FINANCING FOR WOMEN CHILDREN AND ADOLESCENT HEALTH IN KASESE DISTRICT, UGANDA
CSO Scorecard

Rwenzori Center for Research and Advocacy (RCRA)

October, 2019; RCRA Uganda
Executive Summary
Results Based Finance (RBF) has become an essential tool in bridging the financing gap that countries like Uganda face in providing Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) services. Kasese district in Uganda has a high need for RMNCAH services given the structure of its population. An estimated 55% of the people in Kasese are children below the age of 18 years. In addition, 20% of the people is Kasese are women of reproductive age (15 – 49 years). However, the district has a high rate of maternal deaths with some of sub-counties having maternal death rates that are above the national average. These challenges have persisted in spite of the RBF efforts to improve health service provision in the district.

Against such a background, the Rwenzori Centre for Research and Advocacy (RCRA) with funding from Population Action International (PAI) commissioned this study to assess the implementation of RBF in Kasese district. The study was mainly aimed at assessing the level of CSO participation in improving WCAH services (Awareness and involvement in implementation), analysing the funding for WCAH services at district level.

Overall, it was found that Results based financing has had and will continue having a positive effect on the provision of RMNCAH services. Among the immediate impacts RBF has had is to increase funding for RMNCAH services. It is notable that the total amount of RBF funds received by the fourteen beneficiary facilities in one year far outstrips the combined total of PHC Non-wage grant and PHC Development grant received by both the district and municipal council. This funding has enabled the beneficiary facilities to improve their infrastructure and expand the scope of their care.

In addition, the benefits of the RBF funding have transcended the funding to also include enhancement in staff capacity which has resulted in improvements to the standard and quality of care which has minimised the number of avoidable deaths. The full extent of the benefits accruing from the RBF projects in Kasese needs empirical quantification, an objective that is beyond the scope of this paper but very important nonetheless.

However, the implementation of the RBF projects has had its operational challenges too. The main challenge reported was the delay in the disbursement of funds to pay for the verified results – a challenge also noted among the URMCHIP beneficiary districts. It was reported that the delay in some instances resulted into the health facilities being indebted as they await the arrival of the funds.

Finally, among the structural challenges noted was the limited nature of participation of CSOs in the implementation of the RBF projects in Kasese. It was noted that there was no platform such as the expanded District Health Management Team to ensure a designated space for CSOs to participate.

Against such conclusions, this paper recommends the following;

- Enabel in collaboration with Ministry of Health should consider incorporating an Expanded District Health Team structure in the implementation design of the
Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (SPHU) project. This is especially important because the project is still in its nascent stages and is in place until July 2021.

- There is therefore a need for a scorecard which will measure/assess the performance of the CSOs in monitoring and evaluating the implementation of the RBF project in Kasese. The scorecard should however be replicable to other projects in the rest of the country.

- In line with CSO participation, there is need for CSO collaboration platform on RMNCAH which should bring together the national and subnational CSOs. This will ensure that the evidence generated from the subnational work on RMNCAH finds its way in policy discussions at the national level where most of the decision makers are located.

- It is essential that all RBF projects around the country are switched to the RBF digitalised system in order to limit the delays in disbursement of funds.
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
</tr>
<tr>
<td>BTC</td>
<td>Belgian Technical Cooperation</td>
</tr>
<tr>
<td>CSOs</td>
<td>Civil Society Organisations</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health officer</td>
</tr>
<tr>
<td>EMHS</td>
<td>Essential Medicines and Health Supplies</td>
</tr>
<tr>
<td>FY</td>
<td>Financial/Fiscal Year</td>
</tr>
<tr>
<td>GFF</td>
<td>Global Financing Facility</td>
</tr>
<tr>
<td>GoU</td>
<td>Government of Uganda</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>MoFPED</td>
<td>Ministry of Finance, Planning and Economic Development</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NMS</td>
<td>National Medical Stores</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PNFP</td>
<td>Private Not For Profit</td>
</tr>
<tr>
<td>RBF</td>
<td>Results Based Financing</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>Reproductive, Maternal, Neonatal, Child, and Adolescent Health</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>SPHU</td>
<td>Strategic Purchasing of Health Services in Uganda</td>
</tr>
<tr>
<td>UDHS</td>
<td>Uganda Demographic Health Survey</td>
</tr>
<tr>
<td>UGX</td>
<td>Uganda Shillings</td>
</tr>
<tr>
<td>URMCHIP</td>
<td>Uganda Reproductive Maternal Child Health Improvement Project</td>
</tr>
</tbody>
</table>
Introduction

Over the years, Uganda has experienced significant and accelerated improvements in most of its Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) indicators. Most notable are the marked reductions in under-five and maternal mortality rates, respectively plummeting from 151 to 64 deaths per 1,000 live births, and from 524 to 368 maternal deaths per 100,000 live births between 2000 and 2016 (UBOS & ICF, 2017).

Despite such achievements, health system challenges in areas such as inadequate health infrastructure, equipment, and medical supplies continue to constrain positive RMNCAH outcomes. There are three main factors constraining the provision of RMNCAH service delivery in Uganda. These include poor resourcing of the sector with regard to financing, human resources, medicines and other health inputs to effectively respond to the high disease burdens; capacity constraints, especially at the health facility level which has rendered the majority of districts unable to deliver services as mandated; and citizen dynamics with regard to poverty, women empowerment and traditional practices which contribute to reduced access to health services, especially RMNCAH services (Republic of Uganda, 2016).

In July 2015, Uganda became one of eight pathfinder countries globally to receive support from the Global Financing Facility (GFF) Trust Fund. The GFF seeks to support countries with an integrated health system approach that looks for evidence-based solutions to improve RMNCAH outcomes. The GFF uses a financing model that combines domestic financing, external support, and innovative sources of resource mobilisation and delivery (including the private sector) in a synergistic way, and promotes measures to reduce inefficiency in health spending through smarter financing (World Bank, 2016).

Consequently, the Government of Uganda (GoU) revised the 2016-2020 RMNCAH Sharpened Plan in the context of the GFF which now is the Investment Case for RMNCAH - Sharpened Plan for Uganda. The Sharpened Plan introduces five strategic shifts for RMNCAH: (i) emphasising evidence-based high-impact solutions; (ii) increasing access for high-burden populations; (iii) geographical focusing/sequencing; (iv) addressing the broader context-education, empowerment, economy and environment within a multi-sectoral approach, with a particular focus on adolescents; and (v) strengthening mutual accountability for ending preventable deaths. The plan covers the key service delivery shifts that will need to occur to improve RMNCAH outcomes, including scaling up Result-based Financing (RBF) for facilities and vouchers to address demand-side constraints (Republic of Uganda, 2016).

The plan was developed jointly with key stakeholders in a bid to improve alignment between key financiers, and engagement in a broad set of stakeholders in supporting a common set of priorities. In 2017, the Civil Society Organisations (CSOs) working in the health sector developed an expanded CSO engagement framework to support implementation and accountability in the RMNCAH Investment Case specifically the GFF component. The CSO engagement framework has an annual work plan that details some of the activities that will be undertaken by the coalition with regard to achievement of GFF objectives in Uganda. Among these activities is development of a national RMNCAH Investment Case Accountability Scorecard.

Uganda, similar to other developing countries is faced with significant health financing gaps. In the absence of official cost-sharing mechanisms, Government of Uganda (GoU) has over
the years sought to put in place alternative health financing approaches in order to bridge the health financing gap. The National Health Financing Strategy by the Ministry of Health (MoH) identifies Results Based Financing (RBF) as one of those alternative financing approaches. The Health Financing strategy observes that country needs to increasingly move away from input-based purchasing and embrace RBF (MoH, 2016a).

Uganda has had Results Based Financing (RBF) projects implemented especially in the health sector for more than a decade and half. The earliest experience of RBF was in 2003 when the World Bank implemented its Performance Based Contracting study up-to 2005 (MoH, 2016b). Since then, the country has seen numerous RBF projects implemented with all the districts in the country either benefiting from an RBF project or are earmarked for one.

Currently, there are three major RBF projects running in Uganda’s health sector (see annex 1 for their coverage details). The largest RBF project currently being implemented in Uganda’s Health Sector is the Uganda Reproductive Maternal Child Health Improvement Project (URMCHIP) with funding from the Global Financing Facility, World Bank and the Swedish International Development Cooperation Agency (SIDA). The total financing for the project is USD 165 million which includes a loan of USD 110 million from the World Bank, a grant of USD 30 million from the Global Financing Facility (GFF) as well as a USD 25 million grant from SIDA (Wemos & CEHRD, 2019). The project has currently been rolled out in 79 districts covering an estimated 27 million people – about 65.9% of the estimated population in 2018. Other major RBF projects in Uganda’s health sector include The USAID/Uganda Voucher Plus Activity (running from 2016 - 2021), Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (MoH, 2019).

In Uganda’s health sector, RBF is taken to refer to “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 undertakes other agreed actions) upon achieving pre-defined results. Payment explicitly depends on the degree to which services are of approved quality, as defined by protocols for the processes or outcomes” (MoH, 2016b).

Overview of RBF in Kasese District
Kasese district is one of the earliest beneficiary districts of RBF initiatives funded by the Government of the Kingdom of Belgium through Enabel (formerly BTC). Over the last five years, Enabel has implemented three different RBF projects in Kasese along with 11 other districts in both the Rwenzori and West Nile region.

The first among these projects was the Institutional Support for the Private-Non-For-Profit (often abbreviated as PNFP) for which implementation started running in the year 2014 and ended in July 2018. The four year project had the overall objective of the PNFP project was to contribute to the strengthening of service delivery capacity among districts such as Kasese to effectively deliver Primary Health Care (PHC) services and ultimately deliver the Uganda National Minimum Health Care Package to their respective populations.

While the PNFP project was considered beneficial to the health sector, GoU’s commitment came into question during the mid-term review in 2017 most due to the fact that public funding
to PNFP facilities had relatively remained the constant. This is likely to limit the sustainability of the gains made over the course of the project (Enabel 2017).

The subsequent RBF projects in Kasese were the Institutional Capacity Building Project in Planning Leadership and Management in the Uganda Health Sector – ICB Phase I and Phase II. The recently concluded ICB-II started in July 2015 and ended in July 2019. It built on the work that had been undertaken under ICB-I which ran from 2011 to 2015 and was complementary to the work undertaken within the PNFP project. The overall aim of ICB-II was to strengthen the planning, leadership and management capacities of public health staff, particularly at local government level in the beneficiary districts located in the Rwenzori and West Nile sub-regions. The total project budget for the two sub-regions was Euro 5 Million with GoU providing an in-kind contribution (staff, infrastructure etc) equivalent to 10% of the project amount (Enabel, 2015).

Currently, all the Enabel RBF projects in Rwenzori and West Nile sub-regions have been consolidated into one project known as the Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (SPHU). This has been effective since July, FY 2018/19. The SPHU project is an extension of the recently concluded PNFP and ICB-II projects and aims at “promoting universal health coverage in Uganda through a rights-based approach” (MoH, 2019). The project has a total budget of €5,840,029 and is expected to run until June 2021.

Building onto the work undertaken under the PNFP and ICB-II projects, the SPHU project is designed to fund three aspects of health performance at each level of care. These three aspects include administrative and financial management; quality of care; and human resource development. The SPHU project is being implemented in the districts that are not benefitting from the URMCHIP which ensures that there is no duplication in the implementation of RBF in Uganda. Nonetheless, the project is being implemented under the MoH’s RBF Framework and therefore has complementary efforts towards the attainment of the health sector goals targeted under URMCHIP.

In the Kasese, the SPHU project is covering a total of fourteen (14) health facilities at three levels of care, that is, General Hospital, Health Centre IV and Health Centre III levels. Of the fourteen health facilities covered, six are public health facilities (5 HC IIIs and one General Hospital) and the remainder are PNFPs including 4 HC IIIs, 2 HC IVs and 2 General Hospitals (MoH, 2019).
**Background**

The 2018 Kasese district statistical abstract indicates that the district has a total of 105 health facilities which are representative of four major levels of care. These include 3 general hospitals, 5 health centre IVs, 42 health centre III, and 69 health centre IIIs. Each health sub district has got a health unit implying a well distributed health services related maternal, infant and child feeding services. In 2018, the district was estimated to have a total population of 737,274 people – majority of whom (51%) are female.

The district population structure of Kasese district majorly comprises of children below 18 years, adolescents and youth (10-24) as well as women of reproductive age (see figure).

**Figure 1: Kasese District Population Characteristics in 2018**

![Population Characteristics of Kasese District](source: Kasese District Statistical Abstract – based on UBoS Mid-year projections 2016)

This population structure as reflected in Figure 1, places a significant demand on RMNCAH services in the district. However, access to the full range of RMNCAH services remains low in 17% (5) of the sub counties. The 2018 district Statistical Abstract indicates that the sub-counties of Bwesumbu, Buhuhira, Bwera, Nyakatonzi and Isango only have centre II facilities – a challenge which limits the delivery of a full package of MCH and HIV/AIDS services to the respective populations. Indeed Bwera is among the areas where high maternal mortality rates were reported in the district.

The 2018 District Statistical Abstract indicates that most of the maternal deaths occurred in Kagando Hospital (458/100,000 live births) followed by Kilembe Hospital (169/100,000 live births) and then Bwera Hospital (104/100,000 live births). At HC IV level, Rwesande HC IV (with 394/100,000 live births) and St. Pauls HC IV (with 234/100,000 live births) had the highest maternal deaths. These maternal mortality rates imply that Kasese is a high burden district considering that the rates in Kagando Hospital and Rwesande HC IV are higher than the national average of 336/100,000 live births.
The afore limitations in access to RMNCAH services and the resultant outcomes have persisted even in the face increased funding arising from the RBF projects in the district. In the design of the RBF framework (MoH, 2016), Civil Society Organisations (CSOs) have an important role to play especially in the service monitoring and validation of results. However, there is limited information on the implementation of RBF projects in Kasese along with the role that the CSOs are playing.

It is against such a background that the Rwenzori Center for Research and Advocacy (RCRA) commissioned a study to assess the implementation of RBF in Kasese district. The study is envisaged to generate evidence to support advocacy at district level (Kasese) and national level through by ultimately informing the design and development of a district level CSO scorecard on RBF implementation. The specific objectives of the study were to

- Analyse the funding for WCAH services at district level including RBF funding
- Assess the level of CSO participation in improving RMNCAH services (awareness, involvement in implementation)
- Establish recommendations in regards to RMNCAH policy and practice at district and national level

Approach and Methodology

The study was mainly qualitative in design which utilised the two methods of Key Informant Interviews (KIIs) and review of available documents. These were complemented by active observation and together the methods generated financial, statistical and graphical data to be analysed.

The actors consulted were purposively sampled from the RBF Unit at MoH, the District Health Office and the RBF Coordinator at the District Headquarters as well as health workers from ten RBF beneficiary health facilities. In addition, six CSOs were consulted that undertake RMNCAH related work. The consulted CSOs included Baylor Uganda-Kasese Cluster, Action for Community Empowerment and Rehabilitation (ACER), Kasese District Youth Focus on Aids (KDYFA), Creations Forum Africa, Girl Empowerment Foundation (GEF), and Peoples action for development of Africa (PADAfrica).

The health facilities consulted included are listed in table 1. These were purposively selected from a list of RBF beneficiary health facilities availed by the RBF Coordinator at the District Administration.

**Table 1: Sampled Health Facilities for the Study**

<table>
<thead>
<tr>
<th>Sub-County</th>
<th>Health Facility</th>
<th>Level</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bwera Sub-County</td>
<td>Kasanga PHC</td>
<td>III</td>
<td>PNFP</td>
</tr>
<tr>
<td>Katwe Town Council</td>
<td>Katwe</td>
<td>III</td>
<td>GoU</td>
</tr>
<tr>
<td>Kasese Central Division</td>
<td>St. Paul</td>
<td>IV</td>
<td>PNFP</td>
</tr>
<tr>
<td>Kasese Central Division</td>
<td>Katadoba</td>
<td>III</td>
<td>PNFP</td>
</tr>
<tr>
<td>Mpodwe Town Council</td>
<td>Nyabugando</td>
<td>III</td>
<td>PNFP</td>
</tr>
<tr>
<td>Rwesande Sub-County</td>
<td>Rwesande</td>
<td>IV</td>
<td>GoU</td>
</tr>
</tbody>
</table>
Data management and analysis: The data collection process generated both qualitative and quantitative data for objective one and two respectively. The analysis of the quantitative data was done using Ms Excel. Qualitative data on the other hand was transcribed (verbatim) from the recorders into Ms Word documents. These transcripts were then entered into ATLAS.ti for analysis.

Limitations of the Study: In undertaking this study, the scope of the qualitative aspects of the study was restricted to health workers, district health administrators and Civil Society Organisations. The study therefore does capture perceptions of the communities on all aspects of RBF and the resultant effect on the quality of care for the users of the services. This therefore represents an area for further study.

Findings
This section presents a synthesis of the findings from the field along with the observations from the available literature. The findings from the field are reconciled with the context observed from the literature to give an accurate picture of the funding and the practices implied by the objectives.

Funding for Women, Children and Adolescent Health Services
It is notable that WCAH services fall under the overall bracket of RMNCAH services. At national level, the funding for WCAH services is mostly for the purchase of Essential Medicines and Health Supplies (EMHS) which are divided into credit line commodities and non-credit line commodities. Credit line commodities are handled by National Medical Stores (NMS) and fully funded by GoU. On the other hand, the non-credit line commodities are handled by MoH and are co-funded between GoU and the development partners.

In FY 2018/19, the non-credit line commodities were funded to a tune of UGX 1.146 trillion with the development partners contributing 54% of the funding and GoU co-funding the rest. The credit line commodities were funded to a tune of UGX 275.6 Billion, representing a 19.4% increment from the FY 2017/18 funding levels. Table 2 presents the funding patterns of selected EMHS that support RMNCAH at district level.

| Table 2: RMCAH Related EMHS Funding Patterns at National Level (UGX) |
|---------------------------------|-----------------|-----------------|
| EXPENDITURE ITEM               | FY 2017/18      | FY 2018/19      |
| Supply of EMHS to HC II, III & IV | 75,030,473,942  | 46,641,457,671  |
| Supply of EMHS to General, Regional and National Referral Hospitals | 39,845,600,000  | 55,974,843,025  |
| Supply of Emergency and Donated Medicines | 2,500,000,000   | 3,383,718,000   |
| Supply of Reproductive Health Items | 11,484,763,000  | 11,300,000,000  |
| Immunization Supplies          | 17,000,000,000  | 19,450,000,000  |
Supply of Laboratory Items to accredited Facilities
5,000,000,000
11,613,962,600
Supply of ARVs to Accredited Facilities
94,891,375,000
77,566,508,800
Supply of ACTs to Accredited Facilities
8,108,625,000
12,779,901,700
Supply of Anti TB drugs to Accredited Facilities
6,999,999,664
8,400,000,000

Source: Annual Health Sector Performance Report FY 2018/19

While most items experienced increments across the two financial years, major reductions in funding were observed in the supply of EMHS to HC II, III and HC IVs which experienced a 38% reduction in funding, supply of ARVs which suffered an 18% reduction and the supply of reproductive health items which suffered a 2% reduction in funding.

At subnational level, RMNCAH services are funded through Primary Health Care grants from central government to local governments. These are disaggregated by function into the Wage, Non-Wage, Development grants and Sanitation grants as illustrated in Figure 2.

Figure 2: Trends in PHC Grant Allocations

Source: Computations based on Approved Estimates of Revenue and Expenditure for the respective years. These documents can be downloaded from budget.go.ug

Over the last three financial years, the PHC wage which pays salaries for the health workers has been increasing constantly. However, the PHC Non-Wage grant which facilitates service delivery at health facilities remained constant up until FY 2019/20. These constant trends are also observed in the sanitation grant and they do not bode well for service delivery given the rapidly growing population. The increase observed in the development grant between FY 2017/18 and 2018/19 is down to the upgrading of HC IIs to HC IIIs in sub-counties around the country which only had HC II facilities.

Trends in PHC Funding for Kasese Local Government

The patterns observed nationally are also similar to the patterns observed in the PHC financing to Kasese district. Over the three years considered, the Wage grant has been constantly growing over the years while the non-wage grant remained constant until FY 2019/20. This pattern is also similar to the funding transferred to Kasese Municipality. It is notable that the district has not received any PHC grants for sanitation across all the years considered. Thus the negative
implications on service delivery arising from the non-wage grant remaining constant in light of a growing population also apply to the district.

**Table 3: PHC Funding Transfers to Kasese Local Government**

<table>
<thead>
<tr>
<th>Local Government</th>
<th>Functional Grant</th>
<th>FY 2017/18</th>
<th>FY 2018/19</th>
<th>FY 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kasese District Local Government</strong></td>
<td>PHC Wage</td>
<td>6,459,425,201</td>
<td>9,837,801,305</td>
<td>10,068,059,37</td>
</tr>
<tr>
<td></td>
<td>PHC Non-Wage</td>
<td>971,256,400</td>
<td>971,256,400</td>
<td>1,720,912,775</td>
</tr>
<tr>
<td></td>
<td>PHC Development</td>
<td>0</td>
<td>1,134,543,803</td>
<td>723,289,147</td>
</tr>
<tr>
<td></td>
<td>Sanitation Grant</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Kasese Municipal Council</strong></td>
<td>PHC Wage</td>
<td>1,992,948,036</td>
<td>2,924,713,428</td>
<td>2,924,713,428</td>
</tr>
<tr>
<td></td>
<td>PHC Non-Wage</td>
<td>44,709,783</td>
<td>44,709,783</td>
<td>102,239,923</td>
</tr>
<tr>
<td></td>
<td>PHC Development</td>
<td>0</td>
<td>12,025,794</td>
<td>539,377,138</td>
</tr>
<tr>
<td></td>
<td>Sanitation Grant</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Computations based on Approved Estimates of Revenue and Expenditure for the respective years

From table 3, it is notable that both the district and the municipality started receiving PHC development grants in FY 2018/19. This marks a funding reform that resulted in PHC development funds being decentralised from MoH to the local governments. It also marks the period when GoU started implementing its health infrastructure improvement agenda by upgrading HC IIs to HC IIIs, starting with sub-counties without a HC III. This is bound to benefit the district greatly because as pointed out earlier, it had 5 sub-counties without HC IIIs. This is envisaged to ultimately result into increased access to RMNCAH services across the district.

Further consideration of the PHC non-wage grant reveals that the all the health facilities at the same level of care generally receive the same amount of funding. However, as depicted in table 4, there are variations in the amounts across ownership type and the location of the health facility.

**Table 4: PHC Non-Wage Allocations to the Sampled Health Facilities**

<table>
<thead>
<tr>
<th>Sub-County</th>
<th>Health Facility</th>
<th>Ownership</th>
<th>FY 2017/18</th>
<th>FY 2018/19</th>
<th>FY 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bwera Sub-County</td>
<td>Kasanga PHC HCHI</td>
<td>PNFP</td>
<td>5,300,668</td>
<td>5,300,668</td>
<td>5,928,783</td>
</tr>
<tr>
<td>Katwe Town Council</td>
<td>Katwe HC III</td>
<td>GoU</td>
<td>9,977,177</td>
<td>9,977,177</td>
<td>11,233,406</td>
</tr>
<tr>
<td>Kasese Central Division</td>
<td>St. Pauls HC IV</td>
<td>PNFP</td>
<td>7,067,563</td>
<td>7,067,563</td>
<td>8,323,792</td>
</tr>
<tr>
<td>Kasese Central Division</td>
<td>Katadoba HC III</td>
<td>PNFP</td>
<td>5,300,668</td>
<td>5,300,668</td>
<td>9,004,886</td>
</tr>
<tr>
<td>Mpondwe Town Council</td>
<td>Nyabugando HC III</td>
<td>PNFP</td>
<td>5,300,668</td>
<td>5,300,668</td>
<td>5,928,783</td>
</tr>
<tr>
<td>Rwesande Sub-County</td>
<td>Rwesande HC IV</td>
<td>PNFP</td>
<td>7,067,563</td>
<td>7,067,563</td>
<td>8,323,792</td>
</tr>
<tr>
<td>Nyamwamba Division</td>
<td>Kasese Town Council HCIII</td>
<td>GoU</td>
<td>13,678,836</td>
<td>13,678,836</td>
<td>21,087,271</td>
</tr>
<tr>
<td>Mpondwe Town Council</td>
<td>Bwera Hospital</td>
<td>GoU</td>
<td>151,971,546</td>
<td>151,971,546</td>
<td>489,746,510</td>
</tr>
<tr>
<td>Karambi Sub-County</td>
<td>Karambi HC III</td>
<td>GoU</td>
<td>9,977,177</td>
<td>9,977,177</td>
<td>11,233,406</td>
</tr>
<tr>
<td>Kisinga Sub-County</td>
<td>Nyabirongo HC III</td>
<td>GoU</td>
<td>9,977,177</td>
<td>9,977,177</td>
<td>11,233,406</td>
</tr>
</tbody>
</table>
Across all the financial years it is notable the public/ GoU owned health facilities receive more PHC non-wage grant funding than their PNFP counterparts at similar levels of care. This mostly due to the fact that GoU funding to PNFP facilities is only part-contribution in nature to complement what the PNFP facilities receive from their foundation bodies such as the religious institutions and other non-governmental organisations. The pattern in non-wage funds could also be explained by the fact that half of the PHC funds allocated to the PNFP facilities are dedicated to credit line commodities (EMHS) as per the sector grant and budget guidelines. This then leaves only half of the funds available as a PHC non-wage grant to the health facilities. This in contrast to the GoU facilities where the PHC non-wage funds are entirely dedicated to the day-to-day running of the facilities and additional funding is availed for the purchase of EMHS.

It was however also noted that Health Centre IIIs in the municipal council area received more PHC non-wage grant funding than Health Centre IVs in rural settings, despite the Health Centre IVs being at a higher level of care. This difference mostly arises from the annual GoU estimated cost of running a health facility in a given location as well as the populations served by the different health services. These are both key parameters in the allocation formula for the PHC non-wage grants.

These variations in the amount of PHC non-wage grants received are a cause for concern because they do not necessarily reflect the health needs of the communities surrounding the health facilities. For instance, while urban areas like municipalities have larger populations compared to the rural sub-counties, the disease burdens in the urban areas is likely to be lower given their access to better water, sanitation and hygiene services which usually offset the incidence of disease. Thus health facilities need to be allocated PHC funds commensurate to the average number of patients they actually serve. In addition, the performance of the health facilities could equally be taken into account during the resource allocation. Unlike the RBF mechanism where funding is based on performance, PHC funding to health facilities is not affected by the health facilities’ performance.

**Implementation of RBF in Kasese**

One of the main features of the RBF system is the payment for results/performance. According to MoH (2019), “payment of RBF funds to health facilities is based on the invoiced services and assessment of quality of care. Health facilities produce invoices, which are processed at the regional and national levels. Data verification is done by the District Health Management Teams (DHMT) quarterly. Validation of invoices is done by the National RBF Unit of the MoH”.

In FY 2018/19, the beneficiary health facilities in Kasese districts received a total pay-out of UGX 2,965,006,200. This however marked a 5% decline from the amount received in FY 2017/18 where the facilities received a total pay-out of UGX 3,130,997,750 from Enabel. This suggests a slight drop in the performance/results of the health facilities in the district given that the pay-outs are based on results.
Nonetheless, Kasese district received the highest amount within the Rwenzori region in FY 2018/19. In the addition, even when West Nile is considered the amount was the highest pay-out for the entire project in FY 2018/19. Kasese alone accounted for 30% of the total pay-outs as illustrated 3. Comparing the RBF pay-outs with the PHC funding over the same period (as illustrated in Table 3), it is notable that the total amount of RBF pay-outs to the fourteen beneficiary facilities in FY 2018/19 far outstripped the combined total of PHC Non-wage grant and PHC Development grants received by both the district and municipal council over the same period. These funding patterns illustrate the significance of RBF to health service delivery in Kasese district.

Selecting Beneficiary Health Facilities

A number of health facilities have benefited from the RBF in Kasese. Consultations with the RBF coordinator revealed that a total of fourteen health facilities are currently benefiting from RBF. These include Maliba, Bugoye, Kasanga, Nyabirongo, Karambi, Kitholhu, Kabatunda, Isule, Kinyamaseke, Katwe, Kitswamba, Kyarumba, Nyabugando and Kitabu. The RBF coordinator also indicated the selection criteria set out by Enabel was strictly followed in selecting the health facilities. The health facilities had to meet set requirements on infrastructure and availability of staff among others in order to be considered. Additionally, quantity and quality of RMNCAH services provided was also taken into account. Therefore health facilities receiving high patient turnouts daily stood a better chance at being selected. The location of the health centre was also considered and care centres far from urban centres were more likely to be considered.

*We looked at number of clients who use these health centres. For example Karambi and Bugoye are very busy. You find the health workers still very busy with long lines even in the evening. We also looked at the location of the centre. Some health centres like Kabatunda, Isule and Kitholhu are deep in remote areas where support is really needed. So this was to support them because Kasese is far…RBF Focal Person Kasese District*
After being selected as a beneficiary, health facilities are faced with the task of maintaining high standards of care to remain beneficiaries. As a pre-requisite for receiving initial funding, selected health facilities and district health management teams were required to have an approved coverage plan which among other things detail strategies to reach underserved populations in their catchments. It was also indicated that by some of the facilities that adherence to the ministry of health guidelines in providing care was essential while others said that proper reporting was equally important for the care facility to keep receiving RBF.

First you have to carry out your work following the approved ministry of health guideline. This guideline conforms to the world health organisation standards. So for a health centre to get any money, you have to show proof of having followed the right procedure in diagnosis, treatment and referral…

Health Worker Katwe HCIII

They pay for work you have done, so you just have to follow the guidelines and report. Otherwise you won’t get paid…

Health Worker Nyabugando HCIII

You have to report to get the money. And your reports must show you follow the correct procedure in handling patients. Its results based so no one will push you. Your work alone will push you out…

Health Worker Rwesande HC III

Services Covered by RBF and Evaluation Criteria

Consultations with the Health facilities indicated that the RBF services are subdivided in two categories namely quality and quantity. Under Quantity, RBF covers Outpatient Department (OPD) service/care for children under 5 years of age; OPD services for children above 5 years care; referrals at the respective level of care (HC IIIs get referrals from HC IIs, HC IVs get from HC III and Hospitals get referrals from HC IVs); Chronic care which includes ARV Therapy, Nutritional assessment, Tuberculosis, Diabetes and Hypertension); discharges out, MCH services (visits, tetanus, family planning, admissions in maternity and OPD within MCH); minor surgeries at HC IIIs and major surgeries at HC IVs and Hospitals.

Under the Quality of services, RBF covers system leadership and governance (frequency of management meetings, finance, staff meetings, staff files and compliance to standards); infection control (receivers, bin-system, availability of water within the department, connection to electricity and functional laboratory); clinical support (availability and functionality of laboratory and scan services, availability of protective gear, radiography – level of advanced effect reactions); departmental meetings; staff attendance; waste management system; and sanitary facilities.

It was reported that the indicators on the quality of services are measured within all the departments at the health facilities which include administration, OPD, Wards, Compound and Security.

The health facilities enter information on the above services on quarterly basis into a standard RBF tool which has a star rating system based on performance. Each star gained is equivalent to UGX 1 million at HC III, UGX 5 million at HC IV, and UGX 10 million at Hospital level. The amount to be paid is therefore dependent on the number of stars received. Prior to payment,
the health facility results have to be verified at both local government (DHO) and Ministry of Health level which then approves the payments. Upon approval, Enabel transfers the funds directly onto the health facility accounts.

**Benefits of RBF to the Health Facilities**

Overall, most of the respondents indicated that RBF had contributed much towards better provision of health care in the health centres. Responding to the question as to whether RBF had enhanced the performance of the health centres, most of the responded indeed indicated that it had. Some of Health facility respondents expressed being more confident in handling any number of patients due to the support they had received.

*We are now able to manage any number of clients with confidence because we are sure they will be taken care of. All we need now is the right number of staff to swallow the work load.*

*Actually cases of poorly managed clients have decreased to nearly zero. People with untreated diseases like gonorrhoea have decreased… Health Worker Katwe HC III*

Some of the respondents consulted indicated that the health facilities had acquired new equipment to furnish their wards such as beds and mattresses. These had been procured strictly using RBF funding. As a result of these improvements, the health facility respondents indicated that were now able to enrol more volunteers and to attend to more patients.

*If you move around, all those wards, you see children and mothers having given birth or waiting to deliver. That’s where we have impact… Health Worker Nyabugando HCIII*

*Our enrolment has drastically increased. We now have a full maternity ward, more than 2 children being born daily. We are also able to give some small finance to our volunteers in appreciation for the work they do here… Health Worker Rwesande HC III*

In addition, respondents reported that they had received training courtesy of the RBF support which has improved staff performance especially in limiting preventable deaths. Respondents indicated that many patients had previously been managed poorly which would sometimes lead to preventable deaths. It was also indicated that the RBF had helped improve record keeping as all work done needs to be documented using various ministry of health record books and forms.

*We have been going for trainings. First on what RBF is because we did not know about it. Then went through the guidelines, proper care, ethics and conduct among others… Health Worker Katwe HIII*

*Following the guideline properly has resulted into decrease of death cases. Most clients were poorly managed before. Even the clients are now better guided on how to handle themselves while at home… Health Worker Katwe HIII*

*More care is taken into proper handling of the client. Following the proper guidelines is the key thing in this RBF project. You have to note everything and must follow the guideline not just jumping and assuming. You can’t prescribe any drugs without a laboratory test for example… Health Worker Nyabugando HCIII*
Our staffs are now more careful at following the procedure because we can’t get the money if they mess it up. This ultimately shows up in the number of clients who get discharged on time and the recuperation rates. Supervision is now very important… Health Worker Kasanga HCIII

Is RBF Paying Attention to What the Communities want

The success of the GFF and RBF ultimately rests on how well it improves the health of women, newborns, children and, adolescents. The RBF framework is anchored within a context of increasing suboptimal coverage of the 11 priority RMNCAH interventions whose coverage was less than 50% by 2016. These were derived from a bottleneck analysis that informed the development of RMNCAH Sharpened Plan investment case document Key among these services include: (i) ANC 1st – 4th consistent visit; (ii) safe delivery under skilled care; (iii) comprehensive emergency obstetric care and referrals; (iv) essential newborn and postnatal care services at 06 days and 06 weeks; (vi) family planning both short term and long term excluding condoms; (v) complete immunization for children (vi) Pregnant women received second dose of Intermittent Preventive Treatment of Malaria (IPT2).

Coverage gaps of Interventions along the continuum of care against national targets

Source: Investment Case or Revised RMNCAH Sharpened Plan for Uganda 2016/17 – 2019/20

Interviews with community targeted beneficiaries (women of reproductive age 15- 49 and adolescents 10 -19) shows an appreciation of the RBF focus in improving services around the continuum of RMNCAH with particular emphasis on indicators with suboptimal coverage like
ANC (1st- 4th), Safe deliveries under skilled care, family planning, OPD attendance, children fully immunized. Targeted RMNCAH investments by development partners like Enabel and other local partners that have through construction of standard maternity wards and equipping them, staff houses, donation of project motor vehicles, water systems and capacity building of VHTs have supplemented critical RMNCAH interventions in Kasese. However, some of the causes for suboptimal coverage are a result of social cultural norms like customs and culture, socio economic conditions like poverty and therefore, there should be a matched strategy to address the underlying causes for the suboptimal coverage of priority RMNCAH interventions in a mutli-sectoral way.

“Beds in the facility were very few but since 2018 our beds in the maternity has increased. We had few staffs (Doctors/Nurses and midwifes) but now the number has increased. Our maternity was the worst but now we are provided with nice and enough maternity ward.”

Community member participant at Nabiganda HC III

Although health facilities had taken the initiative to ensure supply-side challenges are addressed like purchase of additional medicines and health supplies, equipping of the maternity wards and operation theaters, extension of water and improvement of rain water harvesting at some health facilities, purchase of additional stock of medicines procured through RBF, communities highlighted the following challenges affecting RMNCAH services.

Table 5: Analysis of expressed community needs and URMCHIP priorities

<table>
<thead>
<tr>
<th>Community RMNCAH needs</th>
<th>Detail</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning commodities stock outs and community myths</td>
<td>Family planning is a core area where outputs are paid for with unit price varying for short term and long term. The current strategy in most health facilities is using ANC and deliveries to promote family planning. VHTs also conduct community level awareness but to be more effective a robust approach to bring men on board.</td>
<td>Family planning education in communities rather than reliance on ANC attendance. Target men for spousal support especially for long term family planning services. Increase stock of some highly preferred family planning commodities especially Depo-Provera.</td>
</tr>
<tr>
<td>Occasional medicines and essential supplies like Mama Kits stock outs</td>
<td>Within the RBF startup, expenditures reviewed showed a high prioritization of medicines procurement to supplement NMS supplied ones. However, complaints of stock-outs still persist.</td>
<td>Improve allocations for medicines, mama kits to mitigate stock outs.</td>
</tr>
<tr>
<td>Referral and ambulance services weak and costly to patients</td>
<td>There are some guidelines on ambulance system where communities together with leaders are supposed to define costs of ambulance services to the next referral point.</td>
<td>Provide funds for operations of the referral and ambulance services.</td>
</tr>
</tbody>
</table>
Challenges in Implementing RBF

It is worth noting that most of the beneficiary facilities consulted complained about delays in receipt of funds, with many also reporting that the process of claiming for the funds after implementing the activities was difficult. The delays have at times also resulted in the health facilities being indebted.

*Some money is not paid for over un-necessary small issues ad you end up losing as the implementer. Then funds coming late after you have done the work. This holds certain work…*

*Health Worker Kasanga HCIII*

*Health workers are complaining that we demand too much from them yet they don’t get anything. Some have threatened to move out. But the project is soon ending. Also Some times the money comes late when the health centre has debts. But it’s a good project…RBF Focal person*

The challenge of delays in disbursement of funds is consistent with some of the challenges reported in the implementation of the URMCHIP. The Annual Health Sector Performance Report, FY 2018/19 indicates that while start-up grants had been paid to all the District Health Offices and health facilities in the URMCHIP beneficiary districts by the end of June 2019, there had been delays in the disbursement of RBF performance grants. The report indicates that RBF performance grants for Quarter 3 2019 had not been disbursed by the end of June 2019 for up-to 337 health facilities in the initial 28 RBF districts. This was far beyond the 15th May deadline for the disbursement of the funds.

Finally, health facility respondents also indicated that they sometimes failed to agree with the evaluators when validating the amounts presented by the health facilities. The evaluators often end up reducing the money leading to losses for the health facilities.

*Sometimes they cut our money yet we have spent on those clients. The payment should be streamlined…Health Worker Nyabugando HCIII*

**CSO Participation in the RBF Projects to Improve WCAH Services**

The implementation of RBF in Kasese has yielded several benefits in the provision of RMNCAH services as detailed in the foregone sections. As per the National RBF Framework, the implementation of RBF in all districts is meant to also comprise participation of CSOs especially in monitoring roles. CSOs are especially envisaged to play a key role in the
verification of results reported by the health facilities (MoH, 2016b). This study therefore sought to assess the participation of CSOs along two main fronts; that is involvement in RBF related activities and access to information on RBF.

During the consultations it was noted that while several CSOs monitor health service delivery, Baylor Uganda – Kasese Cluster was the only district based CSO that is participating in the implementation of RBF in Kasese district. The rest of the CSOs consulted did not have any idea about the RBF project and in some instances, the respondents did not know about RBF as a whole. Baylor’s participation is however as a funding partner to Community Based Organisations that undertake monitoring of HIV/AIDS services in the districts rather than validation of results under the Enabel funded RBF project. This work is particularly related to HIV/AIDS care. The project covers HIV/AIDS testing of adults, enrolment for adults and children; testing and enrolment of key persons (persons with disability and sex workers); financial assistance to enrolled vulnerable children (such as scholarships for orphaned children due to HIV); referrals for complicated cases as well as re-enrolling former patients that had gone off care.

*We empower local CSOs in helping us do our work in the district. So we give them trainings, finances and other logistical support to enable them work efficiently. We also support health facilities so they can offer care to HIV clients. We also reach out direct to support the clients financially where need be…Baylor Respondent*

Further, consultations with Baylor Uganda – Kasese cluster revealed that the organisation is undertaking a RBF project of its own. Baylor-Kasese Cluster works with health facilities and community based organisations to implement its project and pays for results.

*We have local partners that we work with. They move around in communities, look for patients, speak to them, and refer them among other things. They fill forms on what they are doing. We verify from both the clients and the partner health facilities and pay their invoice if they are above 50% accurate. We pay for the percentage of accuracy. For instance, we pay for performance if the accuracy of results is 50%, just like that. Below 50%, we do not pay at all… Baylor Respondent*

While all the CSOs consulted reported be undertaking WCAH related activities in their work, none of them reported it to be related the implementation of RBF. These were all district based CSOs and not community based such as the ones that partner with Baylor – Uganda Kasese Cluster.

Consultations with the RBF focal person at the District Headquarters confirmed that there was indeed limited participation from the CSOs. This implies that the platforms for CSO participation in RBF are not existent in Kasese District, a practice which is contrary to the provisions in MoH RBF Framework

*.... we are not working with any NGOs in RBF…RB Focal Person*

Indeed the focal person consulted was not aware of the CSO representation on the District Health Management Team (DHMT). Similarly, the respondent from the District health office
indicated that there is no Expanded DHMT which is the platform built into the URMCHIP to ensure CSO participation. The limited CSO participation was also highlighted by the respondent from the RBF Unit in the MoH who indicated that CSO participation is also limited at the National level. It was also noted that there is no platform to link national and subnational CSOs undertaking RMNCAH or RBF related work. Such a platform would ensure that the evidence generated by subnational CSOs find its way in the policy discussions at national level.

Therefore, while the CSO consultations were meant to yield evidence to design a scorecard that assesses performance of CSOs in the implementation RBF, the absence of CSO participation meant that the scorecard had to be designed based on the available published literature.

**Conclusions and Recommendations**

Overall, Results based financing has had and will continue having a positive effect on the provision of RMNCAH services. Among the immediate impacts RBF has had is to increase funding for RMNCAH services. It is notable that the total amount of RBF funds received by the fourteen beneficiary facilities in one year far outstrips the combined total of PHC Non-wage grant and PHC Development grant received by both the district and municipal council. This funding has enabled the beneficiary facilities to improve their infrastructure and expand the scope of their care. In addition, the benefits of the RBF funding have transcended the funding to also include enhancement in staff capacity which has resulted in improvements to the standard and quality of care which has minimised the number of avoidable deaths. The full extent of the benefits accruing from the RBF projects in Kasese needs empirical quantification, an objective that is beyond the scope of this paper but very important nonetheless.

However, the implementation of the RBF projects has had its operational challenges too. The main challenge reported was the delay in the disbursement of funds to pay for the verified results – a challenge also noted among the URMCHIP beneficiary districts. It was reported that the delay in some instances resulted into delayed procurement of EMHS which affected the quality of care provided by limiting the services available to the communities. In some instances, the health facilities ended up being indebted to their service providers as they await the arrival of the funds.

Finally, among the structural challenges noted was the limited nature of participation of CSOs in the implementation of the RBF projects in Kasese. It was noted that there was no platform such as the expanded District Health Management Team to ensure a designated space for CSOs to participate.

Against such conclusions, this paper recommends the following;

- Enabel in collaboration with MoH should consider incorporating an Expanded District Health Team structure in the implementation design of the Establishing a Financial Mechanism for Strategic Purchasing of Health Services in Uganda (SPHU) project. This is especially important because the project is still in its nascent stages and is in place until July 2021.
• There is therefore a need for CSO and communities to monitoring the implementation of the RBF project especially in order for the reported RBF results to be verified. Scorecards can be adopted as of the methods to be used for the monitoring.

• In line with CSO participation, there is a need for the formulation of the Expanded District Health Management Team as per the guidelines of the National RBF Framework with representation of CSOs.

• There is also need for CSO collaboration platform on RMNCAH which should bring together the national and subnational CSOs. This will ensure that the evidence generated from the subnational work on RMNCAH finds its way in policy discussions at the national level where most of the decision makers are located.

• It is essential that all RBF projects around the country are switched to the RBF digitalised system in order to limit the delays in disbursement of funds.
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Annexes

Annex 1: Roll out of RBF Projects across the Country as of June 2019

Legend

Uganda_Districts-2018

RBF

- URMCHIP
- URH VP
- SPHU ENABEL
- EHA ENABEL and USAID VPA
- Earmarked for URMCHIP
- URMCHIP and USAID VPA

Source: Annual Health Sector Performance Report FY 2018/19