeholders as resource persons on an ad hoc basis.

Role and functions:

- Supervise the respect of the engagements of the parties
- Assess the development results obtained by the programme (strategic purchasing, quality assurance and control) and approve planning and recommendations from the programme's annual results reports
- Validate Execution and Financing Agreements proposed by the team
- Approve eventual adjustments or modifications of results described in the TFF, while respecting the specific objective, programme duration and total budget as described in the specific agreement while ensuring coherence and feasibility of the actions
- Resolve any problems that cannot be solved at the Programme management team level
- Approve and ensure the follow-up of recommendations formulated in the reviews (MTR and ETR) reports
- Based on the financial reporting and audit reports advice on corrective actions to ensure the achievement of the programme's objectives
- Ensure approval of the final report and the final closure of the programme.

Operating mode:

- This PSC will continue to hold joint meetings for all three interventions (PNFP, ICB II, SPHU).
- The PSC establishes his rule of order during its first meeting
- The PSC meets upon invitation of its chair at least twice a year. Extraordinary meetings can be held upon request of one of its member. The invitation shall be received by the members at least 7 days before the meeting. The invitation shall include an agenda, suggested decisions and supporting documents
- The PSC meets for the first time (at the latest) three months after the signature of the Specific Agreement
- Decisions of the PSC shall be taken by consensus. Decisions of each meeting of the PSC shall be recorded in minutes signed by its present voting members
- A PSC is held at the latest three months before the end of the programme activities in order to approve the final report and prepare the modalities of the programme closure
- The Programme management Team will act as the Secretariat for the Steering Committee and will provide the necessary information to its members in advance of each meeting

5.5.2 Programme Management Office (PMO)

The PMO is the operational level in the Programme.

The MoH designates the Director of Planning (or person appointed by Director) as the **Programme Change Manager** and BTC contracts – after no-objection from the MoH – an international technical assistant as the Programme **Co-manager** for 50% of his/her time and Intervention manager for 50% of the time.

Manager and Co-manager work in close collaboration and take operational and strategic decisions in order to ensure that the Programme strategy is fully implemented, in time, within budget and as approved by the PSC. They are jointly responsible for the achievement of results and specific objective of the Programme.

The Management of the Programme's responsibilities comprise:

- Develop and provide orientations for the Programme strategy and operational plans
- Overall Programme coordination management
- Overall Programme monitoring : operational and financial planning, adjustments and reporting of the Programme on a quarterly and annual basis (See 5.6.5)
- Ensure proper management and apply stringent accountability arrangements for the management of the financial resources allocated to the Programme
- Ensure that procurement processes and procedures used by the Programme are conform to the applicable procurement guidelines
- Ensure proper human resources (technical and support teams) management practices conforming to the applicable guidelines
- Compilation of the final report at the end of the Programme.

The Management team will at least meet shortly on a weekly basis and have a more detailed planning meeting monthly in an informal way and upon request. A more formal planning meeting is required every quarter to assure proper coordination and synergies between the different components of the Programme and provide guidance for an optimal use of the available expertise.

The Management team is assisted by an **international administrative and financial expert (RAFI)** and the support team whose cost will be allocated to PNFP, ICB II and SPHU interventions, and any future overlapping intervention in the same sector.

The management and technical teams will be supported by the following staff:

- Within the MoH Directorate of Planning and Development (BTC contracting party): 1 financial controller; 1 financial officer, 1 logistics and procurement officer, 1 administrative assistant; 3 drivers (co-shared with PNFP and ICB II)
- Within the Regions: 2 administration and finance officers and 2 drivers per region (co-shared with the PNFP and ICB II interventions)

5.5.3 Programme Technical Team

The technical team headed by the Programme management team is responsible for the operational implementation of the activities. It will be anchored in the MoH Directorate of Planning and Development, with antennas in the Rwenzori and West Nile Region. It will be composed of:

- 1 National Technical Assistant (NTA) responsible for policy design and general monitoring and evaluation

- For the RBF Unit to be established : 1 ITA RBF/Strategic Financing expert and 1 NTA Database manager (both BTC contracting party) who will provide his/her expertise and support capacity building within the newly established RBF Unit (MOH contracting party): .
- Within the regions (West Nile and Rwenzori): 2 NTA per supported per region, responsible for supporting the implementation of RBF and of capacity building activities in selected health facilities and districts.

The technical team will meet on a regular basis, and at least quarterly. Field visits of the management team will permit sufficient coordination and follow-up. A mechanism will be set to have a regional coordination team so that resources can be shared between the ongoing interventions (vehicles, supporting personnel, offices, etc.)

5.6 Operational management

A Programme Implementation Manual (PIM) (in conformity with BTC procedures and manuals) will be adopted at the start of SPHU that will further detail all the areas of the operational management in close collaboration with PNFP and ICB II.

5.6.1 Human Resources Management

Table 7: HR Management

	Programme Change Manager	**Programme Co-Manager**	**ITA Health financing**	**RAFI**	RBF Unit staff	**NTAs**	**Support Staff**
FUNDED BY	MOH	Intervention	Intervention	Intervention	MOH	Intervention	Intervention
Responsibilities							
ToR	Joint (in the TFF)	Joint (in the TFF)	Joint (in the TFF)	Joint (in the TFF)	Joint (in the TFF)	Joint (in the TFF)	Joint
Publication	NA	BTC	BTC	BTC	MOH	JOINT	JOINT
Candidates pre selection	NA	BTC	BTC	BTC	JOINT	JOINT	JOINT
Selection of candidates	NA	BTC	BTC	BTC	JOINT	JOINT	JOINT
Signature of the contract	MOH	BTC	BTC	BTC	MOH	BTC	BTC
Individual evaluations	MOH	BTC	BTC	BTC	MOH	BTC	BTC

Publication: Positions are open for men and women. Female candidates will be encouraged to apply.
Contract Legislations :

- Human resources recruited in Belgium will have a contract governed by Belgian law.
- Human Resources recruited in Uganda will have contracts governed by Ugandan law.

Additional remarks: If the ToR defined in this TFF needto be revised before advertisement, the revised ToR need to be approved by the PSC.

5.6.2 Financial management

The management of the Belgian contribution is done according to both co-management and BTC-management. The general means remain under BTC-management and the funds will be made available according to the appropriate system.

In accordance with the partnership principles between the Belgian and Ugandan parties, the planning and execution of the financial commitments will be done, for both co-management and BTC-management, with mutual agreement.

Bank Accounts
Co-management

From the signature of the Specific Agreement a main bank account in co-management will be opened at a commercial bank in Uganda or at the Bank of Uganda named "BTC project – co-management – SPHU " in EURO. Other bank accounts in co-management (operational accounts) can be opened when needed.

In terms of signature, the double BTC-signature is compulsory with the following specifications:

Mandate Partner	Mandate BTC	Ceiling	Account
Authorizing Officer or his substitute	Co-Authorizing officer or his substitute	According to the rules of his organisation	Main and operational account
Authorizing Officer or his substitute) or delegate	Programme Co-Manager or his substitute (RAFI)	< 200,000 EUR	Operational account

The Authorizing and Co-Authorizing Officer are together responsible for the opening of the accounts. They are responsible for adding and removing signatory rights on the mandatories of the accounts, in accordance with the internal rules of their respective organization. In case of modification, the party concerned shall communicate it to the bank and formally inform the other party.

All payments made under the co-management budget line must be paid from funds on the co-management bank or cash accounts.

BTC –management: For payments made under BTC -management budget lines, BTC opens specific bank account with only BTC personnel signatory rights.

Funds transfer
First Transfer

From the notification of implementation agreement between the Belgian State and BTC and after the opening of the main accounts, a cash call can be submitted by the Programme Management to BTC Representation. The requested amount must be in line with the financial needs of the first three months and will follow the BTC internal procedures.

Subsequent transfers

To receive subsequent transfers, the Programme (Programme Coordination Team – PCT) must request a cash call to the RR following BTC procedures.

Subsequent requests for transfers must be based on action and financial plans approved by the PSC.

Each transfer should equate to the estimated funding requirements of the programme as prepared by the PCT for the succeeding three months, plus a small margin for contingency, possibly paid in several tranches. The transfer of funds by BTC to the bank accounts will be made provided that:

- The financial accounts for the programme are up to date and have been submitted to the BTC Representative

- All required reports have been submitted to the local representation of BTC
- Any recommendations proposed by external audits and/or MTE have been followed up or implemented and reported to the BTC representation

In addition, intermittent urgent cash transfers may be requested; but such urgent cash calls are only acceptable if they are fully justified in relation to extraordinary events.

The final payment of the programme will follow the same conditions as described above.

The cash management procedures and rules of BTC (transfer to operational accounts, cash management) apply.

Preparation of annual and multiannual budgets

Each year, the Programme team must develop a budget planning proposal for the next year following BTC procedures. In this budget proposal, an indicative budget for the following years should also be included. This budget proposal must be approved by the SC.

The annual budget is part of the annual plan and provides the basis for the monitoring of budget execution of the next year. (See. 5.6.8)

Monitoring and budgetary commitments

Each quarter, the Programme must report on the budget execution and the forecast of expenditure, compared to the total budget and annual budget approved. The reporting is done according to the format provided by BTC and is part of the quarterly reporting.

The Programme must ensure proper control and regular budget monitoring of commitments (See. 5.6.8).

Accounting

Accounting is done on a monthly basis according to BTC rules and regulations and its own financial system and tool.

The accounting documents must be signed for approval by the Programme Co-Manager and RAFi sent to the Co-Authorizing Officer (BTC Resident Representative).

The accounting documents must be up to date, accurate, and reliable and conform accounting standards and rules in place.

Eligible costs are actuals costs which meet the following criteria:

- They are identifiable and verifiable, in particular being recorded in the accounting records of the programme according to the applicable accounting standards
- They relate to activities and criteria as specified in the TFF and necessary for achieving the results
- They are indicated in the budget and registered under the correct budget line
- They comply with the requirements of sound financial management.

Budget Management

Budget constraints:

The total budget and the budget per execution mode may not be exceeded. The budget of the Programme sets out the budgetary limits within which the Programme must be executed.

Budget changes:

- Overshooting of a general means section or a result less than 20% of the amount budgeted for on this section or result in the latest version of the budget is authorized.

- At budget line level, budget overshooting is allowed if the overshooting is less than 10% of the amount of the latest approved budget for this line or if it is less than 50,000 EUR.
- At the level of the annual budget, there are no constraints, except for the general means section for which the annual budget overshooting can be no more than 5%.
- For all other budget changes, a written agreement of the Authorizing Officer and Co-Authorizing officer is sufficient.
- For each request for budget change, the programme team must elaborate a budget change proposition according to BTC's procedures.
- The contingencies budget can only be used for Programme activities and after approval of the PSC.

5.6.3 Public Procurement Management

Procurement for items under co-management budget lines will be done according to the Ugandan procurement rules and regulations and the technical support of the procurement team at the Representation.

The procurement of goods and services for the budget under co-management lines will be carried out in conformity with the Public Procurement and Disposal of Assets (PPDA) Act 2014, which provides the legal framework for procurement activities by all public institutions.

The opening and analysis of the offers will be organized according to the national procedures. BTC must participate in the analysis of the offers if the value is greater than 5,000 EUR. The award proposal has to be approved by MoH according to their normal internal procedures.

Procurement for items under BTC-management budget lines will be done according to Belgian procurement rules and regulations.

The following activities will be managed according to Belgian Law and BTC system (BTC-management)[24] with a support of team of experts on procurement based at the Representation:

- Staff contracting
- All Investments (Except operational/running costs)
- All the Consultancies
- Audits
- Mid-term and End-term reviews

5.6.4 Grant agreements

In accordance with Article 8 of the BTC Law, BTC can provide financing through a grant to one or more third-party partners for the achievement of part of the activities of the TFF or for an action of the third-party partner that contributes to the achievement of the objectives of the intervention. Grant Agreements are specific tools that will enable public and non-profit private actors to be contracted when the public procurement regime does not apply, and by this mean promote a multi-actor approach for the implementation. Grants enable an improved ownership of the beneficiaries and increased technical financial and administrative skills.

5.6.4.1 RBF

Grants will be awarded in accordance with the modalities described in the *BTC guide for the elaboration and follow-up of Grant Agreements.* Public entities that are awarded grants are called

[24] Not exclusive list, See management mode defined in the project budget

"beneficiary parties". The beneficiaries' entities will be the 15 districts of the West Nile and Rwenzori. The beneficiaries of the actions funded by the grant are called "final beneficiaries". The final beneficiaries will be the public and PFNP health facilities, HC 3, 4 and General hospitals.

This programme will continue ongoing activities related to RBF at the level of the public and in private health care facilities of Rwenzori and West Nile Regions: HC II[25], III and IV level and at district (general) hospital level.

Currently grants agreements are used by ICB II and PNFP interventions as a contractual solution for RBF.
The general objective of grant agreements to be signed for SPHU is to contribute to the Uganda's effort to increase accessibility and quality of health services towards the UHC goals through the use of the RBF mechanism to finance the public and private health facilities through the District Local Governments (DLG).
More specifically the grant agreements will provide means to support in the elaboration, the validation and the monitoring of strategic plans/quality improvement plans of the qualified health facilities through RBF funding, and will support qualitative operational and financial implementation of the public health facilities strategic plans/quality improvement plans through RBF funding.
It is foreseen to sign fifteen grant agreements with the fifteen selected DLGs of Rwenzori and West Nile regions in which the current interventions are implemented.

The grant agreements for RBF will cover all activities under result 2 aiming at implementing the RBF approach in the selected health facilities.

Budget line	Activities title	Budget (€)	Potential partner	Status public/private	Motivation
A 01 03	Sign new grants to continue RBF financing at public and PNFP HC3	1,500,000	District Local Governments	public	The general objective of grant agreements to be signed for SPHU is to contribute to the Uganda's effort to increase accessibility and quality of health services towards the Universal Health Coverage goals through the use of the RBF mechanism to finance the public and private health facilities through the District Local Governments (DLG).
A 01 04	Assure RBF verification and monitoring	135,000	District Local Governments	public	
A 02 03	Implement the RBF approach at the level of all selected public and PNFP General Hospitals & HC4	1,237,500	District Local Governments	public	

Reporting and channelling RBF funds:

The health facilities will report quarterly to the DHO and issue the corresponding invoice according to the conditions set in the RBF Implementation Manual. RBF procedures foresee quarterly validation of the performance on which payments are done and quarterly verification of the use of previously received funds. DHO as well as programme TA are members of the controlling committee.

Chapters 2 and 3 provide more technical details on the RBF mechanism.

5.6.4.2 Others

The contribution of the programme to the Partnership Funding fund will be organized through a grant agreement with the MoH. This grant will follow BTC's procedures. Details about de establishment of the fund are to be determined at the beginning of the intervention.

[25] Which will be upgraded to HC III

5.6.5 Monitoring & Evaluations

Monitoring and Evaluation (M&E) contribute to achieving more and better results while strengthening accountability, continuous learning and strategic steering.

5.6.6 Monitoring

	Report Title	Responsibility	System	Frequency	Users
Baseline	Baseline Report	Programme Team	BTC	Unique	Programme, PSC, BTC
Operational Monitoring	MONOP	Programme Team	BTC	Quarterly	Programme, BTC Rep office
Results Monitoring	Progress report	Programme Team	BTC	Annually	Programme team, partner, PSC, BTC rep office, BE Embassy
Final Monitoring	Final Report	Programme Team	BTC	Unique	PSC, Partner, BTC rep office, BE Embassy, donor

Baseline

A comprehensive Baseline Report will be established by the Programme Team ideally within the 6 months after the first PSC. The logical framework mentions the baseline values for the specific objective and the results of the Programme. At the start of the programme the existing indicators will be valued as the starting point. As mentioned earlier (chapter 2) the activities and the themes of interest will need also their indicators and follow-up. These will be addressed in the Comprehensive Baseline Report.

The baseline report comprises:

- A monitoring plan, constituted of the description of the initial situations of specific subjects of attention considered strategic for the sector. These subjects were identified in chapter 2. During the lifespan of the programme, new subjects might be added and subsequently will be described according the proposed procedures. Both qualitative and quantitative indicators will be part of each described topic. For each topic, process and impact indicators will have to be defined.
- A risks management plan
- An updated operational work plan

The PSC takes note of the Baseline Report and validates the way the programme will be monitored.

Operational Monitoring

Operational monitoring refers to both planning and follow-up of the programme's management information (inputs, activities, outputs) and its purpose is to ensure good management. It is an internal management process of the programme team. Every quarter the Operational Monitoring update is sent to and discussed with BTC representation.

Results Monitoring

Results Monitoring refers to an annual participatory reflection process in which Programme team reflects about the achievements, challenges, etc. of the past year, and looks for ways forward in the year(s) to come. The progress for each specific topic of attention will be judged. The PSC approves or disapproves recommendations made by the Programme team in the annual result Report.

Final Monitoring

The purpose of final monitoring is to ensure that the key elements on the Programme's performance

and on the development process are transferred to the partner organization, the donor and BTC and captured in their “institutional memory”. This enables the closure of the Programme (legal obligation for back-donor of BTC), the hand-over to the partner organization and the capitalization of lessons learned. It can be considered as a summary of what different stakeholders might want to know at closure or some years after closure of the Programme.

5.6.7 Reviews (Evaluations) and Audits

	Responsibility	System	Frequency	Users
Mid-term Review	BTC HQ	BTC	Unique, at mid term (year 1) – combined with the final review of ICB II.	PSC, partner, programme, BTC, donor
End-term review	BTC HQ	BTC	Unique at end term (year 2) (6 months before operational closure)	PSC, partner, programme, BTC, donor
Audits	BTC	BTC	At least once	PSC partners, programme, BTC, donor

Mid-Term and End-term Reviews

Reviews are organized twice in a lifetime of a Programme: at mid and end of term. BTC-HQ is responsible for organizing the reviews. The ToR of the reviews and their implementation are managed by BTC Brussels, with strong involvement of all stakeholders. The role of the PSC is to approve or disapprove the recommendations made in the reviews. Given the timeframe of the Programme, it is expected to only have an End-term review to be conducted. The end term review will follow a realistic evaluation methodology, in which the accent is put on the way the programme contributed to the sector and local changes and on the explanation of changes in the indicators. The review will focus on the why and how questions rather than on the attributable impact.

Audits

The programme must be audited at least once during the implementation following BTC procedures. BTC will deploy an independent qualified audit firm (International Accounting Standards) to audit the dedicated programme accounts annually. BTC will write the terms of references of the audits. Theses audits will be carried out by the auditors according to the BTC framework contract in force. BTC and the Steering Committee may request additional audits if necessary.

The auditor’s reports must be presented to the SC. The audit reports will include recommendations and proposal of corrective actions.

The PMT will prepare an action plan to improve the procedures and justify that corrective measures were taken.

Additionally to intervention audits, the College of Commissioners will yearly audit BTC accounts. They also audit the interventions at that moment. BTC Audit Committee can also request that BTC internal auditors audit an intervention.

5.7 TFF modifications

The formal agreement of the Belgian State and the Ugandan Government is needed for the following changes:

- Modification of the duration of the Specific Agreement
- Modification of the total Belgian financial contribution
- Modification of the Overall and Specific Objective of the programme.

The request of the above modifications has to be motivated by the PCT and approved by the Steering Committee. The exchange of letters requesting these modifications shall be initiated by the Ugandan Government and shall be addressed to the Belgian Embassy in Uganda.

The following changes to the TFF will have to be approved by the Steering Committee:

- The programme results and activities and their respective budgets
- The execution modalities
- Competences, attributions, composition and tasks of the SC
- The indicators at the level of the specific objective and the results
- The mechanism to change the TFF.
- The financial modalities to implement the contribution of the Parties.

All other changes to the TFF should be approved by the chairman of the PSC and the BTC resident representative. The adapted version of the TFF shall be communicated to the BTC headquarters and to the Belgian Embassy in Kampala.

6 CROSS CUTTING ISSUES

SPHU will particularly focus on gender, SRHR and HIV/AIDS as crosscutting issues conform the priorities set forward in the NHP II. It continues the orientations already highlighted in the ICB II TFF.

6.1 Gender, SRHR and HIV/AIDS

In NHP II the MoH points at gender inequalities as one of the main hindrances to the improvement of the national health outcomes. NHP II calls for a gender-sensitive and responsive health care system that should be achieved through the mainstreaming of gender in the planning and implementation of all health Programmes. The use of the Health Impact Assessment (HIA) is promoted as a tool for measuring the potential impact of new health policies in other sectors, on the population in general, and on various population categories in terms of gender, age, socio-economic status (including the more vulnerable, disadvantaged and marginalised strata of the population).

More than so far realised in ICB II, FP services will get the necessary attention through a positive bias in remunerating these services through RBF. Specific proactivity in proposing FP will be promoted through new guidelines for health facilities in that respect.

6.1.1 Strong link with the Health Related SDGs

Gender is an important determinant in health seeking behaviour and decision making. The Uganda Demographic and Health Survey 2011 (UDHS, 2011) reveals that husbands are still the most important decision makers on women's health and that only 23 per cent of married women independently decide on their own health care. This may result in a delay or even denial of the woman's need for seeking appropriate health care. Poor health seeking behaviour at personal/family/women/community level – including the lack of partner support – has been identified as the second commonest avoidable cause of maternal mortality.

Gender is particularly significant for the achievement of the health SDGs. In spite of the fact that hsdp 2015/16 – 2019/20 prioritises reduction of maternal mortality, improving child health and fighting HIV/AIDS. The latest report of the UDHS 2016, reveals a reduction in maternal mortality ratio (from 438/100.000)[26] in 2011 to 336/100,000 in 2016, an increased in the proportion of births attended by skilled health staff from 58% in 2011 to 74% in 2016), a still low contraceptive prevalence rate (39%)27, a high adolescent birth rate (25%)28 and only 46% of young women and 45% of young men have comprehensive knowledge about HIV. (38%). The under-five mortality rate (64/1000) and infant mortality rate (43%) are still far from the SDG target (of respectively 51/1000 and 30/1000).

In Uganda the commitment to give priority to the achievement of the SDGs has been channelled through a number of top-down, vertical and parallel Programmes that did not result in a sustainable strengthening of the health system and even reduced the capacity of the health sector to develop a more appropriate response. There is a need to strengthen the role of the DHO in the areas of gender, SRHR and HIV/AIDS and to invest in their leadership and stewardship regarding the adaptation of national policies to the local needs and priorities.

According to the Service Availability and Readiness Assessment findings 2011/2012 (SARA 2011/2012) almost none of the health facilities surveyed dispose of the full package of 19 tracer items needed for the provision of basic obstetric care. Only three in ten hospitals provide the full package of

[26] The SDG target for Uganda is to reduce maternal mortality by 75% to 219 maternal deaths per 100,000 live births in 2020.
[27] The contraceptive prevalence rate increased from 30% in 2011 to 39% in 2016, but is still far below the HSDP target of 50% BY 2020.
[28] Twenty-five per cent (25%) of women aged 15-19 are already mothers or pregnant with their first child. In the conflict affected areas of Teso region (31.4%), Tooro region (30.3) and North-Central region (30.3%). The culture of early marriage is partly responsible for the country's high maternal mortality ratio and high fertility rate.

comprehensive obstetric care. Only 17% of all health facilities provide the full package of basic emergency obstetric care (EmOC).

Currently 81% of the health facilities[29] provide modern contraceptives, of which male condoms (78%) and injectables (78%) are the commonest. Particularly among the catholic PNFP resistance against the promotion of modern contraceptives remains high. They rather focus on the promotion of natural contraceptive methods for married couples. In order to boost the use of modern contraceptives the MoH issued the Uganda Family Planning Cost Implementation Plan 2015-2020. (AHSPR 2011/2012)

In spite of the fact that Uganda has one of the highest adolescent pregnancy rates in the world and the highest in Sub-Saharan Africa, only 47% of the health facilities provide adolescent friendly health services. (AHSPR 2011/2012)

National HIV prevalence in the age group of 15-49 years is on the rise again and increased from 6.4% in 2004 to 7.3% in 2011. In some districts, such as Kabarole district, the prevalence rate is even as high as 12.9%. The percentage of health facilities offering HIV counselling and testing services has only slightly increased from 37% in 2009/2010 to 38% in 2011/2012. According to the National HIV Prevention Strategy 2010-2015 every health facility providing antenatal care services is expected to test pregnant women for HIV and to ensure that at least 95% of HIV-exposed infants receive combination ARV therapy. By the end of 2015, all districts in the country were implementing Option B+. PMTCT services were offered in 3,637 health facilities of all levels by July 2015. These were comprised of 16 referral hospitals, 133 general hospitals, 191 HC IVs, 1,186 HC IIIs, and 2,327 HC IIs (AHSPR 2015/16).

6.1.2 Approach

The mainstreaming of the crosscutting themes will align with the national strategies, policies and guidelines as well as with the priorities put forward by the districts. Since the programme aims at improving the quality of health care through strengthening planning, leadership and management capacities, SRH and HIV will inevitably be covered by most activities such as improved drugs and medical supply, quality of care, supervision and continuous training, ambulances and referral systems, the introduction of RBF, the organisation of regional health fora, etc.

In order to ensure that real progress will be made in the mainstreaming of gender, SRHR and HIV/AIDS, the programme has identified a limited number of activities and indicators (for three out of the four results). This should also allow for proper monitoring and evaluation as well as for proper capitalization of the approach taken.

In the comprehensive baseline study that will be conducted at the start of the programme implementation due attention will be paid to the crosscutting issues with the aim to create a sound base for the further process of action research/reflective action and realist evaluation in these areas. Moreover, a series of progress markers in the field of gender, SRHR and HIV/AIDS have been identified that should enable the programme team to mentor the progress made and to underpin the reflection process on how to best to address the challenges that may arise. This integrated mainstreaming approach should ensure that the crosscutting themes receive the necessary attention throughout the programme implementation process.

[29] Public and private health facilities, with a higher rate in public facilities

Overview of gender, SRHR and HIV/AIDS specific activities and indicators

Result Area	Proposed activities	Proposed indicators/progress markers and targets
R1: The equitable access to quality health care at selected public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point	Providing support for the operationalisation of the guidelines on patient centred care. HIV care decentralisation and global performance Select health facilities for upgrading to be eligible for RBF in the poorest areas (equity)	• % of HC IV and GH with patient-centred care guidelines • 75% of clinical staff at all levels is trained in patient centred care including gender and human rights aspects • Number of HC III providing HIV care according to norms (RBF-based) • Number of Health Facilities in poorest catchment areas upgraded to meet RBF criteria (based on coverage plan and district health indicators) •
R2: The equitable access to quality health care at selected public and private non-for-profit General Hospitals & Health Centres 4 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point	Referral system ambulance service Quality of care Free health care Reproductive health and family planning organization and performance	• Number of maternal evacuations per district/ total institutional deliveries • Hospital hygiene score (cleanliness, maintenance of toilets, needles and blood product treatment, etc.), • Maternity care score (drugs and equipment for 0_2 treatment, blood transfusion, general hygiene, reanimation protocols for mother and new-born available as well as the necessary equipment (reanimation masks for adults and babies, emergency drugs, functional theatre for C-sections, etc.) • National medical and drug supply system (including ARV and FP) for public facilities studied and under discussion • HMIS indicators on FP, C-sections, maternal mortality, blood transfusion, number of deliveries, neonatal reanimation

R3: The capacity of District Health Offices to manage the quality of care, the right to health and the integrated local health system is strengthened	Interpret coverage plan for HC II & III: due attention is paid to the SDG related health priorities as well as to the issue of access to modern contraceptive methods. Reinforce demand-side mechanisms	• FP services, including access to modern contraceptives, are integrated and 75% of all HC III and HC II provide the services • HIV care and treatment services, including PMTCT, are integrated and functioning at 95% of performance or more, conform RBF norms • HC III based deliveries have increased and the average quality is >75% of performance according to RBF norms • Number and % of HC III per district providing the complete national minimal health care package • % of RBF enrolled health institutions with a functional Patient Satisfaction Survey system
R4: The capacity of MoH to steer strategic health financing mechanisms has improved	Capitalize from field experiences developed in Rwenzori and West Nile regions	• The capitalization exercises include reflections on the crosscutting issues (gender, SRHR and HIV/AIDS)

In the spider diagram a score of 4 was given.

6.2 Environment and climate change

There are no important environmental measures to be taken within the framework of this programme as the activities will not particularly affect the environment negatively. On occasion, investments in the facilities might include creating an ambient environment such as a more rational ambulance-service network, the introduction of e-patient files, separation of waste in health facilities, tree-planting in hospital premises or organising (human and medical) waste disposal. These elements will be included in the accreditation criteria for health facilities and their progress will be appreciated.

In the spider diagram a score of 1.5 was given.

6.3 Migration – Peace and stability

Quality health care is an important element to give a sense of security to a population, and renders public authority visible and credible. It therefore contributes to social stability and indirectly fights migration.

In the spider diagram a score of 1 was given.

6.4 Domestic resource mobilisation

SPHU seeks stimulating community participation which demands for domestic resource mobilisation in kind. Additional monetary efforts at the demand side are not envisaged in this intervention. But RBF

remains in its conception an intermediate stage before getting to universal health insurance. To convince people though to adhere to health insurance, basic quality of services and credibility need to be reinstated. RBF will definitely boost credibility of services.

In view of sustainability of strategic financing the special partner committee between GoU-Belgium of April 2017 had decided upon a local contribution of 1,500,000 EUR (25%) to the programme.

In the spider diagram, domestic resource mobilisation got a score of 3. As mentioned, it is not about literally increasing patient contributions at this stage, but it concerns the efforts of the intervention to keep health insurance on the policy agenda and to allow for community participation where possible. One of the aspects is community participation in ambulance services which is actually constrained by the generalised policy of free health care.

6.5 Digitalisation

Digitalisation already got the necessary attention in chapter 2. It got an 'importance' score of 4 in the spider diagram because several digitalisation efforts already in place should come to tangible results in the coming 3 years: e-patient files, coverage plans, DHIS2, digitalised RBF e-M&E, etc.

6.6 Entrepreneurship

The direct financing mechanism and the increased autonomy of health facilities to decide on investments and health service organisation (within the frame of quality of care as defined by RBF norms) boosts entrepreneurship of services in an important way. Hospitals need development plans to be eligible for RBF support and for the first time will look at their institution as an enterprise with long-term vision on its development goals, short term financial management and accounting system and proactive strategies in the use of scarce resources.

The change at the Ministry's level will be important. They become much more the regulators of the sector, through policies and norm setting, and will leave the actual organisation of services increasingly to the individual facilities. RBF (and health insurance in future) will be the contractor between government and health facilities in order to make rights and obligations of both parties clear.

Entrepreneurship got a score of 4 in the spider diagram.

6.7 Peace – stability and migration

Peace, stability and migration are important societal factors on which health care has a demonstrated positive impact. The link is indirect though an impact can only be observed in the long run. Therefore these aspects are receiving a score of 2 in the spider diagram only. Aspects to report upon are: number of population touched upon by the intervention, essential drugs availability as a tracer of quality which is sensed most directly by the population and number of evacuations ambulance services.

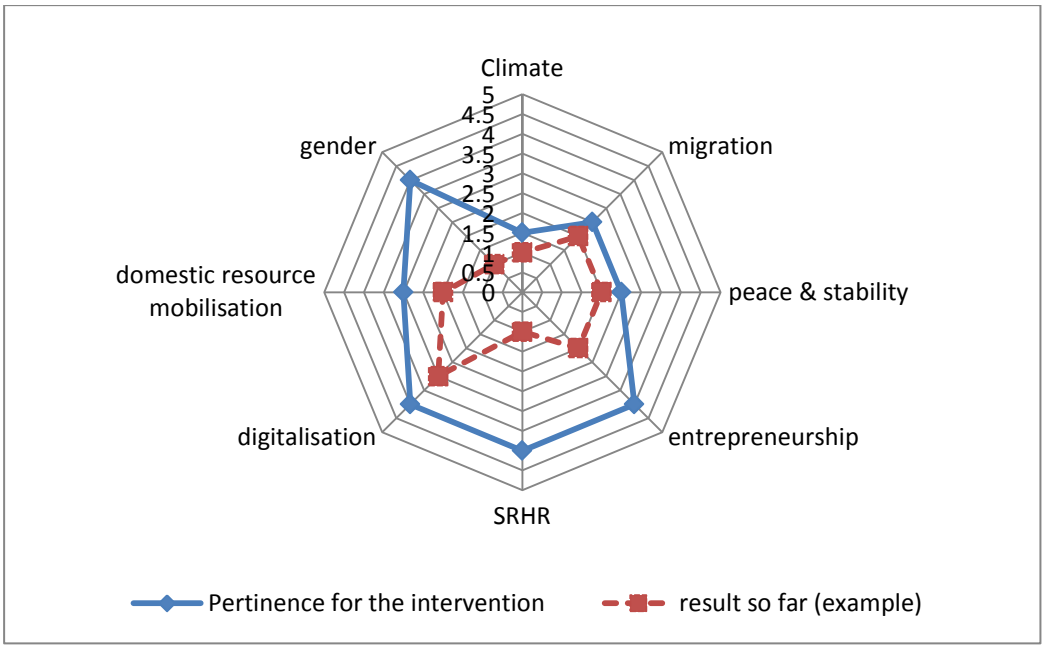


Figure 11: Baseline and expected results transversal themes

7 ANNEXES

7.1 Logical framework

	Intervention logic	IOV (See. section 3.5)	sources (See. 3.5)
OG	Contribute to Universal Health Coverage in Uganda following a Rights Based Approach.		
OS	Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups		
R1	The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point		
R2	The equitable access to quality health care at public and private non-for-profit General Hospitals & Health Centres 4 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.		
R3	The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened		
R4	The capacity of MoH to steer the implementation of the health financing strategy is strengthened		

The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point				Means	Budget
A	1	1	Select HC III on the basis of the district coverage plans	1 workshop per district for completing the coverage plans and updating the district development plan (including HC IV and hospitals)	30,000
				1 workshop per district for planning outreach activities	
A	1	2	Provide investments for new HC III and for priority needs of already enrolled HC III	1 workshop for the selected HC III staff to develop their business plan	90,000
				Initial (clinical and managerial) training according to identified needs	
				Basic equipment and minor rehabilitations/constructions for HC III (on the base of need assessment)	
A	1	3	Sign new grants to continue RBF financing	Finance RBF for (public and PNFP) HC III with RBF (exact nb to be selected at start)	1,500,000
A	1	4	Assure RBF verification and monitoring	Support supervisions and other activities for RBF through grants	135,000
				Joint analysis at district level of the performance of health facilities enrolled in RBF together with the major stakeholders in health	
The equitable access to quality health care at public and private non-for-profit General Hospitals & Health Centre IVs in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.				Means	Budget
A	2	1	Support priority hospitals and HC-IV to update their business plan	1 workshop per region for update and evaluation of the business plan of HC IV and general hospitals	10,000
A	2	2	Complete basic requirements for quality of care	Medical equipment (X-ray equipment)	400,000
				Continuous (clinical and managerial) training	
				Ophthalmological workshops / clinics to provide reading glasses in 2 hospitals	
				Preventive maintenance workshops 2x/y (JMS)	
				Coaching staff on drugs and medical supplies management	
A	2	3	Implement the RBF approach at the level of all selected public and PNFP General Hospitals & HC IV	Implement the RBF approach at the level of all selected public and PNFP General Hospitals & HC IV	1,237,500
				Financing RBF for (public & PNFP) HC-IV (exact nb to selected at start)	
A	2	4	implement a functional e-patient file system in selected public & PNFP hospitals & HC IVs	National consultancy to monitor the set-up of the system (2 national consultants)	99,000
				Purchasing of hardware and network according to needs	
				Training the staff & follow-up of implementation	
The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened				Means	Budget
A	3	1	Support the bottom-up planning at district and health sub-district level	District planning workshops	15,000
A	3	2	Assure Quality of care through RBF verification and supportive supervision and continuous training	Continuous training and mentorship of districts regarding RBF implementation and quality of care (T&M - 15 exchanges a month)	36,600
				Quarterly district meetings on M&E (incl. gender & Human Rights based approach	
A	3	3	Assure specific monitoring of the PNFP Health facilities by the Medical Boards and MoH	Quarterly meetings between MB and MoH	24,000
				Support of MB to PNFP through supervision, workshops and meetings	
A	3	4	Support continuous training by regional hospital specialists	Mentorship of clinical specialists (T&S - 15 exchanges a month)	62,000
				Setting-up teleconference (material etc.)	

A	3	5	Set-up a cost-effective, independent strategy for Patient Satisfaction Surveys	Consultancy to set-up a cost-effective, independent strategy for Patient Satisfaction Surveys	10,000
A	3	6	Assure the set-up of a coordinated referral-system with functional ambulance-services at district and regional level	Development of community based financing systems for maintenance and sustainability of the ambulance services with a comprehensive district emergency plan	87,000
				(decreasing) support to operational costs for ambulance services	
				Set up of a commission within the regional health forum with semestrial meetings to develop a referral framework between the different levels and between public & PNFP health facilities in the West-Nile and Rwenzori region	
				Coordinating body at the regional hospital for emergency services to implement the referral framework and coordinate the ambulance services	
A	3	7	Adapt the national guidelines on the referral system based on the experiences on West-Nile and Rwenzori	Development and monitoring of a national strategy on the ambulance-service and its financing (using domestic resources) with support of consultancy	15,000
A	3	8	Reinforce the functioning of the quarterly Regional Fora and regional planning	Support the regional planning process to guide the development of district annual plans	93,340
				Support to the quarterly regional fora and 6-monthly regional health assembly as well a regional planning	
				Support to the production and dissemination of the reports and guidelines	
				Standardization of the regional review process based on existing experiences	
A	3	9	Support to the regional programme team	2 National Technical Assistant in each of the 2 Regions (4)	215,400
				1 Regional financial officer in each of the 2 regions (2)	
				Maintenance, fuel and insurance of vehicles (4)	
The capacity of MoH to steer the implementation of the health financing strategy is strengthened				Means	Budget
A	4	1	Support the creation of the RBF Unit	Database Manager	394,500
				Health Financing Expert-ATI	
				Running cost unit	
				IT equipment for the RBF Unit	
				Maintenance, fuel and insurance of vehicles (1)	
A	4	2	Assure capacity building of the RBF teams	Organise specific short-term trainings (preferably online)	61,000
				Make provisions for exchange visits	
				Accompany field visits	
A	4	3	Support the utilisation of the digitalised RBF information system	On-the-job training and coaching on the use of the digitalised RBF information system	44,000
				Participation of the RBF team in the action-research concerning RBF at the level of the regions	
				Support to the production and dissemination of the Periodic Performance Reports	
				IT consultancy for the maintenance and (if necessary) upgrading of the digital RBF system	
A	4	4	Capitalise/consolidate the BTC-MoH RBF experience of Rwenzori & West-Nile	Produce a concise, well-argued concept note on RBF based on evidence from the BTC-MoH RBF experience in Rwenzori & West-Nile	7,000
				Strategic meetings on RBF with all stakeholders at regular intervals (e.g. 6-monthly) to produce a revised version of a national RBF approach	

A	4	5	Support the dissemination of a sustainable national RBF strategy to all regions	Communication of the RBF policy and roll-out strategy to the regions through workshops at central and at decentralized level	42,000
				Set-up of a proper national monitoring system for close follow-up in the initial years of implementation.	
				Organise the training of trainers at central level	
				Support capacities of regional RBF teams in the Rwenzori & West-Nile regions specifically	
A	4	6	Assure capacity building in relation to strategic financing	Collaboration with the task force on social health insurance within the Planning department of MoH	85,000
				Benchmarking visits / study tours (e.g. Ghana, Belgium, Rwanda…)	
				Resources for consultancies	
				Support to the PNFP human capacity of the Medical Bureaus (See A0304)	
				Inter-ministerial reflection forum on strategic financing	
A	4	7	Contribute to the Partnership Fund	Financial contribution to the fund	80,000
A	4	8	Support to the national programme team	Support for national programme change manager	508,800
				1 International programme co-manager	
				1 National Technical Assistant (PPH….)	
				Maintenance, fuel and insurance of vehicles (2)	

7.2 Budget

TOTAL BUDGET UGA 1603611				modality	Amount in Euro	%	YEAR 1	YEAR 2	YEAR 3
A		**OS**	**Build the capacities of the Ugandan health system in order to roll-out a Strategic Purchasing mechanism for Public and PNFP Health Services, with a particular focus on women, children and other vulnerable groups**		**5,288,740**	**88%**	**2,422,407**	**2,705,733**	**160,600**
A	*01*		*The equitable access to quality health care at public and private non-for-profit Health Centres 3 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point*		*1,755,000*	*29%*	*757,500*	*977,500*	*20,000*
A	01	01	Select HC3 on the basis of the district coverage plans	BTC-management	30,000		30,000	0	0
A	01	02	Provide investments for new HC3 and for priority needs of already enrolled HC3	BTC-management	90,000		90,000	0	0
A	01	03	Sign new grants to continue RBF financing	co-management	1,500,000		600,000	900,000	0
A	01	04	Assure RBF verification and monitoring	co-management	135,000		37,500	77,500	20,000
A	*02*		*The equitable access to quality health care at public and private non-for-profit General Hospitals & Health Centres 4 in the regions of West-Nile and Rwenzori is strengthened using RBF as an entry-point.*		*1,746,500*	*29%*	*957,000*	*782,500*	*7,000*
A	02	01	Support priority hospitals and HC-IV to update their business plan	BTC-management	10,000		10,000	0	0
A	02	02	Complete basic requirements for quality of care	BTC-management	400,000		367,000	28,000	5,000
A	02	03	Implement the RBF approach at the level of all selected public and PNFP General Hospitals & HC4	co-management	1,237,500		495,000	742,500	0
A	02	04	implement a functional e-patient file system in selected public & PNFP hospitals & HC 4	BTC-management	99,000		85,000	12,000	2,000
A	*03*		*The capacity of Health Districts to manage the quality of care, the right to health and the integrated local health system is strengthened*		*563,440*	*9%*	*219,540*	*322,200*	*21,700*
A	03	01	Support the bottom-up planning at district and health sub-district level	BTC-management	15,000		0	15,000	0
A	03	02	Assure Quality of care through RBF verification and supportive supervision and continuous training	BTC-management	36,700		11,200	20,400	5,100
A	03	03	Assure specific monitoring of the PNFP Health facilities by the Medical Boards and MoH	BTC-management	28,000		8,000	16,000	4,000
A	03	04	Support continuous training by regional hospital specialists	BTC-management	62,000		23,000	39,000	0
A	03	05	Set-up a cost-effective, independent strategy for Patient Satisfaction Surveys	BTC-management	10,000		10,000	0	0
A	03	06	Assure the set-up of a coordinated referral-system with functional ambulance-services at district and regional level	BTC-management	88,000		59,000	23,000	6,000
A	03	07	Adapt the national guidelines on the referral system based on the experiences on West-Nile and Rwenzori	BTC-management	15,000		15,000	0	0
A	03	08	Reinforce the functioning of the quarterly Regional Fora and regional planning	BTC-management	93,340		93,340	0	0
A	03	09	Support to the regional program team	BTC-management	215,400		0	208,800	6,600

A	*04*		*The capacity of MoH to steer the implementation of the health financing strategy is strengthened*		*1,223,800*	*20%*	*488,367*	*623,533*	*111,900*
A	04	01	Support the creation of the RBF Unit	BTC-management	394,500		165,600	213,000	15,900
A	04	02	Assure capacity building of the RBF teams	BTC-management	61,000		34,500	26,000	500
A	04	03	Support the utilisation of the digitalised RBF information system	BTC-management	44,000		22,000	20,000	2,000
A	04	04	Capitalise/consolidate the BTC-MoH RBF experience of Rwenzori & West-Nile	BTC-management	8,500		2,500	4,500	1,500
A	04	05	Support the dissemination of a sustainable national RBF strategy to all regions	BTC-management	42,000		5,000	35,000	2,000
A	04	06	Assure capacity building in relation to strategic financing	BTC-management	85,000		32,500	52,500	0
A	04	07	Contribute to the Partnership Fund	BTC-management	80,000		26,667	53,333	0
A	04	08	Support to the national program team	BTC-management	508,800		199,600	219,200	90,000
X	01		**Contingency**		**104,550**	**2%**	**0**	**104,550**	**0**
X	01	01	contingency CO-MANAGEMENT	co-management	54,550			54,550	
X	01	02	Contingency BTC-management	BTC-management	50,000			50,000	
Z			**General means**		**606,710**	**10%**	**144,630**	**366,430**	**95,650**
Z	*01*		*Personnel costs*		*356,260*	*6%*	*31,230*	*296,430*	*28,600*
Z	01	01	International administrative and financial coordinator (RAFI)	BTC-management	195,000		0	180,000	15,000
Z	01	02	Support staff	BTC-management	161,260		31,230	116,430	13,600
Z	*02*		*Investments*		*70,000*	*1%*	*70,000*	*0*	*0*
Z	02	01	Equipment	BTC-management	65,000		65,000	0	0
Z	02	02	Office refurnising	BTC-management	5,000		5,000	0	0
Z	*03*		*Functional costs*		*45,450*	*1%*	*17,900*	*21,500*	*6,050*
Z	03	01	Running costs	BTC-management	28,200		9,900	13,500	4,800
Z	03	02	Representation costs and external communication	BTC-management	6,000		2,500	2,500	1,000
Z	03	03	Missions	BTC-management	10,000		5,000	5,000	0
Z	03	04	Financial transaction costs	BTC-management	1,250		500	500	250
Z	*04*		*Audit, monitoring and evaluation*		*135,000*	*2%*	*25,500*	*48,500*	*61,000*
Z	04	01	M&E costs (baseline, 1 EF)	BTC-management	35,000		5,000	0	30,000
Z	04	02	Audit	BTC-management	18,000		0	0	18,000
Z	04	03	Missions	BTC-management	32,000		8,000	16,000	8,000
Z	04	04	scientific support (including Quamed)	BTC-management	50,000		12,500	32,500	5,000
TOTAL					**6,000,000**	**100%**	**2,567,037**	**3,176,713**	**256,250**

BTC-management	**3,072,950**		**1,434,537**	**1,402,163**	**236,250**
co-management	**2,927,050**		**1,132,500**	**1,774,550**	**20,000**

7.3 Synergies and domains of collaboration between Belgian development interventions in the health sector

Aspects in which FSPH programme will be supported by other Belgian interventions		
Support and synergies provided by ICB II project	Support and synergies provided by PNFP project	Support and synergies provided by SDHR project
• Intervening at the operational level, complementary to FSPH approach • Reinforcing DHMT • RBF rules for DHMT • RBF conception for government facilities • Support regional coordination • Capacity building at MoH level	• Intervening at the operational level, complementary to FSPH approach • Reinforcing DHMT • RBF rules for DHMT • RBF conception for government facilities • Support regional coordination • Capacity building at MoH level	• Provide trainings for health personnel in general and health managers, complementary to the capacity building in management and leadership • Organise trainings, also with none-state stakeholders
Domains of collaboration		
ICB II	PNFP	SDHR project
• Qaulity of care • Filling gaps in the offer of care: chronic diseases, epilepsy, mental health disorders, ophtalmologocal disorders.	• Help formulate policies concerning PNFP facilities • Give feedback on global performance of PNFP facilities in the country • Inform about specific problems PNFP facilities encounter	• Identification of needs for training • Evaluation of proposals for training • Information on possible training institutes • Contacts with training institutes • Particular attention for the capacity building of human resources in the area of SRH and HIV (incl. complementary midwifery training for comprehensive nurses) • Help in selection of quality training courses • Provide network of useful contacts

7.4 Programme Change Manager (PCM)

The MoH (Director of Planning) assigns the programme change manager of SPHU. Besides the routine work within the MoH Director of Planning, this person will facilitate the objectives and work of SPHU. The PCM will refer to the Programme Steering Committee (PSC) and ensure that the members are well informed of the programme progress and are adequately supplied with sufficient information to carry out their decision-making responsibilities. The PCM will feed back to the MoH any changes in policy or direction that the PSC may wish to carry out within the Project framework.

The PCM's specific tasks include:

- Providing overall leadership of the Programme team and liaise with the other departments within MoH and coordinate the programme activities with the ones of MoH

- Coordination and networking with other national and international partners;
- Organising, coordinating and supervising the implementation of programme activities in accordance with the approved programme work plans;
- Technical guidance on programme strategy and implementation;
- Organise bi-annual PSC meetings and prepare the contents and agenda of the PSC meetings;
- Act on behalf of the Chairman of the PSC when authorised, and report back to the Chairperson on actions taken;
- Ensure the capturing and integration of lessons learnt and experience drawn in the implementation of programme activities;
- Ensure coordination and exchange of experiences between the programme and other related experiences;
- Be authorised account-holders for the accounts.

7.5 ToR international long-term staff

The programme aims at consolidating the current interventions. Most of the ICB II and PNFP staff will remain. Their job-descriptions and profiles are already described in these interventions. In this section, only the ToR for the new international long-term personnel will be described. For the staff of the RBF Unit to be created, their ToR will be developed jointly with the MoH at the start of the programme.

7.5.1 Programme (co manager)

Directorate	- **Department**
Operations	
Function: field (Kampala) – 30 months	

JOB OBJECTIVE

The Programme Change Manager is in charge for BTC to steer and manage the Health programme in Uganda. He/she coordinates the interventions and engages in a strategic, technical dialogue at national level, based on his/her expertise & experience of the health sector. He/she assures the technical and financial follow-up, necessary to reach the objectives and results of the health programme. He/she reports to the Programme Steering Committee.

RESULTS AREAS

Results area 1: As**Strategy officer**	Time in %: 15%
Create optimal conditions for implementing the Programme within the set frameworks and in accordance with the strategy choices and decisions of the steering committee	
in order to achieve the strategic objectives.	
Main tasks:	• Maintain steering committee relations (primarily with the Resident Representative and representative of the partner country); • Ensure that the implementation of the Programme remains aligned with the strategy choices of the steering committee; • Ensure that the decisions of the steering committee are implemented; • Determine priorities within the Programme in accordance with the decisions of the steering committee; • Submit the governance strategies to the steering committee (and via the

	Resident Representative) to allow for the optimal implementation of the Programme; • Put important issues and risks on the agenda of the steering committee; • Report on a regular basis and in accordance with the Internal Rules of Procedure to the steering committee about the progress of the Programme, including the budgetary state of affairs and the achievement of the objectives; • Maintain the relations with other main stakeholders; • Deliver analyses and ideas for the development of future interventions; • Provide evidence of the Programme's added value for the development results; • Ensure that the general priorities of international cooperation are complied with (human rights, service delivery, new technologies…).
Results area 2: As **Programme manager**	Time in %: 15%
Coordinate all interventions of the health Programme in association with the partner; as per agreements	
in order to ensure optimal implementation at the operational level and in accordance with the set objectives and resources.	
Main tasks:	• Elaborate the Internal Rules of Procedure that lay down the functioning principles; • Organise and chair the Programme coordination committee, i.e. reach agreement on operational choices, on decision-making frameworks for different members; • Elaborate a global strategic framework for programmeming within the various Programme components; • Ensure there is a common M&E framework across interventions and that it is being used; • Organise exchanges of experience and lessons between interventions and stimulate synergies; • Organise an efficient, effective, transparent and participatory decision-making process whilst ensuring the coordination committee spirit is collegial. • Ensure information and communication is efficient and correct in accordance with the latest technological possibilities; • Elaborate a global approach to knowledge building and knowledge management in accordance with the BTC strategy.
Results area 3: As **Manager**	Time in %: 15%
Strategic steering of the interventions	
in order to achieve the Programme goals in accordance with set objectives and with optimal use of available resources.	
Main tasks:	• Ensure that the interventions deliver high-quality annual operational plans, in accordance with the Programme's strategy priorities; • Manage strategy and/or resource issues arising between different interventions; • Monitor the main risks of the interventions in view of achieving Programme results; • Steer the adoption process of appropriate preventive and corrective measures; • Follow up the expected outputs of the interventions within the Programme in association with the intervention coordinators; • Report internally on a regular basis about the progress of the Programme, including the budgetary state of affairs and the achievement of the objectives; • Ensure that the interventions build knowledge and manage knowledge in a professional way.

Results area 4: As **Coordinator**	Time in %: 15%
Monitor and follow up the processes of the health Programme and the interventions within the programme;	
in order to ensure overall consistency and synergies under the Programme.	
Main tasks:	• Support the preparation, start-up and closing of interventions; • Steer the planning and reporting processes of the interventions; • Ensure that the method and procedures to be used are communicated with the staff members concerned; • Optimally provide internal and external expertise; • Organise evaluation missions and backstopping missions; • Facilitate and follow up scientific and technical missions.

Results area 5: As **People manager**	Time in %: 10%
Lead the team of which one is the hierarchical supervisor	
in order to have qualified and motivated staff.	
Main tasks:	• Put in place an appropriate organisation in terms of roles and responsibilities • Ensure that the roles and procedures which the head office has determined are respected; • Determine the objectives and priorities of the staff members; • Contribute to the recruitment of staff members; • Motivate, coach and follow up staff members; • Create an atmosphere of trust and accountability; • Develop the competences of co-workers; • Promote a positive internal atmosphere and manage conflicts within the entity.

Results area 6: As **Support to the Programme Change Manager**	Time in %: 5%
Support the Programme Change Manager in leading the change processes	
in order to contribute to the achievement of the objectives.	
Main tasks:	• Support identifying responsibilities in the results chain; • Support identifying and resourcing transition activities; • Support determining needed outputs which the Programme must deliver to enable the transition; • Facilitate involvement of users/beneficiaries in view of fostering ownership.

Results area 7: As **Facilitator**	Time in %: 20%
Capacity development of partner entities (selected health facilities, districts, regions, Planning Department MoH – RBF Unit)	
in order to contribute to the improvement of their organisation, processes and systems and of their staff's competences.	
Main tasks:	• Assess the maturity of management of partner entities; • Advise partner entities on actions to be taken to improve their management as well as how to implement these actions; • Facilitate the change process; • In association with the partners, adapt the organisational structure, optimise the processes, improve the systems and strengthen staff competences.

Results area 8: As **Formulation manager**	Time in %: 5%
Manage the formulation process	
in order to ensure the Technical and Financial File is produced.	
Main tasks:	○ Coordinate the technical input for the next Programme of Indicative Cooperation ○ Coordinate and integrate the whole process; ○ Produce – in a participatory way – the formulation phase documents whilst respecting the required quality criteria, deadlines and earmarked budgets, and

	coordinate the contributions to these documents. Namely: ▪ Formulation scenario: method, planning, budget and composition of a team in consultation with the middle managers concerned; ▪ Technical and Financial File and accompanying memo: strategy, beneficiaries, risks, budget, organisation etc.; o Inform and train the members of the formulation team – including the joint manager – in formulation, and facilitate mutual exchanges; o Ensure permanent good communication/participation of the different stakeholders in the process, and in particular the partners, the preparation fund of BTC, the Embassy and the members of the Validation board, to avoid the process getting stalled; o Ensure the scenario is complied with: planning, budget, etc., including the working hours of the members of the formulation team to stay within the limits of the scenario budget; o Coordinate, organise and, where applicable, carry out formulation missions and other activities provided for in the formulation scenario, including the possible recruitment of national/ international consultants; o Ensure that the Technical and Financial File is consistent with the identification form (continuity and/or founded reorientation); o Where appropriate, ensure consistency and synergy between the Technical and Financial Files of the interventions that are part of the Programme; o Ensure the final quality of the Technical and Financial File, stand up for it before the Validation board and incorporate any resulting changes.

POSITIONING

Whose subordinate are you? (Whom do you report to?)	Resident Representative
Who do you supervise?	Number of **direct co-workers** the jobholder supervises **hierarchically**: 7 Functions: Intervention Managers, Technical experts, RAFI Number of **indirect co-workers** the jobholder supervises **hierarchically**: 13 Functions: financial & admin & logistical support staff => Total number of hierarchically subordinate workers: approx.. 20

AUTONOMY

Entitled to decide independently on the following: *(without explicit consent of the supervisor)*	• Methodology • Organisation of one's own work • Proactive actions to manage daily problems and risks
Authorisation from the management is required for the following:	• Implementation of new procedures, processes • Actions pertaining to major problems or risks • Matters with a budgetary impact (decisions exceeding one's budgetary mandate) • Decisions that have a general impact on BTC/the Programmes/interventions… • Decisions that exceed the scope of the function • …

DIPLOMA AND/OR LEVEL OF EDUCATION REQUIRED FOR THE JOB

Master's Diploma in Medicine with a complementary master's degree in Public Health and/or Health Economy or a
Master's Diploma in Economy with a complementary master's degree in Public Health (and eventually Health Economy)
Note: complementary profile to the other International Senior Health Sector Expert

EXPERIENCE REQUIRED FOR THE JOB

- At least 8 years of relevant experience with steering Programmes/interventions in international development cooperation; with minimum 4 years of these in a supervising function.
- At least 7 years of relevant experience in the sector or thematic domain
- Experience in institutional support and work at a ministry's level.
- Previous experience of coordination and leadership in a similar context
- Experience with RBF and/or health insurance is an asset
- Proven experience with drawing up policy papers, strategies, evidence-based papers
- Proven experience with giving presentations at seminars and international conferences
- Experience in dealing with crosscutting issues (gender, SRHR, HIV, Human rights) is an asset
- Experience in action-research and capitalisation exercises is an asset
- Knowledge on complexity concepts and management in complex environments is an asset
- Experience in the country of assignment is an asset
- Experience with formulating Programmes/interventions is an asset

TECHNICAL SKILLS REQUIRED FOR THE JOB

- Broad and in-depth insight in all aspects of development cooperation
- Thorough knowledge of project/programme management methodologies
- Familiar with results-based management
- Technology-savvy
- Knowledgeable about change theories
- Knowledgeable about health system approaches
- Expert in knowledge management and knowledge building
- Expert in writing evidence-based papers (and eventually writing of scientific articles)
- Expert in capacity development
- Analytical skills
- Leadership and coaching skills
- Good interpersonal skills
- Good communication skills (negotiation, moderation, representation, presentation of results)
- Very good oral and writing skills in English

INNOVATION

Innovation is important to the job

-

Working methods (planning, M&E, action-research)
Products such as a national RBF model, concept paper on strategic financing, concept paper on referral system,…
Internal rules of procedure

-

Personal experience and experience of co-workers: technical experts, RAFI, BTC representation, colleagues of BTC Brussels, external experts...
On the job training
Specialised literature
Networking & attendance to state of the art international conferences

7.5.2 International Expert in RBF and Strategic Financing

Directorate	• **Department**
Operations	
Function: field (Kampala) for 21 months	

JOB OBJECTIVE

Contribute to the expected results of the health Programme in Uganda by executing activities with stakeholders, ensure continuous quality improvement and ensure knowledge building and knowledge management of the Programme/intervention.

RESULTS AREAS

Results area 1: As **Expert**	Time in %: 30 %
Contribute to the implementation of the health Programme by providing inputs for planning, execution, coordination, follow-up and monitoring, evaluation and capitalisation of activities	
in order to ensure that the results of the Programme (outputs – outcomes) are achieved within the set execution deadline.	
Main tasks:	• In the matter of planning: o Analyse the situation and the needs; o Determine the activities and outputs in a participatory way; • In the matter of execution: o Provide the necessary inputs for activities to be organised well; o Determine technical specifications when preparing procurement documents; o Identify additional technical expertise required for implementing the activities; o Contact and establishing relations with all interesting or needed stakeholders; • In the matter of monitoring and evaluation: o Permanently update information so that it is available at any time, mid-term and end-of-term of the Programme/intervention, to the M&E systems and that the performance of the Programme/intervention can be measured; o Update the factual data to be fed into de decision-making process; o Put in place a genuine learning dynamic through permanent monitoring of activities fostering short learning loops; o Develop/complete the databases in order to allow for digital and up-to-date management of information; o Provide for mechanisms and methods allowing for correct scientific monitoring of results.
Results area 2: As **Advisor**	Time in %: 20%
Provide the authorities with all inputs required for the cooperation Programme in the field of health, in particular related to strategic health financing	
in order to promote a strategic cooperation Programme that is highly relevant, consistent and sustainable.	
Main tasks:	• Remain informed of recent interesting evolutions in the specific area of expertise; • Participate to scientific and technical forums in that specific area; • Present the necessary strategy and technical papers with and for the partner depending on the needs; • Carry out required prospecting to remain innovative and creative in achieving the expected change; • Participate to all meetings of the technical committee and exchange platform in one's area of expertise;

	• Provide structured and comprehensible feedback to all team members
Results area 3: As **Facilitator**	Time in %: 20%
Organise knowledge building and knowledge management in the field of public health/strategic financing in order to create an inclusive, informed climate of trust within the Programme	
Main tasks:	• Put in place a learning climate; • Establish a setting that is conducive to writing, reflection, self-criticism and self-assessment; • Help members of the Programme/interventions become familiar with literature research; • Help members of the Programme/interventions become familiar with writing scientific or vulgarised articles; • Develop platforms where virtual or live ideas are shared; • Introduce new technologies in the learning process; • Explore and develop digitisation with the Digit4Dev expert of the Belgian development agency; • Produce all kinds of information formats (blogs, videos, newspapers articles, scientific articles...).
Results area 4: As **Facilitator**	Time in %: 30%
Capacity development of partner entities (selected health facilities, districts, regions, Planning Department MoH – RBF Unit) in order to contribute to the improvement of their organisation, processes and systems and of their staff's competencies.	
Main tasks:	• Assess the maturity of management of partner entities; • Advise partner entities on actions to be taken to improve their management as well as how to implement these actions; • Facilitate the change process; • In association with the partners, adapt the organisational structure, optimise the processes, improve the systems and strengthen staff competences.

POSITIONING:

Whose subordinate are you? (Whom do you report to?)	Programme Manager
Who do you supervise?	Number of **direct co-workers** the jobholder supervises **hierarchically**: 1-3 Functions: NTA team RBF Unit ……. Number of **indirect co-workers** the jobholder supervises **hierarchically**: 0 Functions: none => Total number of hierarchically subordinate workers: ……

AUTONOMY

Entitled to decide independently on the following: *(without explicit consent of the supervisor)*	• Organisation of one's own work • Proactive actions to manage daily problems and risks • ...
Authorisation from the management is required for the following:	• Implementation of new instruments, procedures, processes • Actions pertaining to major problems or risks • Matters with a budgetary impact

	• Decisions that have a general impact on BTC or the programme • Decisions that exceed the scope of the function • ...

DIPLOMA AND/OR LEVEL OF EDUCATION REQUIRED FOR THE JOB

Master's Diploma in Medicine with a complementary master's degree in Public Health and/or Health Economy or a
Master's Diploma in Economy with a complementary master's degree in Public Health (and eventually Health Economy)

EXPERIENCE REQUIRED FOR THE JOB

- At least 7 years of relevant experience in the sector or thematic domain
- At least 3 years of relevant international experience in development cooperation
- Experience in institutional support and work at a ministry's level.
- Previous experience of coordination and leadership in a similar context
- Experience with RBF or strategic financing
- Experience with health insurance is an asset
- Proven experience with drawing up policy papers, strategies, evidence-based papers
- Proven experience with giving presentations at seminars and international conferences
- Experience in dealing with crosscutting issues (gender, SRHR, HIV, Human rights) is an asset
- Experience in action-research and capitalisation exercises is an asset
- Knowledge on complexity concepts and management in complex environments is an asset
- Experience in the country of assignment is an asset

TECHNICAL SKILLS REQUIRED FOR THE JOB

- Familiar with results-based management
- Technology-savvy
- Knowledgeable about change theories
- Knowledgeable about health system approaches
- Expert in knowledge management and knowledge building
- Expert in writing evidence-based papers (and eventually writing of scientific articles)
- Expert in capacity development
- Analytical skills
- Leadership and coaching skills
- Good interpersonal skills
- Good communication skills (negotiation, moderation, representation, presentation of results)
- Very good oral and writing skills in English

INNOVATION

Innovation is important to the job.

Working methods (planning, M&E, action-research)
Products such as a national RBF model, concept paper on strategic financing

Personal experience and experience of co-workers: programme (co-)manager, RAFI, BTC representation, colleagues of BTC Brussels, external experts...
On the job training
Specialised literature
Networking & attendance to state of the art international conferences

7.6 Financing Health Facilities through Results-Based Financing, as a first step towards Universal Health Coverage

7.6.1 General Principles

The potential of RBF or output-based financing has not to be proven anymore. The Belgian Cooperation has large experience, not only in the conception but also in the execution and monitoring of such systems. Good examples are Rwanda, Burundi and Benin.

The advantages are numerous and one of the most important ones is to render local actors responsible for their performance with real decentralization of decision-making combined with a financial motivational aspect. It generally goes together with a substantial increase of the recurrent budget at the operational level, which of course adds to realizing the potential created.

Possible side-effects are by now well-known as well and should be taken into consideration when introducing the system.

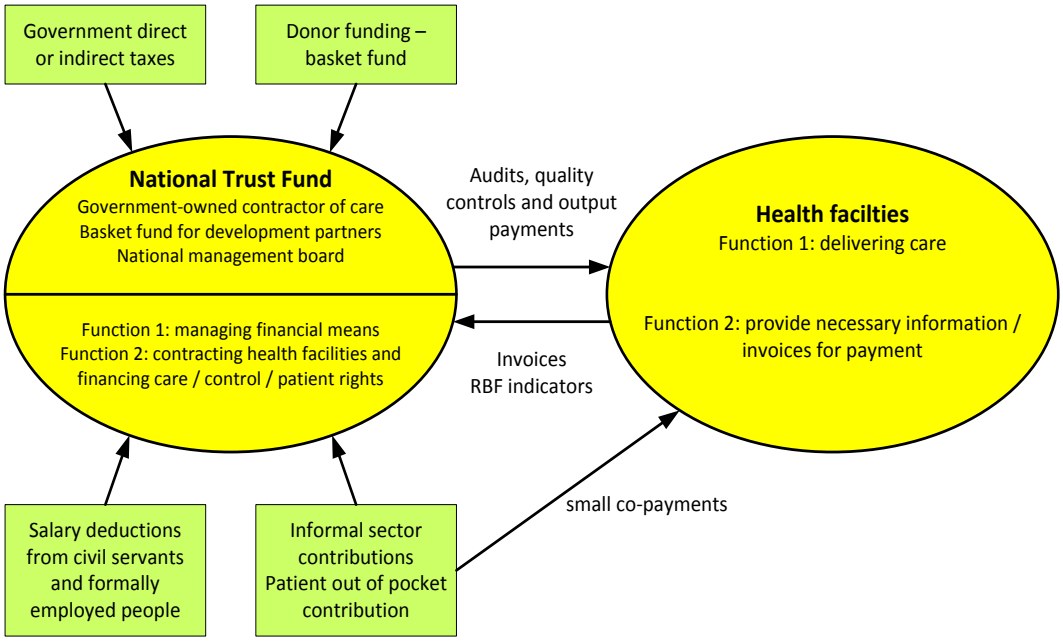
The most important dangers are:

- Lack of strong leadership and engagement from both Government (MoH) and the donor community. RBF is not possible without serious increases in the global budget for health, although some existing funding mechanisms and fund allocations can be switched to RBF eventually.
- Falsification of indicators. This is the most obvious side-effect if financing depends on indicator values. It has been observed everywhere where RBF has been introduced. There is need for rigorous control mechanisms and for quality indicators that are more difficult to falsify. It is important that impunity is not allowed to settle in. Clear rules for allocation of funds with restrictions on salary allocations are necessary. Basic salaries should remain decent and the financial motivation factor should not become the leading principle for RBF. A strong salary policy for civil servants remains a cornerstone of the system and RBF should not try to replace such policy.
- Neglect of activities that are not included in the RBF indicators. This is a natural tendency in any RBF funding mechanism. The widely heard criticism is that when projects target very specific activities and provide particular staff salary increase, the overall service gets disrupted. The indicators should therefore cover the majority of activities that are foreseen in the health care package for a specific level of care. The measured activities should not be exclusively clinical and comprehensive “global” indicators that try to look at quality of care of complete packages (e.g. antenatal care, under-fives’ clinics) should be included.
- Costly control exercises and biased evaluations. Control exercises should be at least partly independent from the health care services and authorities. Otherwise falsifications might not be corrected or quality estimates exaggerated. However, the costs of control can be extremely high if the most “independent” and “complete” form of control is chosen (i.e. through special contracting of NGO for example). The costs of the control exercises should therefore not outweigh the cost of the opportunistic behaviour of providers in a situation of no control.
- Using the funds for savings. This is a rather particular perverse effect that HC do not inject the received funds back into the system but save them for more precarious periods. Rules should be put in place that oppose this tendency e.g. savings should not represent more than a certain percentage of total funding except when major investments are planned for necessitating more than one quarter savings to cover the purchase.

- Irrational organization of services when specific services are remunerated. This is one of the least-known side-effects. There is more and more evidence for instance that when C-sections are specifically remunerated, the indications for this surgical intervention change and the C-sections rate increases. If hospitalization is financed at HC level, this might cause serious delay in referral to hospital. Lastly, if outreach activities are encouraged to be conducted by the hospitals, while HC provided by the necessary means could conduct them even at a much lower cost, irrational allocation of funds will be institutionalized.
- Too powerful controlling mechanisms. A last side effect worth mentioning here, is the creation of a huge and diverse controlling mechanism (plenty of NGO solicited) that become the real authority in the districts (they decide on the money) and with different standards. This project proposes that the long-term vision should be the creation of a government-owned National Trust Fund that becomes the contractor of health services. The Trust would receive the funds from government (tax money), from development partners (basket funding in the Trust) and from contributions from the population (small health insurance). In the national management board all contributors could be represented including CSOs such as the Uganda National Health Consumers Organisation mentioned earlier. (see figure 1 below)

To avoid to a maximum these side-effects, RBF should be introduced only after thorough preparation and initially at a manageable scale, without necessarily returning into micro-pilots, to ensure enough time to install the system, including the control procedures, and to offer sufficient training to all stakeholders.

Figure 1: Model of financing mechanism that insures affordable and quality care for a large population

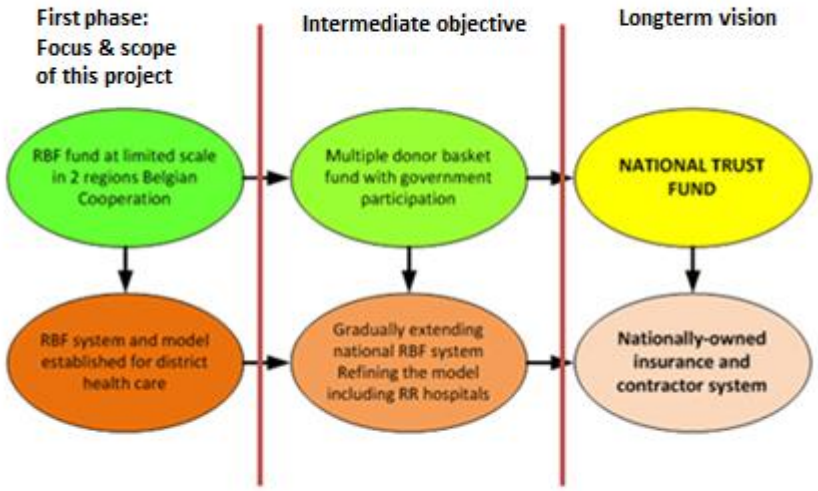


This project proposes to introduce RBF at the PNFP health care organization: at HC III and IV level and at general hospital level (district level). HC IV will be regarded as hospitals if they are the only hospital facility in the HSD (coverage plans – see further), but as urban HC III if a hospital is in the vicinity. HC II will be particularly judged in relation with the coverage plan, minimal quality standards and the opportunity for their upgrading to HC III before including them in a support scheme. The initial design of RBF will provide the necessary criteria.

The preparation will take a year. During that period, initial investments will be done in the PNFP health facilities that are selected according to the coverage plans and capacity building activities can start from the beginning. Some of the necessary conditions that need to be created before starting RBF are mentioned under 2.3.2.

The above model (Figure 1) cannot be realized in one step or with a simple political decision. It should be introduced gradually and the covered health care packages by the system should increase according to the expected increasing financial leverage the Trust Fund would build up. In its actual phase, this project will contribute to attaining the first step out of many, as presented in figure 2. The other two situations represent respectively a mid-term and long-term vision on how the financing of the health care system can evolve gradually to a NHIS, covering the whole population. These are beyond the scope of the actual project.

Figure 2: Phasing the introduction of a national health insurance and financing system



7.6.2 Initial Conditions – Creating an Enabling Environment

Initial Investments

Before starting the RBF, which will take time anyway to put in place, some basic investments in terms of basic equipment and logistics, particularly at the HC levels are needed to render them operational. In later stages, minor equipment replacement and maintenance should be covered by the RBF resources.

Health Coverage Plans

Districts and HSDs in West Nile and Rwenzori regions have been supported to develop explicit and elaborated coverage plans that can be used as a management tool to orient important public health decisions. Decisions on establishment of new facilities have been taken by a variety of stakeholders (health authorities, LGs, politicians, PNFP organizations, etc.) through a relatively uncoordinated process. This has caused a sub-optimal establishment of health facilities on Uganda territory with multiple structural inefficiencies as a consequence. Coverage plans can give more insight and permit better technical decisions and coordination for future decisions in these matters.

Good coverage plans should:

- Identify the actual implantation of existing health facilities, and particularly the HC II and III, with their respective catchment areas and distribution of villages. The catchment areas should not be according to theoretical administrative boundaries but according real utilization. Patients do not respect administrative boundaries.
- Identify underserved (far-away) populations in the catchment areas who might benefit from outreach activities for preventive services organized by the HC of this catchment area. This map must be communicated and discussed with LG officials and be used in dialogue with development partners, PNFP organizations for them to subscribe to this plan. It should allow a more optimal implantation of new health facilities.
- Identify underserved populations with virtually no reasonable access to any HC facility and identify villages where a new HC should be implanted preferentially.
- Identify the most optimal way of organizing support supervision at the HC level and determine supervision circuits that permit individual supervisors or small supervision teams to share a supervision vehicle the same day.

A good health coverage plan is regarded as a pre-condition for the DHMT and the HC in the area to benefit from a RBF. Without this coverage plan, planning activities and rationalizing the service is very difficult.

7.6.3 Support to PNFP Health Centres: From Initial Investment to RBF

This project document proposes a different approach for the direct support to PNFP HCs than for the hospitals. This has to do with the different care packages, self-management capacities and type of efforts needed at the two types of facilities.

HC III in the rural areas is crucial for providing basic health care close to the population. The system has been relatively neglecting them, compared with hospital care. Many of these rural HCs are dysfunctional even though individual HC have low running costs in general and in most cases only need basic investments to (re-)start functioning again.

In the first year of the project, these basic investment needs in terms of necessary basic medical equipment and logistics should be addressed. If coverage plans exist at that level and if outreach activities can be organized with the existing staff to increase coverage of preventive care in their catchment area, these HCs should also be equipped with a motorbike.

To start the RBF mechanism at this level it will probably take a year of preparation work. Performance indicators should permit to subsidize the health facilities accordingly. These support budgets should be able to cover:

- The recurrent costs of the HC, which will make them financially autonomous. Existing subsidies such as the government conditional grants should remain the same or should even increase. This condition will be monitored at central level. In the long run all government support to public services, including PNFP should be integrated in a pooled fund for contracting services (trust fund, see further).
- Basic maintenance and replacement costs for basic equipment, including the maintenance of a motorcycle if present.
- Motivation fees to increase the rewarding of the personnel. Such fees should not be higher than a certain percentage of the total salary, but should contribute to bridging the gap between PNFP and government wages. In the wage analysis, payment in kind such as providing housing, which seems a more frequent practice in PNFP facilities, should be

taken into account as well as special compensations like rural allowances (more frequent in government-owned services).

- Lastly, the subsidies should permit to lower the fees for patients, without necessarily abolishing them. This measure will not significantly lower their income because it will be at least partially compensated by increased use of the services.
- Efforts aimed at improving MCH as well as the fight against HIV/AIDS - including prevention and health promotion as well as the establishment of a functional health infrastructure (ambulances, equipment, etc.) - will be specifically targeted in this respect.

Providing capacity building for the personnel might also be considered by the project. In general it will be organized through training sessions by the DHMT. For other subjects, synergies will be looked for with the ICB and the SDHR project.

Only fully accredited facilities will be taken into account.

7.6.4 Support to PNFP Hospitals: From Initial investment to RBF

PNFP hospitals are largely functional despite the huge challenges they are facing, especially regarding financial resources and maintaining appropriate staffing levels because of salary discrepancies with the public sector.

They have the important operational advantage though, compared with the government-owned hospital facilities, that they are very flexible in decision-making (organizational, but also financially e.g. adjusting fee-paying systems, deciding on budget allocations) and personnel management (engaging and licensing, rewarding systems).

For the hospitals that will be supported by the project a RBF mechanism, based on monitoring of a set of indicators will be put in place. These additional funds should in the first place enable:

- **To increase the financial accessibility for patients to hospital care**. Therefore, the additional funds should be strictly directed towards care of patients referred from lower levels and to typical hospital services. This way the funds will contribute significantly to the complementary service between primary care level (HC III, eventually IV) and the hospital care, and will create a shift of first line health services actually delivered by the hospital towards lower-level (and cheaper) health care facilities. Actual primary care outpatient departments should be operationally separated from the hospital care and regarded as a HC III facility, though without hospitalization facilities. The fee-paying system should be adjusted to such situation.
- **To bridge the gap between government and PNFP health workers' salaries**. Part of the additional funds can be directed towards salary subvention. It will not only create a more equitable global health care system, but also stabilize personnel movements. It will permit in future a more integrated (PNFP-Government) personnel management and support system. If salaries become equitable, shifts between the subsectors can be realized without much difficulty.
- **To increase the financial means for small maintenance and other recurrent costs.** PNFP hospitals already cover these costs in their annual budgets. This should continue of course, but they will have more financial means to cover the real needs.

PNFP hospitals will be equipped with an electronic patient file system. Some of them seem to use already this very useful and powerful management tool. All clinical and support units of the hospital are linked to the same database in which the hospitalization of every patient is individually recorded. The system permits to generate statistics, to manage laboratory and pharmacy supply systems, to

automatize the administrative management of the patient and the invoices for an insurance system. Although the initial investment (financial but also capacity building) is important, it saves several salaries for the next 20 years, which means that it is a very cost-effective investment that reduces operation costs considerably. Moreover the generated data become more accurate and transparent.

The continuation and increase of the government conditional grant is also at this level a condition for the project before supporting the PNFP hospitals.

Only fully accredited facilities will be taken into account.

7.6.5 Designing a National RBF System

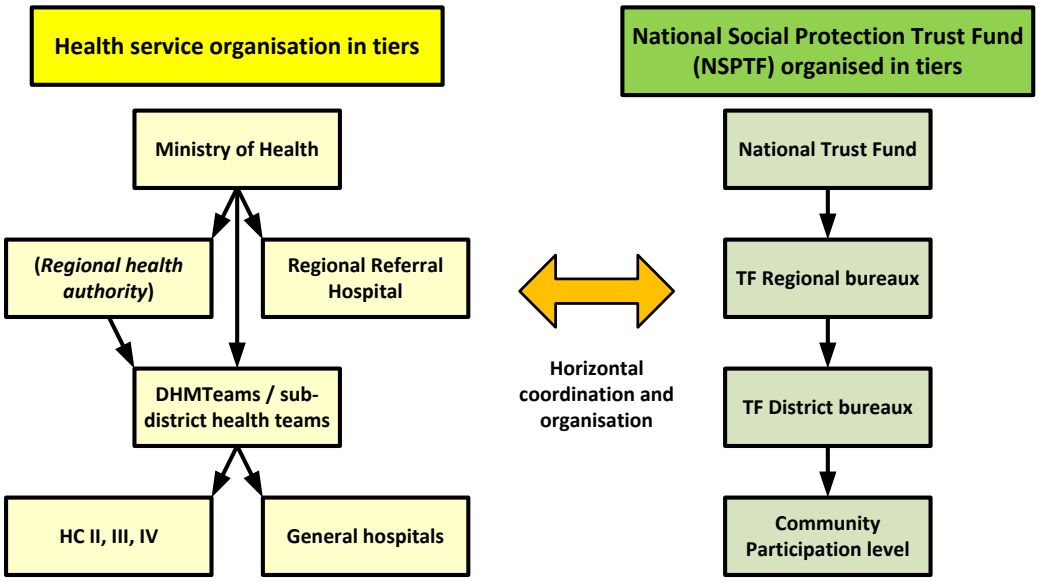
RBF systems are getting relatively widespread in the world. Results are promising on the one hand, whilst it becomes more and more obvious that:

- RBF does not bring the necessary changes in the system when taken in isolation and if other regulating mechanisms for dealing with quality service organization are not developed in parallel.
- Important negative side-effects are inherent to RBF. They actually become predictable as the knowledge on the dynamics of RBF is increasing.
- Output-based financing has its advantages, but input-based financing for basic salaries and important investment and maintenance works should remain a prerogative of the MoH and Public Service.

Therefore, Uganda should consider every known side-effect when institutionalising and scaling up its own national RBF system. The one-bullet-fits-all approach cannot work. Further in this text, the perverse effects will be considered and mitigating measures in the design will be proposed.

Lack of strong leadership and long-term engagement from both Government (MoH) and the donor community. According to the MoH National RBF Framework, a National RBF Interagency Committee will be established to coordinate and harmonize RBF projects / initiatives in the country. This Committee will be composed of the MoFPED, MoH, MoLG, Ministry of Justice and Constitutional Affairs (MoJCA), Ministry of Public Service (MoPS), National Planning Authority and HDPs to oversee implementation of RBF initiatives. The Belgian Embassy has already pronounced its interest in such an organization of the dialogue between partners. It is important that this coordination deals with RBF, but that the long-term vision on creating a national public social protection mechanism should be at the centre of the discussions. The TFF already referred to the concepts, Figure 3 represents a possible operational organisation of a NSPTF.

Figure 3: Possible operational organisation of a National Social Protection Trust Fund in the context of Uganda



Falsification of indicators

This is the most obvious side-effect if financing depends on essentially quantitative indicator values. From experience it appears to be difficult to fight falsification mainly because salaries (topping-ups) are to a significant level influenced by the qualitative performance and controlling agencies “play the game”. As a consequence often controlling mechanisms tend to become more and more important and more expensive.

Falsification of performance figures can be avoided (at least to a certain extend) when salary topping-ups are not directly or in a linear way related to performance indicators. Salaries should not go up with a fixed amount for every ANC consultation or curative care consultation. This approach does not only invite people of falsifying performance figures, it also punishes people working in more remote and less populated areas, where the number of clients by definition is less.

Not linking salaries in a linear way to quantitative performance indicators can be avoided by:

- Working with lump sum increases: Up to 25% of coverage is corresponding with a given sum, up to 50 with another, and so on.
- Working with qualitative or more comprehensive indicators: for example, is the maternity unit functional, according to a number of criteria?
- Salary topping-ups should be limited to a reasonable percentage of the basic salary. Basic salaries should be decent, topping-ups might boost motivation to do better than usual.

Neglect of activities that are not included in the RBF indicators

This is a natural tendency in any RBF funding mechanism. The widely heard criticism is that when projects target very specific activities and provide particular staff salary increase, the overall service gets disrupted. To mitigate this effect, RBF should be inclusive, meaning that all the aspects of the foreseen packages should be included in the performance. The HC minimal package and the general hospital complementary package should be completely covered. Specific other services of hospitals might be added to the system if recognised by the coverage plans for hospitals.

Such an approach will motivate HC to complete the minimal health care package if not yet done. HC often do not yet implement HIV preventive care for instance.

Costly control exercises and biased evaluations

Controls and audits (for the re-investments) are necessary to reduce the overall risk of the system. Control has its price though as well, and in many experiences is more costly than the misuse that is avoided.

Controls have no added value in an environment of impunity. Clear rules for rectification of false situations should be installed and correctly applied if the RBF wants to succeed.

The system should avoid though that it has to verify at the level of precision of a single consultation or other medical act. If the salary topping-ups are limited and also linked to global performance indicators as suggested by the above table. In such case, fraud will be avoided and a little exaggeration of figures of performance will not affect the salary level but will give extra financing for the running of the facility. The latter is less catastrophic.

Using the funds for savings

This is a rather particular perverse effect that HC do not inject the received funds back into the system but save them for more precarious periods. Rules should be put in place that oppose this tendency e.g. savings should not represent more than a certain percentage of total funding except when major investments are planned for necessitating more than one quarter savings to cover the purchase.

Institutionalise inefficiencies through RBF funding

When funds are allocated to inefficient services, such inefficiencies will continue to exist thanks to the injected resources.

This can be avoided through critical coverage plans, respecting policies on basic and complementary packages of care, correct personnel affectation to services according to objectivised workload and by creating urban health centres (remove primary care services from hospitals).

Though it is agreed that corrective measures are not easily introduced (especially for the latter problem), RBF should not fund irrational activity. It could mean that outpatient departments are financed only at the level of a HC although the real costs are higher. It is up to the hospital to look for cheaper solutions.

Creation of parallel authorities

Experience has shown that the risk of creating strong controlling entities that exert power over health facilities and indirectly paralyse existing authorities is real. Auditing should be separated from taking corrective measures for defiant activities. The latter should be corrected by the health authorities. They should also remain in control of the business plans.

	Purchaser responsibility (Fund responsibility)	Care organiser responsibility (MoH, DHMT, hospital directing board)
Control of invoices and performance indicators	**XX**	
Payments	**XX**	
Business plans and salary topping-up authorisation		**XX**
Declaring fraud or anomalies or quality problems	**XX**	
Corrective measures for quality assurance		**XX**
Disciplining measures		**XX**

7.6.6 The auditing and business plans

The amounts facilities receive through the RBF funds should cover recurrent costs, small investments, lowering user fees and salary topping-ups. Rules should be established and applied as described partly in above paragraphs. Investments should be audited and the facilities will get external help to assist in establishing business plans (analytical book keeping and re-investment plans). At HC level the necessary support will be delivered by the DHMT, for the general and referral hospitals the project will provide for the necessary expertise in a first stage.

The auditing and support for the business plans of the health facilities constitutes an additional occasion not only to reduce the risk of fraud, but will also increase the efficiency of the system through an optimal use of the available funds.

7.7 Capacity Development areas (synegy with SDHR)

7.7.1 Capacity Development areas

	Project Results				Capacity development strategies								
Capacity development areas	**1**	**2**	**3**	**4**	**Exchange**	**Facilitation**	**Coaching**	**Research**	**Training**	**Advice**	**Management (substitute management)**	**Implementation (substitute management)**	**Provide equipment and infraestructure**
Individual capacity building or Human Resources Development (HRD)													
Management skills *(development of knowledge and skills of an individual level that are necessary to improve the management of the organisation: development of a policy, planning, strategical thinking, operational management, financial management, conflict solution, M & E, personnel management, etc. HRD can focus on the development of such skills, insights and knowledge at the workers of the organisation.*													
Technical skills *(development and application of technical knowledge and skills. Dependent on the field of operation of the organisation, e.g. the field of agriculture, education, medical care, media, etc.)*													
Attitude and motivation *(The behaviour of people, also working people, is determined not only by their knowledge and skills, but for an important part by their motivation, values, attitudes, and expectations. HRD can focus on the activation or modification of such attitudes and motivation.)*													
Capacity building of the organisation or Organisational Development (OD)													
Strategy and policy *(Long term planning, translation of the mission in concrete objectives and tactics)*													
Capacity to learn *(Capacity to learn from experience and to feedback to own policy and operations)*													
Structure *(Formal and informal division and coordination of roles, positions and responsibilities)*													
Systems *(Internal processes that regulate the operation of an organisation, e.g. administration, blanning, budgetting, accounting, reporting, monitoring, evaluation, learning, etc.)*													
Staff *(Activities / rules focused on the use, motivation, development of the staff and their tasks)*													
Style of management *(Roles and rules for managers and leaders)*													
Networks *(the capacity to maintain relations and finetune them with civic actors that are relevant to the organisation)*													
Culture *(The values, principles and styles that are typical for the organisation)*													
Financial management *(Obtaining funds, financial planning and accountability)*													
Technical competence *(Capacity and means to fulfill certain technical tasks, dependent on field of operation and sector)*													
Institutional capacity building or Institutional Development (ID) (enabling environment/sector)													
Strategical finetuning *(Finetuning between different organisations, that operate within a certain region or sector with the view on a joint external policy.)*													
Operational finetuning *(Finetuning of programs and joint program development)*													
Learning capacity *(Exchange of knowledge and experiences between organisations in a network, that lead to learning processes, by which the policy and execution thereof is influenced by different organisations within the network)*													
External influences *(Capacity to orientate on the dynamic context and the joint influence in the direction of thrids to defend interest and contribute to policies (of goverments, multilateral institutions, donors, private organisations or other NGOs). These thirds can also by less tangible institutions, like the market and the framework of rules that apply.)*													

7.7.2 Specific trainings

LEADERSHIP
STRATEGY
HR
RESOURCES - COMMUNICATION
RESOURCES - LIBRARY
RESOURCES - RECORDS

RESOURCES - WASTE
RESOURCES - FINANCE
RESOURCES - ASSETS
RESOURCES - CATERING
RESOURCES - MOBILISATION
RESOURCES - OFFICE MANAGEMENT
RESOURCES - DRIVERS
RESOURCES - PARTNERSHIP
RESOURCES - PROCUREMENT/CONTRACTS
RESOURCES - PPP
RESOURCES - MARKETING
RESOURCES - MEDICAL EQUIPMENT
WORK PROCESS - GENERAL
WORK PROCESS - HEALTH
WORK PROCESS - HEALTH RESEARCH
WORK PROCESS - HEALTH - PEDIATRIC/NEONATAL
WORK PROCESS - HEALTH - MEDICINE
WORK PROCESS - HEALTH – SURGERY
WORK PROCESS - HEALTH - ANAESTHESIA
WORK PROCESS - HEALTH - LABORATORY
WORK PROCESS - HEALTH - NURSING
WORK PROCESS - HEALTH - BIOSECURITY
WORK PROCESS - HEALTH - EMERGENCIES
WORK PROCESS - HEALTH - ENT
WORK PROCESS - HEALTH - PALLIATIVE CARE
WORK PROCESS - HEALTH - RADIOLOGY AND ULTRASOUND
WORK PROCESS - HEALTH - BLOOD TRANSFUSION
WORK PROCESS - HEALTH - COLD CHAIN MGMT
WORK PROCESS - HEALTH - DISEASE SURVEILLANCE
WORK PROCESS - HEALTH – HMIS
WORK PROCESS - HEALTH - ALLIED
WORK PROCESS - HEALTH - GYNAECOLOGY/OBSTETRIC
WORK PROCESS - HEALTH -QA
WORK PROCESS - HEALTH - NUTRITION
WORK PROCESS - HEALTH - PHARMACY
WORK PROCESS - HEALTH- HRIS
WORK PROCESS - ENVIRONMENT
PME
ICT
POST LEARNING