Management Response & Recommendations Action Plan

Evaluation Report Title: Impact Assessment of the Results-Based Financing Programme for Northern Uganda

Response to Evaluation Report (overarching narrative)

The Northern Uganda (Nu) health programme produced some good process learning for the Ugandan context on implementation of a Results Based Financing (RBF) programme in Private Not for Profit (PNFPs) health facilities. This will serve as good considerations for any implementation of RBF. However, the independent evaluation was not methodologically robust enough to make confident conclusions about the attribution of RBF or input based financing (IBF) to any changes in health facility services or population health/utilisation. The difference in difference method allows us to see changes between these two specific regions in their specific contexts but because they were so different in terms of number and level of facility and income sources it is difficult to say that the difference is because of IBF/RBF. There were many confounders that the difference in difference method cannot account for in this instance. However because the implementation of the programme had a lot of oversight from the implementers and data verification was a large component anyway, there is still some learning about process and output differences seen.

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Recommendations	Accepted or Rejected	If "Accepted", Action plan for Implementation or if "Rejected", Reason for Rejection
The very low quality of clinical care ought to be a priority for improvement in both sub-regions but especially in the RBF sub-region.	Partially Accepted	This evaluation finding relates to the observed quality of care rather than the resources / inputs to provide quality care. The programme focused on the latter with more positive results. We shall share the results on observed quality of care with Ministry of Health particularly the Quality Assurance department. This will feed into the annual quality assurance plan of the MoH to strengthen service delivery.
Clinical quality of care should become a component of the RBF payment formula and assessed with observational probability samples as used in this evaluation. The use of medical records for this purpose was insufficient and not accurate.	Accepted	Future assessments of QoC in DFID funded health programmes to include an element on direct observation of care provision while controlling for the Hawthorne effect.
RBF was particularly effective in small health facilities such as HC-II in improving access and infrastructure. These facilities could be a particular focus for future RBF activities and play a key role in any strategy for strengthening the health system. Improvements to HC-IIs increased access to services and were associated with increased demand for services.	Reject	The evaluation provided some limited evidence that RBF was effective in small health facilities but due to the design of the study the evaluators were unable to control for other influencing factors. We are therefore unable to conclude that the improvements in access and infrastructure in small health facilities were purely a results of RBF.
Human resource planning should coincide with improvements to HC-IIs. While considerable improvements in staffing took place in large facilities, the availability of staff at the lower level facilities diminished a fact that may account for the low quality clinical care we detected. Although access and	Accepted	The challenges of human resources in Uganda are well recognised and are a focus of donor efforts to improve health systems. Given the catchment areas for the lower level health facilities, DFID will influence strengthening of human resource capacity including at lower level facilities.

infrastructure improved, human resources deteriorated. While the RBF payment formula did contain a human resource element, deficiencies persisted at the lower level facilities. It is possible they remained undetected using the RBF payment formula.		
In this study, the fact that 70% of the PNFP in Acholi were HC-IIs and only 20% were HC-IIs in Lango confounded RBF. Nevertheless, RBF was particularly effective in the smaller health centres. Future impact evaluations of RBF should take special care to ensure similar health system structures in both the RBF and the comparison areas.	Accepted	Future evaluation designs to be more methodologically robust to control for confounding factors.Based on the limited evidence we do not accept the conclusion that RBF was particularly effective in the smaller health centres.
The hands-off approach did serve its purpose, which was to assess RBF without other factors, such as observational studies, or capacity building strategies confounding the effect of RBF. However, it should be eliminated in future RBF projects. Had the evaluation data collected at time point two been made available to the district and PNFP managers, management decisions could potentially have been made to rectify the detected problems. High quality, evidence-based M&E systems together with RBF may produce an interaction effect leading to a more complete Theory of Change with a corresponding higher impact on quality, use, disease reduction and sustainability.	Partially Accepted	There is a perceived benefit in sharing lessons emerging during implementation of RBF with the implementers. Future programmes to consider the context and make evidence based judgement on when it will be most critical to share lessons emerging as opposed to waiting till the end when opportunities for corrective action have passed.
This evaluation data should be shared at the earliest possible time with the district management teams and	Accepted	- Results from the evaluation shared at a national level stakeholders meeting in October 2015 - Discussion on programme implementation and the evaluation held

the PNFP managers. While it was appropriate to not share these data during the trial, it is essential to do so now that it has concluded		with DFID Uganda in October 2015 - Dissemination of evaluation findings across DFID through a webinar in February 2016.
Future applications of RBF ought to be undertaken as trials but with modifications learned from this study. The primary ones include: a. Having a neutral external agency assess clinical quality of care using observational techniques effectively used in the R-HFA. However, in this next application the hands-off approach should be replaced by including M&E feedback as a component of the RBF model. RBF without the M&E data very much restricts the steering and guiding mechanisms needed by district and PNFP management. Similarly, the LQAS data used in this same way permits the districts and PNFPs to assess the population based behaviours and to arrest pernicious trends that limit PNFP effectiveness. b. Ideally the RBF and IBF mechanisms should be either randomly assigned or introduced in step-wedge designs in the same cultural settings so as to understand the effects of RBF versus other interactions effects that played an important role in this study.	Accepted	There are potential programmatic avenues that incorporate the recommendations from the implementation and evaluation findings for consideration: 1) Smaller operational trial: implement a more realistic trial in a new region(s) in lower-level health facilities to test whether this will actually work in practice. Based on what has been learnt it would be recommendable for this to be a mixed IBF/RBF where inputs would include a credit-line for drug supply and clinical care interventions (training/ continuing professional development/ supportive supervision/ monitoring in clinical care). 2) Risk-managed scale-up: scale the lower-level facility model up into several regions nationally and set up really good M&E framework for adaptive programming (verification data makes RBF ideal for adaptive programming) 3) RCT: larger scale-up with more rigorous RCT model matching facilities and then randomising to different implementing models (RBF/IBF/mixed)