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TRACKING THE PROGRESS AND IMPLICATIONS OF THE GLOBAL FINANCING FACILITY (IN THIS CASE RESULTS - BASED FINANCING) IN THE HEALTHCARE SECTOR IN UGANDA

Final Report

The Center for Health, Human Rights and Development (CEHURD)

July 2021

Moses Mulumba (Principal Investigator)
Professor Robert K. Basaza (Co-investigator)
Fred K. Muhumuza, PhD (Co-investigator)
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ABBREVIATIONS AND ACRONYMS

AAAQ	-	Availability, Acceptability, Accessibility and Quality
ANC	-	Antenatal Care
CEHURD	-	Center for Health, Human Rights and Development
CAO	-	Chief Administrative Officers
CSO	-	Civil Society Organisation
CSBAG	-	Civil Society Budget Advocacy Group
DHMTs	-	District Health Management Teams
DHO	-	District Health Officer
GAVI	-	Global Alliance for Vaccines and Immunisation
GFF	-	Global Financing Facility
GFTAM	-	Global Fund to Fight Aids, Tuberculosis and Malaria
GoU	-	Government of Uganda
H/C	-	Health Centre
HMIS	-	Health Management Information Systems
IC	-	Investment Case
IDA	-	International Development Association
JMS	-	Joint Medical Stores
KII	-	Key Informant Interview
LQA	-	Lot Quality Assurance
MoFPED	-	Ministry of Finance Planning and Economic Development
MOH	-	Ministry of Health

MoLG	-	Ministry of Local Government
NIRA	-	National Identification and Registration Authority
OPD	-	Outpatient Department
PNC	-	Postnatal Care
PNFP	-	Private Not For Profit
QIT	-	Quality Improvement Team
RBF	-	Results Based Financing
RMNCAH	-	Reproductive Maternal, Newborn, Child and Adolescent Health
SDG	-	Sustainable Development Goal
SDS	-	Strengthening Decentralisation for Sustainability
UCMB	-	Uganda Catholic Medical Bureau
UDN	-	Uganda Debt Network
UPMB	-	Uganda Protestant Medical Bureau
URMCHIP	-	Uganda Reproductive, Maternal and Child Health Services Implementation Project
WRA	-	White Ribbon Alliance

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EXECUTIVE SUMMARY

Result Based Financing (RBF) is "a cash payment or non-monetary transfer made to a national or subnational government, manager, provider, payer or consumer of health services after pre-defined results have been attained and verified". It separates the key health system functions of regulation, fund holding, purchasing, verification and service provision. The approach is aimed at providing more outputs from the available inputs; rationalising the utilisation of inputs; targeting specific population groups with special attention to the poor and vulnerable; and transforming clinical practice towards improved quality of healthcare. RBF is a component of the Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHIP), to which the Global Financing Facility(GFF), as well as other international actors, are contributing. The general objective of this study was to track the progress and implications of the GFF in the Healthcare Sector in Uganda, through the RBF component.

Specific objectives of the study were:

1. Explore the role and contribution of the private sector and Civil Society Organisations (CSO) in the GFF processes and the implementation of URMCHIP.

2. Assess the readiness and effectiveness of the beneficiary health facilities in the implementation of the RBF model, which the GFF contributes to.

3. Examine the control and disbursement of GFF funds from the World Bank to the recipient implementing Government departments and agencies as well as the loan component of the programme.

4. Assess the extent to which the GFF partnership and the implementation of URMCHIP in Uganda is underlined by Human Rights-Based approaches to development using the Availability, Awareness, Access and Quality framework.

Methodology:

A case study research design was employed. It was chosen in order to permit an in-depth focus on the processes and implementation helped in explaining the current practices of RBF in Uganda in both public and private not for profit health facilities. Specifically, the research explored processes, functions and practices in the current separation of the key health system functions of regulation, fund holding, purchasing, verification and service provision. The major quantitative data were from records and statistics reviews. Data sources included all the available district reports and strategic documents, Lot Quality Assurance reports, Health status reports including the Health Management Information Systems, Ministry of Health(MoH) reports, Health facilities' records among others. Qualitative data on the other hand was collected from MoH officials (RBF Unit), Healthcare facilities' RBF focal persons, and District's secretary for health (RBF focal person at the district), Chief Administrative Officers,

Civil Society representatives and Ministry of Finance Planning and Economic Development officials.

Results:

There has been minimal participation of private sector and Civil Society Organisations(CSOs) in the GFF processes, which influenced set up and operations of RBF, but this has been minimal.

The terms of reference for the CSOs were not clearly known by both the Government and CSOs. Since this is the first direct involvement of CSO in formulation and implementation of such global initiative, this has been a remarkable start.

Despite the CSO being part of the sector planning system in Uganda, there has not been a framework to provide the definitive position where the civil society is part and parcel of the implementation process of RBF. Some beneficiary health facilities were not adequately prepared to implement RBF. However, RBF has been welcomed by the health system, especially due to benefits like the additional financing to facilities, staff incentives and improved availability of commodities. The resource mapping for the investment case showed that the funding gap decreased over time from 46% to 29% between 2017/18 and 2019/2020. This reflected an increase to 71 percent of the planned financing.

Conclusions:

The GFF partnership and URMCHIP implementation in Uganda has been underpinned by Human Rights-Based approaches to development. RBF has improved availability of medical supplies within facilities and increased service utilisation by patients and clients. In terms of acceptability, the political and health facility staff did not have enough information about the source of the money used to finance the program. In fact, some thought it was from MoH and almost all of them did not know that there was a loan component from World Bank. There was improved access to healthcare services not only by those covered under GFF and URMCHIP but generally all the services at facilities. This was largely triggered by RBF and is largely realized through increased availability of health workers and outreaches. Attempts have been made to improve the quality of healthcare. The design of the program embedded quality indicators. The districts' committee visits to each participating facility at least once in a quarter to verify the self-reported marks on each indicator were also helpful.

Recommendations:

Key among them are:

1. The health sector should further enhance sensitization of both government staff and CSOs so as to build and expand a common understanding of the mode of operation of the RBF. The partnership was more inclined to entities involved on the supply side with the CSOs left to handle the bulk of the tasks on sensitisation of communities to demand for accountability.

2. There should be continuous support and supervision by the GOU and CSOs to the RBF beneficiary health facilities so as to improve on the operations of RBF at institutional level.

3. There is need by CEHURD and Uganda Debt-Network to press the (MoFPEFD) and (MoH) for details of RBF funds and thus avail detailed information of the disbursement schedules to the public.

4. The Health sector should carry out Operational Research and learning which should be part and parcel of the implementation of the RBF since this is a new phenomenon.

1. BACKGROUND

1.1 Introduction

This study was commissioned by the Center for Health, Human Rights and Development (CEHURD), a not-for-profit research and advocacy organization in collaboration with the Uganda Debt Network (UDN) and Wemos. The core objective was to study the progress of the Global Financing Facility (GFF) in Uganda, which contributes to the Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHIP), and particularly the implementation of the Results Based Framework (RBF) component of URMCHIP. The report is expected to contribute towards the mission of "Upholding Governance and human rights under GFF in the country".

RBF is defined as "a cash payment or non-monetary transfer made to a national or subnational government, manager, provider, payer or consumer of health services after pre-defined results have been attained and verified". As such, RBF is an umbrella term comprising a number of payment terms including, Performance Based Financing, Output-based aid, Performance Based Contracting, Provider Payment Incentives and Pay-for-Performance among others. It can also be defined as a form of pay for performance, where the principal, who provides the funding, pays the agent (who implements the project, or provides the service, or takes other agreed actions). The payment depends explicitly upon achieving predefined results including the degree to which services are of approved quality, as defined by protocols for processes or outcomes. It includes both demand side and supply side pay approaches [1, 2].

The RBF approach promotes split of functions. It separates the key health system functions of Regulation, Fund holding, Purchasing [3], Verification and Service provision. The approach is aimed at providing more outputs from available inputs; rationalising the utilisation of inputs; targeting specific population groups with special attention to the poor and vulnerable; and transforming clinical practice towards improved quality of healthcare [4].

In Uganda, the RBF scheme started way back in 2003 with the World Bank Performance-Based Contracting Study (2003-2005), being the first project in Africa; and later a number of other projects followed. These projects were managed by private entities until 2010 when the Strengthening Decentralisation for Sustainability (SDS) Project (2010 -2016) under Ministry of Local Government (MoLG) - USAID funded was started. Its aim was to provide performance-based grants to districts or sub-national level to improve social service delivery, with emphasis on health, education, and services for orphans and vulnerable children. A number of lessons were picked during the implementation of those different RBF schemes. Some of the highlighted lessons included: the demonstration that supply and demand side RBF projects are both useful for increasing access to health services; the demand side programs can play a key role in increasing utilization of critical under-utilised services while supply side RBF was

instrumental in strengthening the health system and Human Resources for Health; that RBF can be implemented in both public and private facilities [4]. Those lessons and many more provided guidance on the development of the National RBF framework.

1.2 The Global Financing Facility and it's Conceptualization

The GFF was launched in July 2015 in Addis Ababa to support Every Woman Every Child (EWEC). The GFF partnership supports the Government of Uganda (GoU) to coordinate stakeholders to design and fund selected investments with a clear set of priorities in the area of reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N). The mission of the GFF partnership is to contribute to Sustainable Development Goal (SDG) 3 targets: by 2030, reducing the maternal mortality ratio to 70 per 100,000, the under-five mortality rate to 25 per 1,000, and the new born mortality rate to 11 per 1,000, and also improving the health and nutritional status of women, children, and adolescents.

A key unique feature of the GFF is the need to go beyond certain interventions and disease-specific approaches but to consider outcomes at the critical stages of the person's life cycle - pregnancy, birth, early years and adolescence [5]. The Facility supports the mapping of resources and alignment of funders around the selected investment case. It also supports the identification of key health financing reforms needed in the country in order to mobilize sufficient domestic resources. Thus, the GFF must achieve two major aspects: i) strengthening collaboration, communication, and engagement with all key partners at the country level; and ii) continuously prioritize the resources towards those who need them most [5].

The GFF empowers countries by pooling knowledge, financial and other resources from a several multilateral stakeholders to investing in existing institutions. A forum or committee under government leadership brings together the broad set of partners involved in RMNCAH-N to create a multi-stakeholder platform and processes that helps to avoid duplication as well as to create significant synergies. Besides some key multinationals that contribute financial resources, the CSOs play an important role in advocacy, social mobilization, supporting demand for accountability and service delivery. The GFF strives to enable partners and stakeholders to identify their comparative advantages, avoiding duplication and reducing gaps by supporting the government to bring all key stakeholders together to develop and implement a single country-led investment case based on the specific needs.

The major characteristics of the initiative included: putting countries at the forefront of their own development agenda; ensuring scale and sustainable financing; as well as getting results for the women, children and adolescents. The country must have a plan that focuses on women, children and adolescents. It must also have a desire to invest in high-impact areas such as sexual and reproductive health and rights (SRHR), maternal and newborn survival, adolescent health, and improved nutrition in the early years. The GFF provides additional support to the entire health system to ensure sufficient delivery to scale and with sustained impact across all the target areas. The GFF encourages continuous innovation on financing including catalyzing additional domestic and private resources to over-dependency on development aid.

It supports government to strengthen existing health financing strategies as well as assess different options for increasing resources to fund health and nutrition. Consideration is given to the bigger context including trends in public debt and its impact on healthcare provision, attraction of private sector resources, and advocacy for human rights in order to improve delivery of health services. The GFF seeks to increase finances and improve governance to ensure adequate consideration of human rights, equality and accountability. Poor governance can create aspects of exclusion due to lack of adequate prioritization or biases as some people are not adequately catered for due to places where they live or simply because of who they are.

Investment is carried out to resolve the most significant health system bottlenecks, which may be in: governance, health workforce, financing operations, supply chain management, or information systems. Beyond the health sector, the GFF considers how targeted investments in other sectors (such as education, water and sanitation, and social protection) are likely to impact health and nutrition outcomes among the target population. Thus, although the investment case covers a short period of about 5 years, it is developed with a long-term perspective intended to set the country on course to reach the health-related SDG targets by 2030.

After its first five years of implementation, the GFF has now endorsed a new global Strategy for 2021-2025 with five strategic directions:

a. Bolster country leadership and partner alignment behind prioritized investments in health for women, children and adolescents.
b. Prioritize efforts to advance equity, voice and gender equality.
c. Protect and promote high-quality, essential health services by reimagining service delivery.
d. Build more resilient, equitable and sustainable health financing systems.
e. Sustain a relentless focus on results.

Along with this strategy refresh, the GFF also endorsed a new framework for engagement with youth and civil society, and recently launched an Acceleration Plan for SRHR to support countries amid the Covid-19 devastating impacts.

1.3 The Investment Case for Uganda

The selection of Uganda in 2016 prompted the government to revitalize a process of developing the "Sharpened RMNCAH Plan" that was the previous national strategy for women, children, and adolescents' health. This was revised to the "Investment case for reproductive, maternal, newborn, child and adolescent health sharpened plan for Uganda 2016/17-2019/20".

The revised plan had the following **"Strategic Shifts"**:

- Emphasizing evidence-based high-impact solutions. This includes identification of a package of evidence-based interventions for each service delivery level;
- Increasing access for high-burden populations by promoting a set of service delivery mechanisms that operate synergistically;
- Geographical focusing and sequencing to determine the roll out of the package of interventions;
- Addressing the broader multi-sectoral context, with a particular focus on adolescent health; and
- Ensuring mutual accountability for RMNCAH outcomes that includes strengthening data systems.

The Sharpened Plan provided details for each of the "strategic shifts", including the required interventions for health systems strengthening and capacity building. It emphasized strengthening district health management and scaling-up community-based health service delivery. It addressed both supply-side constraints (e.g., scaling-up RBF at the facility level) and demand-side challenges (particularly by expanding the use of vouchers and by including activities to generate demand for RMNCAH services).

The total financing including funds for the RBF Uganda was USD 165 million. This was sourced through a concessional loan from The World Bank's International Development Association (IDA) (USD 110 million), a grant from the GFF (USD 30 million), and a grant from the Swedish International Development Cooperation Agency (SIDA) worth USD 25 million. Out of the total of USD 165 million, USD 85.5 million was allocated to the RBF component. The rest was allocated to health system strengthening for RMNCAH service delivery, strengthen the capacity of the delivery of births and deaths registration services, and enhancing institutional capacity to manage project supported activities.

The Government of Uganda (GoU) also increased its contribution in the process of preparing a new investment case. According to the Annual Report for 2019/20, Uganda's Investments Case (IC) for 2016/17 - 2019/20, had a funding gap that decreased from 46% in 2017/18 to 29% in 2019/2020. The donor contribution increased from 48% in 2017/2018 to 65% in 2019/20, mainly due to more contributions from GAVI, GFTAM and the WB/GFF.

The Uganda National RBF model includes the Fund holder (MoFPED), Regulator (MoH), Purchaser (MoH, RBF Unit), and Oversight (National RBF Committee). In addition, there is verification at district level (MoH, RBF Unit), and at health facilities (DHMT) and health care provides who are both public and private. The program was implemented in phases with

the initial one covering 83 health facilities in 28 districts. This was later scaled up to cover the whole country. The criteria for selecting the initial districts and health facilities included: poverty levels, disease burden (performance on key RMNCAH outcomes), access/coverage of health services, and presence of other Partners. Districts with ongoing RBF programs were excluded.

1.4 General Objective of the Study

The general objective of this study was to track the progress of the GFF in the Healthcare Sector in Uganda, which contributes to the Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHIP), and particularly the implementation of the RBF component of URMCHIP.

1.4.1 Specific Objectives of the Study

- Explore the role and contribution of the private sector and Civil Society Organisations in the GFF processes and the implementation of URMCHIP.
- Assess the readiness and effectiveness of the beneficiary health facilities in the implementation of the RBF model, which the GFF contributes to.
- Examine the control and disbursement of GFF funds from the World Bank to the recipient implementing Government departments and agencies as well as the loan component of the programme.
- Assess the extent to which the GFF partnership and the implementation of URMCHIP in Uganda is underpinned by Human Rights-Based approaches to development using the Availability, Acceptability, Accessibility and Quality (AAAQ) framework.

2. METHODOLOGY

2.1 Research Design and Data Sources

A case study research design was chosen in order to permit an in-depth focus on the processes and implementation of the current practices of RBF in Uganda in both public and private not for profit (PNFP) health facilities. The private for profit health facilities are not included in the RBF initiative. Specifically, the research explored processes, functions and practice in the current separation of the key health system functions of regulation, fund holding, purchasing, verification and service provision.

The study used two approaches to collect data: quantitative and qualitative. The major quantitative data were from records and statistics. Data sources included all the available district reports and strategic documents, Lot Quality Assurance (LQA) reports, and health status reports including the Health Management Information Systems (HMIS), MoH reports, health facilities' records, among others. Qualitative data on the other hand was collected through key informant interviews with MoH officials (RBF Unit), Healthcare facilities' RBF focal persons, and Districts' secretary for health, DHOs (RBF focal person at the district), Chief Administrative Officers (CAOs), Civil Society Representatives (CSO) and Ministry of Finance Planning and Economic Development (MoFPED) officials. The research team also reviewed the RBF feasibility studies, performance reports, service data, and minutes of collaborating partners, among other records. Triangulation of methods and sources provided an opportunity to corroborate findings and to enhance the validity of the data.

2.2 Study Participants and Study Sample

The study participants were MoH officials (RBF Unit), Healthcare facilities' RBF focal persons, and Districts' secretary for health, DHOs (RBF focal person at the district), CAOs, CSO representatives and MoFPED officials, CEHURD and UDN staff.

2.2.1 Sampling Design and Procedure

All study participants were purposively selected. The consultants clustered districts according to their regions. In total, three districts were selected to be included in this study. In choosing the actual districts of study within the cluster, the consultants further categorized the districts according to two criteria; i) Those that had been implementing RBF since 2018 and beginning of 2019; and ii) their performance. Using the Annual Health Sector Performance Review report of 2017/2018, the identified districts were subjected to a criterion of best (top half performing) and worst (bottom half performing) and a total of three districts were selected; Kampala (49th), Namisindwa (114th) and Oyam (6th). The final selection therefore was one district each, from eastern, northern and central regions.

In all the selected districts, all participating facilities were purposely selected provided they are at different level and/or ownership and also, they were part of those chosen to implement RBF at its initiation within the district. Four healthcare facilities were sampled per district, totaling to 12 facilities.

2.2.2 Sample Size

Table 1: **Sample selection and size**

No	Method	Target audience	Proposed sample size
1	Desk review	• Statistics relating to RBF • Records including MoUs and meeting minutes on RBF • HMIS data on key indicators relating to RMNCAH • Lot Quality Assurance (LQA) • Peer reviewed literature on RBF	N/A
2	Key informant interviews	• District Health Officer (RBF focal person at the district) • CAOs • District secretary for health • Health facility RBF focal person • Ministry officials (MoH and MoFPED) – Two from each ministry • Health facility managers • Staff of UDN and CEHURD – one from each institution • CSOs representatives within the target districts	24 respondents

2.3 Data Collection Methods and Instruments

The following data collection methods and tools were employed.

2.3.1 Desk Review

Based on the need for the consultants to familiarize with the project, the key documents reviewed were districts statistics and records, MoH and MoFPED reports, peer reviewed articles and GFF strategic documents.

2.3.2 Key Informant Interviews (KIIs)

These were conducted with all identified respondents as indicated in table 1 section 2.2.2. The interviews explored issues relating to all the objectives of the study. Voice recorders were used as a supplementary data collection tool during KIIs. They were applied after written consent was sought and the participant had agreed to be recorded.

2.4 The Study Process and Quality Control

2.4.1 Recruitment of Experienced Data Collectors

A team of qualified and experienced data collectors was recruited. All those recruited were fluent in English. Special attention was taken to have a mixture of both males and female data collectors in a ratio of 1:1.

2.4. 2. Training of the Data Collectors

The data collectors underwent training to equip them with the essential knowledge and skills to conduct this study. The training covered issues of methodology to be used, interview skills, ensuring data quality, and ethical principles. The training enabled the team to apply the methods and procedures uniformly and consistently.

2.4.3 Pre-testing of the Data Collection Tools

The pre-testing of data collection tools was done in Mukono District because it was implementing RBF. It was also outside the sample districts, and close to Kampala, which was the base of the study. The purpose was to test the quality of the tools and whether they fit the intended purpose as well as the ability of the interviewers' to understand collecting quality data. The findings of this pre-test included exactly who to interview and where to collect the data on all the indicators. These findings were incorporated into the tools, and the proposal.

2.4.4 Field Supervision of Data Collection

The data collection process was supervised by both investigators and staff from CEHURD and UDN.

2.5 Data Management

2.5.1 Data Cleaning and Entry

Upon completion of data collection, quantitative data was cleaned for errors before analysis. For qualitative data, initial themes were developed before actual data collection. Data was transcribed on a daily basis and organized according to themes, and a write-up done.

2.5.2 Data Analysis and Presentation

Quantitative data was entered into Microsoft Excel sheets and analysis done; and tables generated for data presentation. For qualitative data, higher level codes were developed before actual data collection. Data was transcribed daily while playing audio recordings to give more clarity, meaning and ensure accuracy of transcription. Data was analyzed manually through reading the transcriptions and creating memos, which resulted in reviewing the initial themes by combining, separating, and generating overarching themes characterized by internal homogeneity and external heterogeneity. The researchers examined the validity of themes with respect to data set by moving back and forth between the data extracts for codes and themes. The similarities and differences between the themes were analyzed to maintain meaning of the data. All these were

done by two investigators independently and later they came together to review and harmonize the final set of themes to ensure that they answer the research objectives. Finally, the findings were reported basing on the themes, using direct quotations from the data set.

2.6 Ethical Considerations

Data collection adhered to the following:

- The proposal was submitted to National Council of Science and Technology for approval.
- The participants were provided with information about the study, the reasons for participating, and the risks and benefits of their participation. Study participants gave written informed consent and none of the selected participants declined to participate. Participants were also informed that even after the interviews had started, they were allowed to pull out without repercussions. Furthermore, the study didn't have any participant that refused to be recorded.
- Participants were assured of anonymity and none expressly wished to have their names included in the reports. Unique identifiers not names have been used to keep the particulars and identities of the participants confidential.
- Data was kept on a password secured computer only accessible to the researchers and the client. The participants' information was protected at all times.
- No direct costs on the side of participants were incurred to take part in this study. Most of the participants were found in their homes and or offices. KIIs were conducted at their convenient places within or outside office premises.
- Conversations were held in private spaces, conveniently selected by the participants themselves.

2.7 Limitations to the Study and Counteraction Measures

Data collection was done in only three districts and only four facilities in each district. This was due to the cost implications. However, since the study was biased towards its qualitative approach, the researcher ensured saturation during the discussions with the selected participants. Data collection was delayed because of the lock-down due to Covid-19. In some cases, physical interaction was replaced with phone interviews. However, enough time was put aside to explore the research topic.

3. STUDY FINDINGS

3.1 Introduction

The study findings in this chapter are presented to capture the four objectives:

- Explore the role and contribution of the private sector and Civil Society Organisations in the GFF processes and the implementation of URMCHIP.
- Assess the readiness and effectiveness of the beneficiary health facilities in the implementation of the RBF model, which the GFF contributes to.
- Examine the control and disbursement of GFF funds from the World Bank to the recipient implementing Government departments and agencies as well as the loan component of the program.
- Assess the extent to which the GFF partnership and the implementation of URMCHIP in Uganda is underlined by Human Rights-Based approaches to development using the Availability, Acceptability, Accessibility and Quality (AAAQ) framework.

3.2 General Characteristics of the Health Facilities Visited

The study was conducted in the districts of Kampala, Oyam and Namisindwa representing the regions of Central, North and East respectively. In each district, four facilities that had been implementing RBF program since 2018 and beginning of 2019 were chosen to participate in the study. In total, data related to the RBF indicators was collected from 12 health facilities as shown in table 2. Nine were public while the PNFP were three. Eight level three facilities (H/C III) were visited and four level four (H/C IV). Data collected was for 15 months after the introduction of RBF and compared with previous data for 6 months before RBF so as to depict the effect of the project. In all the districts visited, no hospital was chosen to implement the RBF program in the initial selection. The program was initially introduced in health centres III and IV. However, we were later informed by the MoH official that hospitals were on board to act as referral centres.

Table 2: **Number, Ownership and Level of Health Facilities**

District	Ownership		Level	
	Public	PNFP	H/C IV	H/C III
Kampala	2	2	2	2
Oyam	4	0	1	3
Namisindwa	3	1	1	3
Total	**9**	**3**	**4**	**8**

Source: *Primary data*

3.3 Role and Contribution of the Private Sector and CSOs in the GFF Processes and the Implementation of URMCHIP

In this sub-section, the role and contribution of the private sector (both for-profit and not-for-profit) and CSOs in the implementation of the GFF including URMCHIP in Uganda was explored at the national and district levels.

3.3.1 National Level

Even though GFF acknowledges the role of CSOs in strengthening the project outcomes, most are currently playing a minimal role in its implementation. CSOs in Uganda were involved in the initial design and negotiations of the GFF partnership in the country, as indicated in literature. The reviewed literature indicated that, the CSOs key contacts were collected from the initial meetings and then a snowball approach was later used in the project to map out other CSOs and to make a clear distinction between those involved in RMNCAH related work and those conducting advocacy work around World Bank operations and foreign aid in Uganda. Some of those Organisations were UDN, CSBAG, WRA among others. Later, CSOs having knowledge on GFF process in Uganda were interviewed in a follow-up consultation.

The CSOs through their coalition engaged MoH to have representation on the national multi-stakeholder country platform. The representatives were identified but were not invited to participate in national activities when implementation started. Therefore, at the time of data collection, the study found that CSOs were not actively involved in implementation of the program. However, during the introduction of the program at regional and district levels, the MoH instructed the districts' leadership to invite CSOs and other private partners to be part of the district program introduction meetings. While discussing with MoH officials, it was indicated that:

> *"..... CSOs need to proactively and routinely do their responsibility of watchdog. For example, no one from CSOs has ever come to ask any questions about the GFF program but whenever you get somewhere in another meeting, they claim they don't get information"* (MOH Official)

3.3.2 District Level

The program introduction meetings at districts were organized by the district officials with request from MoH. From the discussions with district officials, it was noted that CSOs and private sector were invited but, in some instances, they did not turn up and where they did, some could send very junior staff to represent the Organisations. It was however established that CSO representations among the district meetings were not consistent. In some districts, the officials could not even remember the CSOs that participated in those meetings. It was found that there was no clear framework of engaging CSOs. On the same note, the consultants interacted with some CSOs within Kampala district and it was indeed clear that most of them

had limited knowledge about the GFF. For example, when asked where RBF came from, one of the CSO representative had this to say:

> *I am not very sure. But I think it's a World Bank Health Finance Model"*
> (CSO representatives District level).

In the districts outside the central, it was discovered that there were partners that were working within the districts and indirectly supporting the GFF program. For instance, one of the CSOs representative in the district when asked how they support the program, he had this to say;

> *..... What we have done is not directly like you say you are doing something towards this. Like for example we support facilities to conduct ANC outreaches and of course, ANC is one of the indicators for RBF. We provide cash to the health workers for lunch and transport refund to the communities they are going. Basically, we support them to reach the communities. Then also we support them to get logistics for example we handle HIV tests because every mother is supposed to do an HIV test, so we help with that. We also monitor the stocks of those logistics and we also help them provide stock. I know they get them through transactional means but in cases where they have already run out of stock, we find alternatives to support them. Things like mosquito nets, test kits, with family planning commodities among others".*
> *CSOs representative at district/sub-national level)*

> *…. this would be at the discretion of the district so we would not impose on them who they would invite. We just tell them there is a slot for may be a regional partner, a CSO representative and other stakeholders at that level".*
> (MOH Official)

Nevertheless, during interviews it was found out that, at different levels some private Organisations are playing defined roles in the GFF program as highlighted in Table 3.

Table 3: **Role of Private Organisations in GFF**

Category Partner	Partner	Role/Input
Private sector	Joint Medical Stores (JMS)	Was selected by MoH to ensure that it's the primary source of procurement of RBF medical supplies in both public and private facilities. JMS under this arrangement is able to supply medical supplies ahead of the payment. So, they are very critical stakeholders in ensuring that the supplies that facilities need are available.
Private not for profit healthcare providers	Facilities for both UPMB & UCMB	Service provision, they are participants in RBF through their facilities where they provide services.
Any other (including Academia)	Political leaders (The district committees) on health	They monitor GFF program implementation within the districts. They get quarterly reports from the directorate. They look at what was set out to be done and how it was done. RBF is one of the output areas that they monitor.

Source: *Primary data*

3.4 Assessment of the Readiness and Effectiveness of the Beneficiary Health Facilities in the Implementation of the RBF Model

In this sub-section, the assessment of the readiness and effectiveness of the beneficiary health facilities in the implementation of the RBF, which the GFF contributes to, was explored. While assessing the performance of RBF at district level, related information at national level was captured.

3.4.1 Readiness

Overall, most of the stakeholders were prepared and ready to implement the program. This readiness was noted at the national, district and health facilities' level.

At national level, it was noted that the MoH was adequately prepared to implement RBF through the GFF Investment Case. There was technical assistance to MoH from World Bank and training of program staff. Within the districts, the MoH notified the officials about the program and later scheduled meetings with each of them. The meetings were aimed at introducing the program. A number of issues were discussed during these meetings including: What the program is, the objectives, roles and responsibilities of the different parties, among others. A number of stakeholders were invited to these meetings including, CSOs, private sector Organisations, district political leaders, the technical team, in-charges and

administrators of health facilities. Each health facility was represented by 3 persons. After the introductory meetings, the MoH signed a grant agreement with each district specifying their responsibilities and committing them to implement the program. The districts were given the mandate of managing the program.

It was established that after the MoH orientation meetings, the district officials trained the entire staff of all health facilities to understand how the program works and the prequalification to be able to take part. This was the initial step in preparing the facilities. The district committees ensured that before the assessments, facilities had all the required structures in place like the health management committee, staff resource allocation and procurement committee. The prequalification was later done in all facilities and the pass mark was 65%. Those that did not pass were given a grace period of six months to re-organize themselves and later assessed again. Meanwhile those that passed were invited for one-week training on the implementation of the program. Each facility was required to sign a performance agreement with their respective districts. The same process of introduction phase was followed in all districts and there were no noted differences in this preparation phase. Simultaneously, the MoH never encountered challenges in this phase.

While discussing with health facilities' staff, it was found out that all of them were prepared and ready at the time of starting to implement the program. They mainly got interested in participating in this program because of the additional incentive it brings to the staff. One of the health facility in-charge had this to say:

> "*....It's because we saw we were getting an additional incentive for the staff, instead of waiting for the monthly salary alone. What one gets depends on the efforts one has put in. So, we saw an opportunity in this and that is why we got interested in participating in RBF".* (Facility In-charge in an urban district level).

3.4.2 Effectiveness

In trying to assess the effectiveness, the KIs were asked about the benefits of the program and those were highlighted at both district and health facility levels.

The effectiveness within the district healthcare system was assessed as follows:

1. The quarterly District Health Management Team (DHMT) assessment tool is assessed on support supervision of all the H/C IIIs and above within the districts. Some districts have many facilities and before RBF, the quality of supervision was lacking. There was improvement in the quality of support supervision in all the studied districts. Of noteworthy, now the assessment tool compels them to be detailed. One district focal person urged that:

> *....I could tell you that when RBF came, we realized that what we were doing was good but RBF made us feel that we were not doing the real support supervision. Because now, you cannot supervise two facilities in a day, actually you can take 2, 3 or 4 days to conclude one facility. It was quick previously because efforts were mainly on management support supervision".* (District focal person)

2. Results Based Financing Unit assesses health facilities at the districts on functionality of the DHMT and operational sub-committees. There is an improved functional district quality improvement team (QIT) system and now RBF looks at the quality of the minutes of such sub-committees. There are specific issues that need to be discussed for those minutes to qualify that the meeting took place. This system has been reinforced within the district healthcare system.

Through the health facilities, the program has brought in additional resources within the district healthcare system. The design of the program is that 40% of the funds are earned by the staff and the 60% is reinvested. Besides, equipment, much of this additional funding in public facilities is majorly used to procure medicines and thus cut down the stock-outs.

> *..... we use part of the money earned from RBF to buy more drugs. You know that the medicines from government don't take us for the three months, so we supplement with it by buying more. In fact, the biggest percentage of this money is used to buy more medicines"* (Facility In-charge in an urban district*).*

Despite the benefits of the program, the interviews featured some challenges faced by the program and the opportunities that seemed not to have been seized.

- There are serious delays in conducting the quarterly supervisions/assessments and the subsequent transfer/reimbursement of the funds. All the KIs at facilities and district focal persons were seriously concerned about the delays in reimbursement of funds.

> *These delays affect the whole system within the district. For instance, if we are not facilitated, we are unable to do the quarterly assessments within facilities and all this affects the timelines. The delays are very serious. For example, this August 2020, is when we received money for April-June and July-Sept 2019 quarters".* (Grieved district focal person).

> *.....I don't know what is happening with the disbursement. You submit an invoice to MoH and it takes like another six months for them to come for supervision. I really don't know where the problem is! Why should they delay like that? I though the money was already provided?" (*another Grieved district focal person*)*

> *….RBF funds delay, we are still demanding 3rd and 4th quarter of 2019 financial year yet we are in 2020/2021. We received 1st quarter in January and 2nd quarter April this year 2020" (*Facility In-charge in an urban district*).*

While interacting with the MoH officials, the concern of delays in reimbursement were a result from busy schedules thus delaying the district verifications and subsequent processing of payments and or delays by the MoFPED to disburse the fund.

- There were changes in the recording and reporting of some two indictors: Family planning and number of new OPD visits for children (0-59) as a way of customizing the indicators to fit into program specificity. However, some facilities reported they did not receive any technical assistance in form of training on this. The facilities highlighted the need for training when the changes were introduced.

> *Before the introduction of RBF, we were reporting family planning as a block not minding about the details they introduced. Also, the indicator on number of new OPD visits for children (0-59) was as a result of adjustments. For us we used to record and report 1-5years but now we have to consider children of 0-59 weeks. These changes had to be made but they did not come to meet our records people for a thorough training. We had to fidget around to get it right. The first verification we hard issues but later we learnt how to do it"* (Facility In-charge in an urban district).

- There have been some demands to expand the package being provided under the program. Currently, the benefit package includes maternal, infant health, immunization and family planning methods. However, from the interviews, a number of users and staff have been stressing the need to expand the services to include HIV and also the entire reproductive health services.

> *"We have heard feedback from the community through the management committee that people would like to have HIV as part of this program. They think this will prompt the health workers to become innovative and interest those who don't want to check their status or start ARVs. Also, the sexual and reproductive services among the young people, there should be a way of attracting young people to come for the needed services and this can only be possible if such services are part of RBF"* (Facility In-charge in an urban district).

3.5 Disbursement and control of GFF funds

The control and disbursement of GFF funds from the World Bank to the recipient implementing Government departments and agencies as well as the loan component of the programme.

The disbursement and control of GFF resources from the World bank to the implementing Government Departments and Agencies follows a process that links performance, accountability based on actual health input results and independent verification. The Text box below shows some of the results anticipated from the program.

The text box below shows the key results areas tracked in the programm

- Support evidence that can be used to assess feasibility or potential of a series of tax-financed health trust funds aimed at raising revenue for the health sector. These may include sin taxes and motor vehicle insurance.
- Improved quality and efficiency of health facilities, and increase access to services associated with demand-side vouchers.
- Expanded access to a package of high-impact RMNCAH interventions by level, with a focus on high burden populations in the 40 highest burden districts.
- Improved community-based services and functionality of health centers resulting in provision of good-quality maternal, neonatal and child health services.
- Establishment of skills hubs resulting in increased district-level capacity to drive improvements in RMNCAH outcomes and service provider capacity.
- Broadening the context for health outcomes by focusing on the social determinants of health for adolescents.
- Scaled-up services for birth and death registration at the health facility and community levels.
- Development and dissemination of a communication strategy for civil registration and vital statistics.

Source: *The GFF Annual Report 2018-19*

The process involves monitoring and evaluation by the MoH, which specifically collects the health-related data while National Identification and Registration Authority (NIRA) collect data on births and deaths. The main data sources include: the project's specific database, the Health Management Information System (HMIS) and the civil registration database under NIRA. The implementing agencies collect the relevant information that is used to measure and verify results for the RBF. The project relies mostly on data collected by the District Health Teams from health facility data.

An independent verification agent conducts regular assessment of the facility records that are used to corroborate internal quarterly progress reports by the Districts and the MoH. The reports on actual physical performance are linked to the quarterly Interim Financial Reports that are submitted to the World Bank in accordance with the reporting requirements set out in the Operations Manual. The verified quarterly reports submitted by the District Health Management Teams (DHMTs) are used to effect reimbursements once they have been certified by the RBF unit. The independent verification agent prepares verification reports on a semi-annual basis against which disbursements are made.

The results realized so far indicate a reduction in fee-barriers and improved access to high-priority maternal and child health care interventions especially for the poor across the participating districts and facilities. The results from the participating entities showed that priority interventions in the investment case that includes: health worker mentorship, vouchers, and the RBF approach had supported evolution of an environment that improved coverage of services.

As of July 2020, reports on the URMCHIP indicated a disbursement of 51% for the IDA loan and 43% of the GFF Trust Fund grant [6]. Sida had increased its contribution from USD 9.44 million to USD 14.44 million, out of which 94% was disbursed. Taking into account the IDA, the GFF Trust Fund and Sida contributions, the disbursement of funds by July 2020 was at 49.5% out of the total of USD 165 million. According to the World Bank, the disbursement by November 2020 was 60% for IDA and 63% for the grants. Sida has so far disbursed USD 19.5 million out of the committed USD 25 million.

Given that the project had an original closing date of June 30th 2021, the disbursement was rather low. Specific allocations in 2018/19 and 2019/2 that were made in phase 1 and 2 went to 727 health facilities, of which 627 were at the level of HC III while 100 were at the level of HC IV. Phase 3 provided funding for 520 facilities. The overall allocations amounted to Shs 2,403,453,630 and included the performance-based start-up grant worth Shs 2,270,049,350 and an equity adjustment equivalent to Shs 133,404,280. The recipient 59 districts are indicated in the Table 4.

There is an improved functional district quality improvement team (QIT) system and now RBF looks at the quality of the minutes of such sub-committees.

Table 4: **Start-up Grant allocations for 2018/19 and 2019/2020**

District	Performance Based Start Up Grant	Equity Adjustment	Total
Abim	19153600	3455170	22608770
Agago	37439400	5249020	42688420
Alebtong	46324700	4055530	50380230
Amolator	32269350	0	32269350
Amudat	10335650	2067130	12402780
Amuria	67011400	0	67011400
Apac	5930700	0	5930700
Budaka	70642800	0	70642800
Bududa	37540650	7508130	45048780
Bukedea	63155250	3615590	66770840
Bukomansimbi	23359050	0	23359050
Bukwo	19724350	1764810	21489160
Bulambuli	40816900	3917810	44734710
Bulisa	25602900	2649140	28252040
Butaleja	4446300	0	4446300
Butambala	24899950	0	24899950
Buvuma	14788350	4436505	19224855
Dokolo	29514700	0	29514700
Gomba	34249750	4070180	38319930
Kaabong	25849200	5169840	31019040
Kaberamaido	58508100	0	58508100
Kalangala	19777300	4553360	24330660
Kalungu	67951400	0	67951400
Kapchorwa	16670700	0	16670700
Kapelebyong	27015500	0	27015500
Katakwi	32702850	0	32702850
Kiboga	36955250	1543990	38499240
Kiryandongo	57495950	0	57495950
Kisoro	71734000	13301310	85035310
Kitgum	52801800	10560360	63362160

District	Performance Based Start Up Grant	Equity Adjustment	Total
Kole	47210300	0	47210300
Kotido	61113050	6261260	67374310
Kumi	50861600	0	50861600
Kwania	7615800	0	7615800
Kween	21946500	3393190	25339690
Kyankwanzi	38906650	493640	39400290
Lamwo	69467800	11181850	80649650
Lira	18809600	0	18809600
Lwengo	69748400	0	69748400
Lyantonde	27714350	0	27714350
Manafwa	12951100	0	12951100
Masaka	51186100	0	51186100
Masindi	39186650	0	39186650
Mbale	31202600	0	31202600
Moroto	15417700	3083540	18501240
Mpigi	116363650	442815	116806465
Nabilatuk	16609600	3321920	19931520
Nakapiripirit	31290250	5646360	36936610
Nakaseke	33311200	266120	33577320
Nakasongola	43655100	0	43655100
Namisindwa	18676200	0	18676200
Napak	30531700	5458700	35990400
Ngora	56445100	0	56445100
Otuke	31087400	3580900	34668300
Oyam	11878050	0	11878050
Pader	46581950	6916420	53498370
Pallisa	2616750	0	2616750
Sembabule	56249150	5439690	61688840
Serere	71970000	0	71970000
Soroti	64777250	0	64777250
Grand Total	**2270049350**	**133404280**	**2,403,453,630**

3.5.1 Impact on Resource Mobilization

The resource mapping for the Investment Case (IC) conducted by the MoH in 2018/19, showed an increase in resources as the IC funding gap decreased from 46% to 29% between 2017/18 and 2019/2020. The Annual Report for 2019/20 indicated an increase in the resources to USD 398,000 with a funding gap of USD 113,536. This reflects an increase to 71 percent of the planned financing compared to 54 percent (USD 375,000) that was realized in 2017/18 when the funding gap was USD 173,868. The increase was largely a result of the donor contribution component that rose from 48% in 2017/2018 to 65% in 2019/20 partly due to the RBF. The specific donors who increased funding are: GAVI, GFTAM and the WB/GFF. An additional increase came from the Government, although this did not reflect in relative terms.

3.5.2 Challenges Ahead

The notable challenges to the monitoring and disbursement of funds included need for additional resources to enhance the capacity of the independent verification teams as well as training and support to the DHMTs. The facilities also lacked adequate funding for complementary investments needed to sustain progress made through the GFF funding.

3.6 GFF and URMCHIP as underlined by Human Rights-Based Approaches

This assessment was conducted to determine if the implementation of GFF and URMCHIP in Uganda was underlined by Human Rights-Based approaches using the Availability, Acceptability, Accessibility and Quality (AAAQ) framework. According to medical human rights network [7],

Availability of services requires that public health and healthcare facilities are available in sufficient quantity, taking into account a country's developmental and economic condition. Subsequently,

Accessibility refers to: (i)Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable; (ii) Physical accessibility: health facilities, goods and services must be within safe physical reach of all parts of the population; (iii) Economic accessibility (affordability): health services must be affordable for all; and (iv) Information accessibility: accessibility includes the right to seek, receive, and impart information concerning health issues. For example, governments must ensure that young people have access to sexual and reproductive health education and information presented in an unbiased manner.

Acceptability requires that health services are ethically and culturally appropriate, i.e. respectful of individuals, minorities, peoples, and communities, and sensitive to gender and life-cycle requirements.

Last, **Quality** requires that health services must be scientifically and medically appropriate and of the highest quality.

To a greater extent, the implementation approach followed the human rights-based approaches framework. The MoH officials assess the district level while the district officials assess the health facilities. All the assessments are done on a quarterly basis. At the facility level, a self-assessment and invoicing is done before the district's officials report to verify the self-assessment. The design of the program did not leave room for falsification as it may lead to penalties if done by facilities.

3.6.1 Availability

Additional Medical Supplies and Equipment

In public facilities, the increase in number of patients resulted in increased shortage of medicines and drugs. However, the program has improved availability of medical supplies within facilities. Since the facility procurement committees allocate the received 60% of monies to their priorities, most public providers use it to buy additional medicines, equipment and medical commodities to supplement routine government supplies. Besides medicines and health commodities, it was found that facilities bought equipment, especially those relating to the maternity ward. Also, they used part of the money to conduct renovations of facilities. The major renovations were done in public facilities. Out of 9 public H/C sampled, 77.8% reported having done some form of renovations on infrastructure.

The RBF money was also used for putting signposts within the facilities, doing repairs of broken equipment like facility ambulances, buying facility furniture, among others. This was common in both PNFPs and public facilities. However, public facilities bought more drugs and health commodities than PNFPs. In relation to increasing medical supplies, a facility in-charge in a rural district had this to say:

> *"…. also, the facility is now having the medicines and basic equipment that were lacking before. There is equipment we would not have got but because of RBF money, we have them. Now I could say that 98% of the basic equipment are in place especially in the maternity ward".* (Facility in-charge in a rural district)

In the same vein, the district focal person in one of the rural districts also explained:

> *"…. I have told you about supplies which led to shortages due to limited funding and some equipment were missing at some facilities due to lack of funds to procure them but now they are available (through RBF funds). The communities have easy access to services which previously they would be asked to go procure (in case of drugs) or be referred (in case of some machines) because a specific service is not available".* (District focal person in a rural district)

> *A lot of money our public facilities receive as the 60% is reinvested into buying medicines. If you go there now, there are no more challenges of medicine in such facilities. There are instances they have bought some missing simple equipment but mainly its medicine"* (District focal person in urban district)

While the funding was appreciated in making a difference concerning medical supplies, all visited facilities that were located outside the central part of Uganda decried the delays and the frequent changes in orders by the institution charged with the supplies; Joint Medical Stores (JMS). One of the in-charges in a rural district narrated bitterly:

> *Government earmarked JMS to delivery medicines but we have been disappointed with them. When you order medicines from JMS, they take like one to three months to bring these medicines. This cannot fill the gap for medicines for which it is a problem. Like now, our essential medicines are getting out of stock but we cannot get them soon. Also, JMS is more expensive than our local pharmacies. We have a procurement team; it would buy such medicines as we need them than relying on JMS delays".* (In-charge in a rural district)

Another in-charge in rural district lamented

> *If you order something and it's out of stock in their stores, they will give you what they want without first consulting you. This is not being professional".* (In-charge in a rural district)

From the interviews, service users' complaints were reported in some public facilities. These were mainly about absence of essential medicines. Whenever mothers were told to buy any medicines, they complained about lack of money. All facilities visited, indicated that shortages were due to late delivery by JMS otherwise, they would not have had such a challenge anymore.

Additional Staffing

Due to the ban on recruitment [8] of some medical workers within some districts and because of increased numbers in facilities there were staff gaps, but some were filled using the money received from the program. The additional hired staffs were mainly noted in public facilities. Those were either additional or hired to fill a vacant position. The majority of these were

neither midwives nor nurses but rather other categories of cadres like records assistants and laboratory staff. Such recruitments were common in public than PNFPs. Officials from one sub-National level, they noted that:

> “ *….for example, we had limited staffing for anaesthetist in our local government but from RBF funds, we have hired staff for anaesthesia. This means that in the process we are decongesting one referral hospital in our area because now we can do the C-sections at our health Centre IVs. Also, we can have more than one anaesthetist per facility due to RBF, thereby having 24-hour coverage”.* (Officials from one sub-National level)

A similar account was recorded from a facility in-charge in a rural district:

> “ *We have also hired staff especially the potter and the laboratory person. We have seen that there are some delays, since the turnaround time in the lab was too long. So, we hired a lab assistant to assist the lab technicians. Those staffs have been hired to speed up the process so that the patients do not delay too much. Because initially they used to complain that whenever we come, we delay”.* (In-charge in rural district).

3.6.2 Accessibility

It was clear that there was improved access to healthcare services not only those covered under URMCHIP, and therefore co-funded by the GFF, but generally all the services at facilities. A number of access parameters were documented during the interviews with key informants both at the facilities and district medical office.

3.6.2.1 Improved Presence of Health Workers on Duty

When mothers come to facilities, they need to be attended to. However, it has been the norm in Uganda for health workers to be absent [9] during working hours in public health facilities. The program has improved health workers’ presence on their jobs/work stations and the subsequent attendance to patients. The facilities’ in-charges noted that staffs register every day on arrival and when they are leaving the facilities and at the end of the month, the in-charge compiles each staff’s attendance. This registration has also contributed to their early reporting on duty. Also, it was noted that payments are attached to the number and hours of work in a defined quarter. This finding was very common among public facilities. One of the district focal persons noted that:

> *….has improved access to services. For example, I have told you about the availability of staff at facilities. Because the facilities can be closer to the communities but when health workers come late or are absent – this limits access. Staffs know that when I go early and I'm regularly at work, I will be motivated at the end of the month".* (A district Focal person)

3.6.2.2 Outreaches

Even with improved service delivery, there are people who might not be able to access services due to distance in rural districts. It was noted that facilities were conducting frequent outreaches within their catchment areas. Most facilities conducted "integrated outreaches "that is, they provided most of the facility-based services during such outreaches. The program money was mainly used to facilitate staff but also provide transport for their movements into communities. However, outreaches were more common in public facilities than PNFPs. One health facility in-charge in a rural district narrated how it is done:

> *…. we mobilize mothers using a mega phone. We have a vehicle and whenever there is money, we use megaphones and mobilize people for those outreaches. And during the outreach, we provide almost of the services as if it's at the actual premises. And we do this to the different places within our catchment area".* (Health facility in-charge in a rural district)

All the KIs that were interviewed knew the objectives of the program as mainly being about scaling-up access to some known interventions that were simple but had impact in reducing maternal and child mortality. Additionally, they knew the benefit package covered by the program.

> *RBF is a kind of financing in which services are paid for after implementation of the activities by a facility. The one we have is all about services in maternal and child health care services. On the side of staff incentives, you find that when they come for verification, they look at the output and staff are incentivized". (Health facility in-charge in a rural district) "RBF is results based financing, it's a Maternal and child health programme that is funded by the World Bank and its being implemented by the ministry of health and the aim is it to reduce maternal and child deaths rates in the country but also its based-on performance the number of the outputs determines how much money you have. The objective is to reduce on the neonatal and maternal mortality in Uganda, to improve service delivery in maternal and neonatal child death in the country basically those are major roles"* (Secretary for Health in an urban district).

3.6.2.3 Affordable Services

The RMNCAH services were provided free of charge to all beneficiaries which contributed to eased financial accessibility for users. And where some user fees were charged among PNFPs, we were informed that these had been reduced to attract more users. Nonetheless, some services were not provided in some facilities, for example in all UCMB facilities, there was no provision of artificial family planning methods. One in-charge noted this on this issue:

> *"…. there is family planning and for us the family planning we provide here is we promote natural but whenever we talk about artificial, we do refer them to RHU or Naguru or Kawempe"* (Health facility in-charge in an urban district).

3.6.3 Acceptability

Deliberate actions were taken to promote the RMNCAH service package at its introduction.

During interviews, it was found that all facilities did some form of awareness, sensitization and mobilization of communities to utilize the RMHCAH services at their facilities at the onset of RBF. During such activities, they were trying to attract more users. It was noted that some PNFPs used innovative approaches like going to religious gatherings and car drives within the target communities. People had a chance to ask questions, providers clarified and this contributed to the acceptance of those services. Besides, in some PNFPs, some of the RMNCAH services were newly introduced with the introduced of RBF. So, such avenues provided a platform to inform the communities about the extended package. Some of the in-charges had this to say;

> *"When we rolled off this project we did a lot of awareness we announced in the mosques went to the churches and all worship centers and also we used a car driver. We were telling people that government has provided this, people never knew that we provide delivery services when we give them good services they refer others. So, we have seen that slowly by slowly they are coming".* (Health facility in-charge in an urban district) *We conducted talk shows on radios encouraging people to visit health facilities and even during Covid-19 when people feared to visit health facilities. Also, on two occasions we have conducted dialogue to critique service delivery so we are able to change where we are not doing well. For example, issues on maternity, the Askali was not available and we resolved that; then the issue of power, no paraffin for lamps but we resolved all. Some people see that there is a change in the way we provide maternal and child services".* (Health facility in-charge in a rural district)

Increase in the number of people who access RMNCAH services

The review of HMIS document at all visited facilities indicated an increased in all service parameters for the RMNCAH which in a way indicated acceptability of such services otherwise people could not have turned up to use them. Table 5 provides details of increase in service access on each of the district per RBF parameter.

Table 5: **Service access on each of the district per RBF parameter**

District	Facility ownership	Facility level	No of cases 6 months before RBF (A)	No of cases 6 months after RBF (B)	The effect of RBF (A-B)	No of cases 15 months after RBF	The effect of RBF after 15 months
Kampala	Public	H/C II	10,483	11,638	1,155	28,917	18,434
		H/C IV	18,248	19,883	1,635	64,172	45,924
	PNFP	H/C III	645	764	119	2,910	2,265
		H/C IV	2,466	6,642	4,176	10,805	8,339
Namisindwa	Public	H/C III	15,344	10783	-4,561	33,258	17,914
		H/C IV	N/A	N/A	N/A	N/A	N/A
	PNFP	H/C III	N/A	N/A	N/A	N/A	N/A
		H/C IV	5,184	5,715	531	13,449	8,265

Source: *Primary Data*

It was established that some PNFPs that were Catholic based did not offer family planning as such that indicator was null and void. A slight increase was however realized at the start but progressively the increase was feasible in most services. In Namisindwa, the greatest increase was realized on majorly four indicators, No of new OPD visits for children (0-59), No of PNC visits and No of children with complete immunization. In Oyam, except for number of new OPD visits for children (0-59) which showed consistent increase in all facilities, there was no consistence in the performance of the other indicators and the same scenario was observed in Kampala.

Within six months after the introduction of RBF, there was an increment in attendances in all facilities except in public H/C IIIs of Oyam and Namisindwa. The in-charges within those H/Cs cited change of reporting of some indicators as being one of the reasons that might have contributed to the recorded decline. After 15 months of implement, all the facilities increased attendances.

Some health workers did not understand the program initially

At the introduction of RBF within facilities, some health workers had not fully understood its objectives and benefits and as such resisted it. This was found in some few public facilities and especially within rural areas. We were however informed that this improved with continuous training and sensitization and clear indication of the benefits the program brought not only to the facility but also individual health workers. By the time of the study, no facility was reported having such a problem. One in-charge had this to say;

> *“ …. about the way it’s designed at first the staff did not understand it. The staffs got some difficult and did not understand it very well. Some people did not take time to get involved very fast so those people who were lagging behind they did not have that skill but now are on board. May be because of the training that did not involve so many but with time they have now picked it and as I told you because of the incentive they have started having curiosity of knowing how RBF goes”.* (Facility In-charge in a rural district)

3.6.4 Quality

Quality was assessed not only at facilities but also at district level. It was realized that the design of the program embedded quality indicators. The districts’ committee visits each participating facility at least once in a quarter to verify the self-reported marks on each indicator.

3.6.4.1 District /Sub-National Levels

Each districts’ health management team has a sub-committee on quality improvement, whose work is to ensure quality services are provided at each selected facility. The indicators for which facilities are assessed are both qualitative and quantitative. Apart from the scores and money that a facility gets on the quantitative indicators, they get 30% extra if their quality is at 95% and nothing if it’s less than 75%. We were further informed that if their quality assessment mark drops below 65% for two consecutive quarters, then that facility is dropped from the program, given 6 months to reorganized itself and it gets into the process of prequalification as before. Unless it passes the second prequalification assessment, it can never be reinstated. Among the districts we visited, we realized that this had ever happened once and in Kampala in one public facility.

> *“ ….my thinking is that the quality of services has improved especially in public facilities. If they now have constant supply of medicines what else do you need? That is always been the major quality challenges in most of our public facilities”.* (A district Focal person in a rural district)

3.6.4.2 Health Facility Level

Here, quality assurance mechanisms were noted at two levels. Firstly, each facility had a quality improvement committee. These committees were all chaired by the facility in-charge with the midwife in charge being the secretary and all the other staff were members. These committees held monthly meetings and were reporting to the facility management committees. Secondly, service provision quality indicators were also noted. For example, only delivered live births were compensated, meaning that the whole process of delivering a mother is taken seriously to ensure positive outcomes. Also, if a mother was delivered but there was no evidence that the partograph was used, then such an outcome is not incentivized. More still, it was noted that during the quality improvement committee meetings, discussions and resolutions were considered for incentives. For example, if meetings sat but gaps were not documented, no action points and or progress on action points, such a committee is not incentivized for functionality.

> *"The way we provide the services like deliveries has really improved, we now have the needed medicines and equipment and the staff are on duty! All these are indicators of quality. So, RBF has contributed a lot to the improvement in providing quality services within this facility".* (Health facility in-charge in an urban district)

Some complaints were from the maternity department concerning the sharing of the money. The staffs in these departments were not happy about the fact that colleagues from other department were getting part of the money. This might have affected the quality-of-service provision. However, these were normally managed by the facility in-charges by trying to explain the fact that the indictors are not generated only by the department but rather other colleagues do play a role when for instance a mother visits a facility.

During the discussion, the political and health facility staff did not have enough information about the source of the money used to finance the program. In fact, some thought it was from MoH. Almost all of them did not know that part of it was a loan from World Bank. A district assistant CAO in charge of RBF elaborated:

> *"To be sincere I'm not sure where this money is coming from. But I know the Ministry of Health sends it through Ministry of Finance. Whether its government money or not, I don't know".* (District assistant CAO in charge of RBF).

3.7 Discussion of the Findings

There is minimal participation of CSOs in the GFF processes, as well as in RBF in particular. This lack of participation of CSOs in RBF activities can be attributed to lack of a clear framework and there were no deliberate efforts by framers to actively engage CSOs both at national and district level. The second objective was set out to assess the facility readiness and effectiveness to implement RBF although findings relating to district and national level were documented. All levels of implementation were ready and prepared to implement the program. However, some facilities were not given a thorough training concerning the adjusted indicators by the responsible district committees.

This might have been caused by the delays in disbursement of the start-up funds. There are chronic delays in disbursement of funds at both districts and faculty levels from Ministry of Finance Planning and Economic Development. The implementers decried delays in funds release which takes more than 6 months after the invoice has been accepted. Although these funds are finally transferred, some activities are stalled until the funds are released which might affect the whole program implementation. There has been a reduction in fee-barriers relating to RMNCAH services contributing to its utilization. Presently, government has considered implementing the project in all districts and also expanding it to hospital level. Its funding has also increased in absolute terms although it's still constant in relative terms. The project design is flexible and allows facilities to reinvest the earned 60% of money as they may require.

This has contributed to the availability, acceptability, accessibility and quality of services. This has been reflected in among others; public facilities have been able to restock and supplement government supplies, able to recruit more staff, health workers being motivated to be on duty and taking extra care while providing RMNCAH services to ensure that quality is not compromised.

The review of HMIS document at all visited facilities indicated an increased in all service parameters for the Reproductive maternal, newborn, child and adolescent health which in a way indicated acceptability of such services

4. CONCLUSIONS AND RECOMMENDATIONS

In this section, conclusions and recommendations arising from this study are made:

4.1 Conclusions

There has been some participation of private sector and CSOs in the implementation of the GFF, which has influenced set up and operations of RBF, but this has been minimal. The terms of reference for the CSO where not clearly known by both the Government and CSO. Since this is the first direct involvement of CSO in formulation and implementation of such global initiative, this has been a remarkable start. Despite the Civil Society being part of sector planning system in Uganda, there has not been a framework to guide CSOs participation in RBF implementation.

Some beneficiary health facilities where not adequately prepared to implement RBF although this improved along the implementation lines. However, RBF has been welcomed by the health system especially the additional financing to facilities, staff incentives and improved availability of commodities. The resource mapping for the investment case showed that the funding gap decreased over time from 46% to 29% between 2017/18 and 2019/2020. This reflected an increase to 71 percent of the planned financing.

The implementation of GFF and URMCHIP in Uganda has been underlined by Human Rights-Based approaches to development. RBF has improved availability of medical supplies within facilities and resultant increment of patients and clients. In terms of acceptability: the political and health facility staff did not have enough information about the source of the money used to finance the program. There was improved access to healthcare services not only those covered under URMCHIP (and therefore co-funded by the GFF) but generally all the services at facilities. This was largely triggered by RBF and is largely realized through increased availability of health workers and outreaches. Attempts have been made to increase on the quality of healthcare. The design of the program embedded quality indicators. The districts' committee visits each participating facility at least once in a quarter to verify the self-reported marks on each indicator.

The results realized so far indicate a reduction in fee-barriers and improved access to high-priority maternal and child health care interventions especially for the poor across the participating districts and facilities.

The implementation of GFF and URMCHIP in Uganda has been underlined by Human Rights-Based approaches to development.

4.2 Recommendations

The following recommendations are made:

- The health sector should further enhance sensitization of both government staff and CSO so as to build and expand common understanding of mode of operation of the RBF. The partnership was more inclined to entities involved on the supply side with the CSOs left to handle the bulk of the tasks on sensitization of communities to demand for accountability. It would appear that demand was naturally expected to increase on the basis of improved services and yet social-cultural norms and beliefs can be very prohibitive in the demand for sexual reproductive health, maternal and child care. Investments in increasing the demand side will be critical.

- There should be continuous support supervision of GOU and CSO to the RBF beneficiary health facilities so as to improve on the operations of RBF at institutional level. The study noted limited participation of CSOs, which could partly be due to limited power to enforce their rights as they have to depend on funding from some of the other partners. The CSOs are given the responsibility of policing the others who may be in the wrong, which makes it hard for them to build favorable relationships for partners who may perform below expectations. Unless everybody is committed to the common good of getting the desired results, the CSOs may be excluded from some processes.

- There is need by CEHURD, and Uganda Deb-Network to "press" MOFPEFD and MOH for details of RBF funds and thus avail detailed information of the disbursement schedules to the public. This will not only enable the public and other stakeholders to demand for accountability but also increase demand as the public will be aware of the availability of funds and associated likely improvement of services.

- The Health sector should carry out Operational Research and learning which should be part and parcel of implementation of RBF since this is a new phenomenon. Drawing lessons from previous practices is a common way of learning in service delivery and will, certainly, contribute towards better management of the facility and services.

- The GoU should ensure top-up funds for all staff across the facility with RBF funding. It was noted that the system has disadvantages for staff of the facility who may be working in non-related departments or services. This was having a negative effect on staff motivation given the differentials in earnings and trainings. Alternatively, this should become the norm across the whole country or even financing of health services.

- The health sector should provide complementary funding and services to avoid diluting the improvements in the selected areas of the Programme. Initial improvements in the services are bound to attract more people to the health care facility who may dilute the service delivery.

- The Ministry of Health should address the chronic delays in reimbursement of funds so as to keep this innovation in health financing on track.

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