Jagua Publication

Curr. Res. Interdiscip. Stud., 3(4): 1-16, 2024. DOI: 10.58614/cris341

Current Research in Interdisciplinary Studies

Homepage: https://www.jpub.org/journal-details.php?journal-id=40

ISSN (E): 2583-1887
Current Research in Interdisciplinary Studies
Jagua Publication

Research Article

Accountability Mechanisms In Result Based Financing And Their Implementation In Lira District, Northern Uganda

Nathan Okiror [1*], Aloysius Ssenyonjo[1], Christine Kirunga Tashobya [1], Elizabeth Ekirapa [1], Grace Norah Katooko[2], Mamello Muhanuuzi [1], Edmond Acheka [3], Reuben Odieka[1], Daniel Opuch[5], Eunice Esule[4] and Martin Kasendwa[1]

[1]*School of Public Health Makerere University, College of Health Sciences*
[2]*International Health Sciences University, Institute of Public Health, and Management*
[3]*Lira District Local Government, Department of Health*
[4]*Ministry of Health-Uganda, Results Based Finance Unit*
[5]*Baylor Foundation, Uganda*
[*]*Corresponding author: Okirornathan @gmail.com*

Article Info

Keywords: *Accountability mechanisms , Results based Financing*

Received: *18 April 2024*
Accepted: *15 August 2024*
Published: *8 September 2024*

Abstract

Introduction Results based financing has been proposed as an innovative reform to enhance systems performance in Uganda. Lira District is one of the districts implementing the national results-based financing (RBF) scheme under the Uganda Reproductive Maternal and Child Health services Improvement Project (URMCHIP). The diversity of relationships among various actors in RBF implementation underscores the need for mechanisms to ensure accountability among them. This was a case study which aimed at exploring the RBF accountability mechanisms, their implementation, and related factors in Lira District.
Methodology The study was a descriptive case study employing qualitative methods. The data collection methods included a) focus group discussions with the health workers from RBF facilities, b) key informant interviews with key actors in the RBF program at the MOH as well as in the district including district managers, health facility in charges, verifiers, members of the health facility management committees, c) document review of RBF documents, annual progress and audit reports. were analyzed thematically guided by a framework that explored the relationships and related accountability arrangements in RBF.
Results Several accountability relationships do exist among actors in RBF program and each relationship has associated accountability mechanisms for example, accountability mechanisms between MOH and the district include MOUs and business plans, while between the district and facilities mechanisms include reporting, data verifications, financial audits while display of results on notice boards, complaint boxes are mechanisms between the facility and the community. Regular support supervision and facility innovations such as meetings complimented RBF-specific designs. Challenges hindering smooth implementation of accountability mechanisms included infrequent financial support to enable regular support supervision/verification visits by Expanded District Health Management Team (EDHMT) and corruption tendencies.
Conclusion Implementation of accountability mechanisms in RBF in Lira is suboptimal due to the various RBF design and implementation challenges. There is need to support the EDHMT and facility managers' in terms of capacity building and facilitation to do their work. Additionally, efforts need to be undertaken to address delayed disbursement of funds and corruption impeding the implementation of accountability mechanisms in the district.

Cite as: Nathan Okiror, Aloysius Ssenyonjo, Christine Kirunga Tashobya, Elizabeth Ekirapa, Grace Norah Katooko, Mamello Muhanuuzi, Edmond Acheka, Reuben Odieka, Daniel Opuch, Eunice Esule, Martin Kasendwa. Accountability Mechanisms In Result Based Financing And Their Implementation In Lira District, Northern Uganda. *Current Research in Interdisciplinary Studies*, 3(4):1-16, 2024. https://doi.org/10.58614/cris341

1. Introduction

Globally, a number of countries are striving to ensure their respective populations are healthy since a healthy population is an important driver for economic performance and consequently development [1]. Results-based financing (RBF) has been proposed and applied in various settings as an approach to improve health system performance [2]. RBF is a health financing arrangement that links payments to pre-determined results with payment made only upon verification that agreed upon results have actually been delivered [3]. In theory, the RBF approach by design has accountability arrangements with the inherent potential to foster system-wide improvements in relation to human resources (increased motivation), financial management (autonomy of health structures, management tools), health information and other aspects of governance [4]. Incentives in RBF may be directed to service providers (supply side), program beneficiaries (demand side) or both to motivate the desired actions or inactions [5].

Success in the implementation of RBF arrangements varies widely as a result of variability in the complexity of the set of factors such as emphasis on results, transparency in using funds, strategic use of data for decision making, knowledge sharing among others [6]

The implementation of RBF is considered more successful among the developed countries and less in the low and middle-income countries partly because the former have more developed health systems and support systems such as robust accountability arrangements [7]. In Sub Saharan Africa, governments continue to struggle to meet basic standards of health care for their societies with systems challenges and unsatisfactory health outcomes [8]. Understanding the nature and implementation of the different accountability mechanisms that characterize health reforms such as RBF is critical if the full contribution of such initiatives is to be realized.

A 2012 World Bank study pointed out that while an increase in humanitarian assistance is indeed good, RBF brings about increased attention to monitoring and effectiveness and raises questions regarding sustainability, funding gaps, population equity as well as the need for the addition of funds to the national health budgets [9].

RBF can best be understood using the principal-agent theory in which an actor (called the principal) delegates a task and authority to another actor called (the agent) who receives compensation for doing that task. Agency based approach is crucial in exploring accountability arrangements of RBF initiatives in any given locality by elaborating the various principal-agency relationships, the roles of actors, expectations and mechanisms in place to elicit the expected behaviors from various actors [10]. A study conducted in Kenya established challenges such as complex and centralized accounting requirements and lack of clarity in the roles and tasks of main actors as being a major hindrance to smooth enforcement of accountability mechanisms [11]. In support of the foregoing authors, Brant Lukusious with his colleagues reported that variable stakeholder awareness and competing stakeholder perspectives as bringing about inadequate role clarity [12]. In Uganda , several RBF projects have been implemented in the different parts of the country such as the north and east central regions and in 2016 , the MoH under the Uganda Reproductive Maternal and child health services improvement project (URMCHIP) signed a grant agreement (USD 140Million) with 51 districts under the ministry of local government to improve reproductive, maternal and child health [13] however concerns have been raised regarding the issues of noncompliance to guidelines by the districts, delayed submission of audit reports, illegal financial demands by district officials among other challenges.

Preliminary findings from the MoH RBF unit indicated suboptimal performance of the program with concerns of noncompliance to guidelines, non-submission of reports , financial demands by district officials among others [13]. Lira one of the first districts to implement RBF under the URMCHIP Project was among the poorly performing districts with anecdotal findings showing that the district had received verification funds twice since inception of the program in 2018. By implication, the RBF facilities could not be verified by the EDHMT and hence unable to receive and therefore unable to implement intended programs.

It is against this background that this study was conducted to investigate accountability mechanisms used in RBF as well as the aspects related to their implementation in Lira district local government.

2. Methods and Materials

Study design

This was a case study which enabled in-depth inquiry into the phenomenon of interest [14]. In making use of this design, qualitative research approaches were adopted. The adoption of this approach particularly provided a deeper insight and understanding of why the situation was as it was.

Study area

The study was carried out in Lira District. Lira district is found in northern Uganda and has got one regional referral hospital, 03 health centre IVs, 08 health centre IIIs and 06 HC IIs serving an estimated population of 408,043 people. The health facilities in which RBF was being operationalized are 17 and they include Amach, Ogur and Lira PAG (Health Centre IVs), Ober, Ayago, Anyangatir, A romo, Agali , Barapow,Amuca SDA and Barr (Health Centre IIIs), and then Abunga, Akangi, Alik, Apuce, Onywako, and Walela (Health Centre IIs). The PNFP facilities include Lira PAG, Amuca SDA HC III while the rest are public health facilities. There was no RBF in the regional referral hospital of Lira.

Table 1 below highlights the number of health facilities (both government PNFP) in Lira implementing the RBF program. The facilities are categorized by health sub district and by level of health facility.

Table 1: Location of RBF facilities by HSD in Lira.

Health sub -district	Level of health facility	Total number of health facilities	Number of RBF facilities	Percentage of RBF facilities
Erute North	Hospital	00	00	0%
	HC IV	01	01	100%
	HCIIIs	05	03	60%
	HC IIs	03	03	100%
Erute South	Hospital	00	00	0%
	HC IV	01	01	100%
	HCIIIs	05	03	60%
	HC IIs	04	03	75%
Lira municipality	Hospital	01	00	0%
	HC IV	01	01	10%
	HCIIIs	08	02	25%
	HC IIs	03	00	0%
TOTAL		**32**	**17**	**53**%

Study population

The target population for this study included key stakeholders in the RBF program. These were health workers from the different RBF facilities, facility managers, political and technical district officials and community representatives on facility managing committees. The sample population constituted 70 health workers and 14 key informants. The study purposively recruited healthcare workers from the different RBF facilities in the category of clinical officers, nursing officers, enrolled nurses/midwives and nursing assistants for the FDGs. The composition of each FGD was 10 participants totalling up to 7 FDGs.

Sample size and sampling procedures

Purposive sampling techniques were used to select the facilities and interviewees from the 17 facilities currently implementing the URMCHIP within the district. The sampling method was preferred because the aim was to focus on respondents likely to have information of interest to answer the research questions as follows; 7 FGDs (of 10 participants each) with health workers from selected RBF facilities in the district. A total of 14 purposively selected key informant interviews were conducted. Stakeholders who had specified roles in the implementation of the national RBF program were selected.
One official from MoH, 4 administrative heads, 3 political heads/HUMC members, 6 in charges /administrative facility heads constituted the secondary population making a total of 84. This population was chosen because it oversees the implementation of RBF and also is part of the accountability loop. Table 2 below summarizes the category of stake holders interviewed as key informants' right from the ministry, district, health facility as well as community level.

Table 2: Summary of KIs interviewed by the level of operation.

Level of **operation**	**Stakeholders interviewed**
National level	An official from the RBF unit at the MoH
District level	Ag District Health Officer, District RBF focal person, the honorable secretary for health, Municipal medical officer
Health facility level	One Health sub -district in charge, six health facilities in charges
Community-level	Two Health Unit Management Committee members.

3. Data collection procedures

Focus Group Discussions

Data were collected using focus group discussions consisting of 10 participants. The FGD was guided by a guide which was designed to elicit discussions exploring key themes such as existence of accountability mechanisms. To fully explore the themes of interest, probes were employed. Discussions and interviews were managed by two Research Assistants, one asking the interview questions and the other supporting note-taking. Informed consent was obtained from each participant prior to the discussion. The FGD was chosen because it offers the greatest flexibility in gathering information from homogenous-like participants. The method enabled the collection of data from huge numbers of health workers as they possessed an in-depth understanding of the experiences in relation to the implementation of RBF and the accountability mechanisms in the district. Discussions were conducted with the health workers under strict adherence to Covid 19 guidelines especially hand washing, social distancing and wearing of face masks.

Key informant interviews

Key informant interviews were conducted with stakeholders who had specified roles in the implementation of the national RBF program. Key informants included an official from MoH, administrative heads, political heads/HUMC members, and in charges /administrative facility heads. This population was chosen because it oversees the implementation of RBF and also is part of the accountability loop. All engagements were conducted under strict adherence to the Covid-19 prevention guidelines and precautions such as hand washing, social distancing and wearing of face masks.

Desk document Reviews

During the desk review and literature analysis process, the researcher used a document review guide to obtain information from existing program documents, project performance reports and monitoring plans, work plans, quarterly and annual reports, policies, plans, and activity reports, minutes and key documents to obtain information on accountability mechanisms in RBF, extent of implementation of RBF among other key variables. The documents which were reviewed included the comprehensive support supervision (CSS) strategy for the health sector (July 2020 – June 2025) [15], Uganda reproductive maternal and child health services improvement project (URMCHIP) phase one , RBF quarterly assessment independent verification report for the quarter January to march 2019 [16], the Lira district internal audit report on results based financing [17], the Uganda reproductive maternal and child health services improvement project results based financing implementation manual [17] , the Uganda reproductive maternal and child health services improvement project implementation manual [18], and the Uganda reproductive maternal and child health improvement project readiness assessment report for the period July to December 2018 [19], A desk/document review was chosen as an appropriate method because it offered an opportunity to explore the past experiences in terms of implementation of the program especially in regard to the accountability mechanisms in RBF. Key comparisons and variations were teased out, coded and used to triangulate with feedback from FGDs and KIIs.
Data collection tools such as A KII guide (appendix 4) and FGD guide (appendix 5) were used to elicit data from the study participants. The tools were designed with probes aligned according to the study objectives. In addition, a document review guide was designed and used during the review of documents.

Selection Criteria

Inclusion Criteria

Health workers and facility managers in health facilities implementing RBF, political and administrative leaders within Lira district as well as an official from the RBF desk at MoH.

Exclusion Criteria

Health workers and facility managers in health facilities implementing RBF, political and administrative leaders within Lira district as well as an official from the RBF desk at MoH.

Study variables.

Table 3 below highlights summary of objectives, objects of analysis, data sources as well as data collection methods;

Table 3: Summary of study variables.

Objective	methods analysis/variables	Data sources	Data collection methods
To establish mechanisms currently in place for ensuring accountability in the implementation of RBF in Lira district, Northern Uganda.	• Main principal-agent relationships and expected actions. •Accountability mechanisms in RBF (tools, structures, and process to drive accountability).	KIs Health workers	KIIs FGDs with health workers
To explore the perceived extent of implementation of the various accountability arrangements.	• Perceived extent of implementation of Accountability arrangements	KIs Health workers .	KIIs FGDs with health Document reviews
To explore the factors that influence (enable or constrain) the implementation of accountability mechanisms in RBF in Lira District Northern Uganda, why and how	Factors that nfluence accountability mechanisms - Internal to RBF program - Internal to the health facility - Internal to the district - External to the district	Key informant Health workers	KIIs FGDs with health workers. Document reviews.

Data analysis

The thematic analysis approach was conducted for qualitative data guided by the constructs from the conceptual framework. Qualitative data from the tape-recorded in-depth interviews were transcribed. Following transcription, the transcribed narratives relevant to the study objectives were highlighted and thus treated as codes. Responses from FDGs were as well coded. The groups of related codes were sorted into categories that describe the issue being studied under sub-themes. Appropriate themes that were mutually exclusive and exhaustive were then got from the sub-themes.

Data management and quality control

In this study, two research assistants who had prior experience in qualitative data were recruited and trained regarding the data collection techniques to permit uniformity and also maintain consistency alongside minimization of interview bias. Transcription was done professionally by the researcher as well as the interpretation of the transcribed qualitative data. A pre-test was undertaken among 2 health facilities from the neighbouring district of Kole where the RBF scheme is also being implemented. The feedback guided refining alongside removing ambiguous questions to ensure the validity of the tools.

Ethical Considerations

The researcher sought approval to conduct this study from the Higher Degree Ethics of Research Committee of Makerere University School of Public Health (MakSPH) on behalf of the Uganda National Council of Science and Technology (UNCST). Permission was sought from the office of District Health Officer Lira as well as the in-charges of the health facilities. The principal investigator and the research assistants sought informed consent in which the target respondents were informed about the purpose and objectives of the study. The participants were informed about the voluntary nature of their participation alongside protection and confidentiality of their identity and the information that they provided. They were accorded the right to withdraw from the study and the right not to be tape-recorded. The data collected was locked in a cabinet with the keys only held by the researcher again for purposes of confidentiality.

Study limitations

The study adopted a case study design. This by implication was not able to establish a cause-effect advantage over a long period of time. Additionally, the use of only qualitative methods made it impossible to quantify the extent of issues under study however it provided quite a deeper understanding of issues related to accountability mechanisms and their implementation in Lira district.

4. Results

This chapter contains results obtained from key informant interviews; Focus group discussions as well as document reviews. The information is presented according to the study objectives which were ; To establish accountability mechanisms currently in place for ensuring accountability in the implementation of RBF in Lira district, to explore the perceived extent of implementation of the various accountability arrangements and likely influence thereof on RBF implementation and to explore the factors that influence (enable or constrain) the implementation of accountability mechanisms in RBF in Lira District Northern Uganda, why and how. Some of the information is summarized in table form while some are in narrative as well as quotes of the respondents.

Mechanisms currently in place for ensuring accountability in the implementation of RBF

Several accountability relationships exist in each RBF arrangement under the URMCHIP in Lira district for example between the ministry and the district, between the district and the health facility, between the facility and the health workers, and between the health facility and the community. The expectations according to the design are that the funder, in this case, MoH/WB provides funds to the EDHMT/facilities with clear deliverables to be achieved, the EDHMT carries out routine support supervision/audits of results and funds, the health facilities in turn work to deliver on agreed-upon targets as well as providing accountability for the funds spent. The community through the HUMC/hospital boards provides oversight and managerial function the health facilities. The table 4 below summarizes the accountability mechanisms that exist at different levels and between the different actors in RBF implementation.

Table 4: Summarizes Accountability Mechanisms currently in place by level of relationship between the different actors in RBF .

Theme	Level of Relationship	Accountability Mechanism
Mechanisms currently in place for ensuring accountability in the implementation of RBF	a) MOH and the District	Budgeting, Planning, Priority/Target setting MOUs and Business plans
	b) District and Health facilities	Documentation and reporting Data verification Financial audits
	c) Health facility managers and health workers	Staff attendance registers Human Resource Management participation in budgeting and resource allocation
	d) Health facility and the community	Display of expenditures on facility notice boards Clinic committees Complaint boxes

a) Accountability between the MoH and the district

A contractual agreement (MOU) exists which details the expectations of the MOH as well as the district to achieve successful implementation of RBF. The RBF unit at the MOH is mandated to provide oversight and technical support to the Lira EDHMT to ensure that they carry out their mandate which among other responsibilities includes carrying out site assessments and verification of results. The EDHMT is expected to submit facility audit and verification reports to the MOH which informs payment processes. A respondent was quoted saying.

"Each of the RBF districts including Lira has an agreement (MOU) which details criteria for the accreditation of facilities, the responsibility of the EDHMT in providing routine support supervision, the modality of payment among other issues. It's the responsibility of the RBF unit to provide technical oversight to the EDHMT so they meet their obligation and the unit also acts as a central coordinating point for the whole RBF program in the country." (KI-MOH).

b) Accountability between the district and the heath facilities

In regard to the district- health facility relationship, the following mechanisms were reported

Documentation and reporting of data

Records and reports provide a basis for rewards if found authentic and trigger penalties if falsified. Respondents pointed out that as a measure of ensuring accountability, they had to fill in partographs and documentation of the patient records at each visit. Documentation of patient records and filling in of partographs was used as a measure of accountability during supervision. In this regard, respondents were quoted saying, *"What we always do in the maternity ward is to ensure that partographs are filled well so that when they (district RBF team) come for supervision, all parameters are up to date" (KI- health facility).*

"For any mother who comes during labor, we make sure we monitor them using the partograph. After delivery, we enter the information into the register and later submit it to the hospital records. We also have to ensure that the registers filled well" (midwife- FGD).

"Filling of registers helps to know the number of patients who have come in, those who have received the treatment and those who have gone to the laboratory" (KI-health facility).

Verification of results based on implementation plans

Site visits are conducted to validate data and achievements in line with what was earlier agreed upon. Respondents mentioned that verification of results at both healthcare facility and district level is critical in ensuring accountability in the implementation of the RBF programs.

Results are verified by comparing the healthcare facility and district records for discrepancies. Verification of the results is done quarterly and is complemented by support supervision.

Verification is a very important matter. Before, we would deliver like ten babies and yet in our register, we have only registered two. So, when RBF came, there is a means of verifying what was reported, "You people are working but we have not seen your results" In our register we were recording zero while in the external records show that people are working. So, verification is very important in RBF." (KI- health facility).

"*I must also ensure that the quarterly verifications are done both at the district and facility level. I ensure that they are in the implementation plan of all healthcare facilities. I also carry out assessment of the new facilities." (KI- district).*

"*If they (auditors) come here, they go to the in-charges office and inform her of what they want to do. Even if they want to verify records, a meeting is held so that the funding is delivered to the right staff. If maybe there is an audit query, they will tell us." (FGD).*

"*We do verification after the healthcare facility has done self-assessment which entails organizing out puts according to the targets which were set. From that self-assessment, we verify whether the healthcare facility has done the self-assessment well, and then we generate scores. We put the scores in the invoice at the district which is then submitted to the ministry. Payment is given according to the invoice submitted to the ministry." (KI-district).*

Conducting regular financial audits

Regular audit of books of accounts and financial documents at facility and district greatly deters chances for mismanagement, embezzlement and enforces compliance to standards. Respondents pointed out that there is always acknowledgement of receipt of RBF funds once disbursed to the healthcare facilities. Besides, healthcare facilities are also audited and the audit report is shared with the Ministry of Health and the district management in order to improve accountability. It was also evident that some healthcare facilities had auditors who provided oversight during the budgeting and implementation of the activities. In this regard, some respondents were quoted saying,

"*Fundholding and resource tracking……. Ministry of Finance and the Ministry of Health submit money directly to the healthcare facilities. After receiving the funds, the facilities submit an acknowledgement receipt. We also undergo auditing and our audit report is shared with the Ministry of Health and the district. So, we track the resources that are present."(KI- health facility).*

"*In most cases when the auditors come, actually they do not meet staff directly but they go to the accounts department and do their auditing from there" (FGD).*

When asked whether there is any form of accountability for RBF funds, one of the key informants was quoted, *"Of course, what I know about the budget is that our facility has an accountant who always comes and sees how we have budgeted before doing everything and it is very important." (KI-health facility).*

c) Accountability mechanisms between the health facility management and the staff

As reflected in the table 4, Several accountability mechanisms define the relationships between the health facility managers and staff. They include staff attendence registers, participation in joint budgeting and human resource processes. More findings on each of this mechanisms are as explained below,

Use of staff registers to track health worker performance

Its attendance lists that inform payment processes i.e. how much each staff is entitled to. Respondents mentioned that they use staff registers to track expenditures and to credit any staff who benefits from the RBF program. A respondent was quoted, *"And the attendance book will be used when crediting anybody. That attendance book will also stand on its own without being tempered with." (KI-health facility).*

Performance appraisal for staff

Regular performance appraisals between the line managers and staff seek to evaluate to which extent staff are meeting key performance targets in addition to drawing attention to necessary competencies, practices and behaviors of staff needed to achieve targets. Respondents mentioned that performance appraisals were at times used as an accountability mechanism for RBF. They pointed out that during appraisals, staff performance is assessed and the best performers are credited or awarded.

"*We usually have performance appraisals which are used to assess staff performance. During the staff appraisals, we ensure that we agree on the best performer. We also agree that if everyone is getting some allowance, the allowance for the best performer is topped up. This happens and nobody complains about it". (FGD)*

"*The structures also help the management committee to give rewards to those performing well. These awards are always given at the end of each year to the best performers". (KI- health Facility).*

Departmental participation in budgeting and resource allocation

It is through these sessions that budgets are discussed and feedback is provided and task allocation for new assignments is communicated. Respondents mentioned that members from each department are called upon by the administrators to participate in budgeting and resource allocation meetings. Such meetings help health workers to brainstorm on how to identify gaps and allocate funds. In this regard, respondents were quoted,

"*If the money comes, the administrators ensure that it is properly budgeted for. The percentage which is supposed to go for infrastructure should go for infrastructure. So that even when working, you work tirelessly knowing that your energy is contributing to the future" (FGD).*

"*During the budgeting and resource allocation process, each team is engaged to compile what they need in a specified period of time." (KI-health facility).*

d) Accountability mechanisms between the Health facilities and the community

Accountability mechanisms that exist between health facilities and the community include display of expenditures on facility notice boards, Health Unit management committees and complaint boxes. Details of each are explained below.

Display of expenditures on public notice boards

Summary of expenditure against funds received provides an opportunity for public scrutiny and ultimately builds trust among staff and the community. Respondents in this study pointed out that they displayed their RBF related expenditures that's funds received and how they were spent on public notice boards for public consumption. They pointed out that each of the departments had a notice board that was used to display finances. The display of the results and finances was used to increase transparency, and also motivated staff to work harder.

"Yes, we have a notice board in each department. It is on these notice boards that they often display the expenditures and results. If you go to any of the notice boards at the moment, you will find the expenditures and results displayed. "(KI- health facility).
''If they display results and expenditures at the health unit, you will be contented with how the disbursed money was spent. That transparency can motivate you to work hard." (FGD).

Health facility Management Committees

Health facilities have health unit management committees who are mandated to oversee the facilities on behalf of the communities. Depending on the level of the health facility, the committee is comprised of 7-10 members appointed by district or sub county local government. One of the committee's roles is to play intermediary roles between the health workers and the community as well as be part of the health facility budgeting and administrative activities including financial related functions. The RBF implementation manual (section 7.3) also requires that 2 of the non-executive members of HUMC should be part of the procurement committee.

"RBF has been of help especially in enabling refurbishing of our maternity ward which was in bad condition. We as a committee working alongside the in charge decided to use part of the RBF funds to renovate our maternity ward so that our mothers do not walk for long distances for maternity services" (KI- Community).

Complaint boxes

Suggestion boxes exist, which are expected to collect feedback from patients on all matters concerning service delivery at the facility. The health unit in-charges and health unit management committee are supposed to review this feedback and take appropriate action to ensure the delivery of quality services. However, it was pointed out that most of the suggestion boxes at the facilities are not being used effectively by the patients.

"Suggestion boxes are supposed to provide patients with a channel through which they can raise their concerns e.g. if some nurses are rude or maybe theft of drugs etc. so that management can take action. However, most of the patients prefer going to radios and to politicians to express their concerns instead of using the suggestion boxes" (KI- health facility)

5. Extent of implementation of RBF accountability mechanisms in Lira district

The previous section indicated existence of accountability mechanisms. Under this section, we report on the perceived extent of implementation of accountability mechanisms in RBF in Lira district.

Table 5: Extent of implementation of RBF accountability mechanisms in Lira district.

Accountability Mechanism	**Expected functionality**	**Perceived Extent of implementation**
MOU and contractual agreement between MOH and the district	Ministry does the site accreditation and provides funds while the district among many roles does the verification of results, which informs payments to facilities	Delays in disbursement of funds hence ineffective functioning of the EDHMT.
Documentation and reporting	Verification of results is premised on proper documentation in terms of accuracy and completeness of data tools	Data incompleteness and inconsistency was mentioned. Strengthening and institutionalization for sustainability was largely called for.
Data Verification and financial audits	The EDHMT is mandated to do verification (quality and quantity) on a monthly basis	This was reported to to be very irregular allegedly due to lack of funds to facilitate the district verification teams.
Staff registers	Registers are supposed to provide a basis for rewarding performance	Lower cadre staff expressed dissatisfaction with the fact that they are overworked yet least paid compared to their so-called high-rank counterparts.
Performance Staff appraisal	Staff appraisals are meant to be the basis for reward and sanction.	Majority of respondents reported that in spite of delays, this is by and large being implemented well and in time so far.
Joint Budgeting and resource allocation	As a best practice, facility staff need to participate in joint budgeting and resource allocation.	Lower cadre staff (Nursing Assistants, data clerks, enrolled nurses) reported tha facility managers are doing little to involve them.
Display of expenditures on facility notice boards	Display of financial information on facility notice boards is meant to provide th community stake holders an opportunity to appreciate the amount of funds received in the facility.	Most of the stake holders in the community do not pay much attention to financial details and some engage in misinformation on local radios.
Clinic committees	Health Management committees provide oversight to the facility on behalf of the community	Nonfunctional committees and in some cases less informed members in regard to RBF affairs.
Complaint boxes	These are meant to anonymously receive complaints or community concerns for management to eventually act on,	Communities prefer going on radios to raise raise their concerns.

MOU and contractual agreement between MOH and the district

Accountability arrangements do exist between the Ministry and the district as well as between the district and the facility, and the expected roles include site accreditation exercises by the Ministry, formulation and review of business plans, support supervision, verification exercises, financial audits, submission of performance reports etc. However, these are sometimes characterized by delays in disbursement of funds and noncompliance to guidelines such as some PNFPs who found it convenient to use the 40% meant for staff incentives to pay staff salaries.
Some PNFP facilities especially amuca SDA decided to use the 40% meant for staff incentives to pay staff salaries contrary to the guidelines. (KI-MOH)

Documentation and reporting

Documentation is one of the accountability mechanisms between the district and the health facility. It's premised on proper documentation in terms of accuracy and completeness of data tools that facilities score better. It's an area all facility-based KIs, as well as FGDs, agreed needed strengthening and institutionalization for sustainability.
Documentation is key since it's what the RBF assessment teams use to assess performance. However most of heavy work of documentation is left to us nursing assistants and enrolled nurses, which is not okay. (FGD)

Data Verification and financial audits

Audits and Verification of results (quality and quantity) is meant to be carried by the EDHMT on monthly basis. However, this was reported to be very irregular allegedly due to lack of funds to the district verification teams. In addition, the issues of conflict of interests on the side of the verifiers were reported. Respondents reported suboptimal levels of implementation of RBF accountability mechanisms For example, some RBF facilities had not had a verification exercise since April 2019 (that's over 20 months) allegedly due to lack of funds to facilitate the EDHMT (Verification Team) to reach these facilities. Some facilities had not received any funds despite of having gone through the due process of accreditation. Regarding this, one of the respondents was quoted,
"*We were duly accredited on 12/6/2019, however since then, we have not received any RBF funds in our account and yet we use staff-personal money for printing documents in preparation for the monthly assessment up to a tune of 40 copies every quarter. This has seriously demotivated staff because they hear their counterparts from other facilities benefiting from RBF" (KI- health facility)*

Staff Attendence registers

Staff registers are supposed to provide a basis for rewarding performance. However lower cadre staff expressed dissatisfaction with the fact that they are overworked yet least paid compared to their so-called high-rank counterparts.

Performance Staff appraisal

Staff Performance appraisal carried out annual basis and is meant to be the basis for reward and sanction. Majority of respondents reported that in spite of delays, this is by and large being implemented well and in time so far.

Joint Budgeting and resource allocation

Joint Budgeting and resource allocation is another function ideally meant to be performed at the facility level, however lower cadre staff (Nursing Assistants, data clerks and enrolled nurses) reported that facility managers are doing little to involve them. In addition, some respondents reported allegations of financial mismanagement and corruption where staff sign and do not receive their funds. There was also the issue of delays in delivery of budgeted items by JMS hence causing delays and poor performance during assessments.
Another pertinent area was that of delays in the delivery of procured items. For example, most of the procurement are done through JMS, which in some instances takes over six months to do a delivery of requested items. Lack of some of these essential items affected smooth and timely delivery of services hence impeding attainment of set targets for which payment is based. This makes it difficult to hold the facilities and health workers responsible for failures at the upstream level in such a case. One of the respondents was quoted.
"*Sometimes you place in your procurement request to JMS, and it takes over six months to be delivered. By the time the verification team gets to the facility, some of the targets will not have been achieved, making facilities score poorly. It's, therefore, our humble request that other suppliers to be permitted so that the procurement processes are fast." (KI-health facility)*

Display of expenditures on facility notice board

Display of expenditures on facility notice boards is meant to provide the community stake holders an opportunity to appreciate the amount of funds received in the facility. However, most of the stake holders in the community do not pay much attention to details but instead preferred going to radios and politicians to express their grievances. *We display financial information on notice boards for public consumption but instead some leaders prefer going to radios to express their concerns regarding RBF and PHC.*

Clinic committees

Health Management committees provide oversight to the facility on behalf of the community. However issues of nonfunctional committees whose tenure had expired and in some cases less informed members in regard to RBF affairs.
The views above agree with the Q4 internal auditors report 2019/2020 for Lira (RBF Audit QR I Report 2020), which reported a lack of

functional procurement committees in sampled facilities contrary to section 7.3 of the RBF implementation manual which dictates that out of the 5 members of the Health Unit Procurement Committee (HUPC), 2 of them should be non-executive members of the HUMC.

Complaint boxes

Complaint boxes are meant to anonymously receive complaints or community concerns for management to eventually act on, however it was also noted that the community members prefer going to the radios to express their grievances instead of using the available feedback mechanism like suggestion/complaint boxes in the facilities. He was quoted saying.
We have suggestion boxes in strategic locations within the facility to enable the patients /community members drop in their concerns and complaints, however most of them prefer to go to the radios instead which eventually affects our relationship with the community. (KI – facility Quarter Four District internal auditor's report 2019/2021 generally revealed that while policy and institutional framework for service delivery, especially regarding RMNCAH is explicit and strong, compliance is poor. Accountability is generally low because most in-charges in the RBF facilities are not trained in financial management skills and therefore unable to enforce standards. For instance, Barapowo and Boroboro HC IIIs payment vouchers were not referenced and the cheques being purported to support were not explicit hence unable to detect fraud and errors.

6. Enablers to the implementation of accountability mechanisms and likely influence thereof on RBF implementation in Lira District

The study revealed enablers such as synergies between accountability mechanisms, inherent health system arrangements such as Support supervision , staff meetings , financial controls such as multiple signatories in the expenditure of RBF funds as some of the enablers or facilitators to the implementation of accountability mechanisms in Lira district, the details of which are as discussed below,

Synergies between the different mechanisms

Implementation of different accountability mechanisms in a way complements and reinforces the other. For instance, holding regular staff meetings to review RBF programs in a facility also provides an opportunity to do joint budgeting and resource allocation in addition to enabling the team to review data-related issues for accuracy and completeness.
Respondents mentioned that holding regular staff meetings facilitated RBF accountability programs at the different healthcare facilities. Such meetings are to review accountability/payment vouchers. Besides, such meetings are used to communicate fund disbursement, how much funds are received and how the funds are to be distributed. Some respondents also mentioned that such meetings provided an opportunity to assign responsibilities and to develop timely schedules. These meetings help create an atmosphere of transparency and team spirit. Concerning the role of regular staff meetings in fostering the implementation of accountability mechanisms in RBF, some respondents were quoted saying,
"We hold monthly staff meetings. During these meetings, we ask for progress on supplies that we requested. For example, when we notice that the sterilizer we were supposed to buy is not delivered, we ask the responsible people who will then respond by telling us the reasons for the delays. They will tell us whether it's delaying with JMS or the money was diverted elsewhere. But normally during these meetings, we also check for accountability by seeing the payment vouchers. We always have them." (Clinical officer- FGD). "Through the staff meetings, they can announce that the money has been disbursed, the amount which has been received, how best they are going to distribute that money and what they will use it for." (KI-district). "During staff meetings, we give responsibilities, time schedules and all staff are involved in all duties." (KI-health facility)

Inherent health system arrangements such as regular support supervision

Some Respondents pointed out that much as this are not regular, support supervision visits done by the district health management team were vital in ensuring that facilities keep at par with the implementation of all programs including RBF. Such visits enable the supervisors to know where the different healthcare facilities are standing in terms of results/ performance and provide any corrective action. In this regard, one of the respondents was quoted saying,
"*Support supervision is done monthly. Through this, they also get to know where we are not doing well, and they inform you of where to correct and what to maintain." (FGD)* In addition to the above was the existence of Health Unit Management committees in all the RBF facilities who provide oversight and also mediate between the facility and the committee.

Financial checks and balances

Financial checks and balances in public financing system was pointed out as a good management practice in the successful implementation of accountability mechanisms for RBF activities. Practices such as having multiple signatories to health accounts, regular financial audits, publication of financial information were pointed out as some of the enablers to implementation of accountability mechanisms.
"If they display results on the notice boards, you will be contented that the money was disbursed. It makes the inner you focus on working hard, knowing that; "This money came, we know that things are transparent, you continue working very well" (FGD).

7. Barriers to the implementation of accountability mechanisms in Results-based financing

The study revealed barriers such as corruption culture, knowledge gaps, inadequate incentives, heavy workload, and non-functional structure of procurement committees at the facilities as detailed below,

Lack of transparency and corruption tendencies

At the health facility level, respondents pointed out that one of the biggest challenges to implementing accountability systems in RBF was the lack of transparency, usually exhibited through people signing for monies that they had not received. Some respondents also pointed out that corruption tendencies manifested through some volunteers signing and returning money to some healthcare facility staff hence hindering the successful implementation of accountability mechanisms in RBF. Concerning lack of transparency and corruption tendencies, some FGD participants were quoted saying. *"The biggest challenge I see in the implementation of accountability mechanisms is transparency. They can even just sign for the money on your behalf, yet in reality, you have not received the money." (FGD). "These volunteers are given money, but they return it to some of the staff, which means that money is being eaten by some greedy officials." (FGD)*

Knowledge gaps

Knowledge gaps, especially among low cadre staff and community members, were reported as big barriers. At health facility and community levels, some respondents raised the issue of lack of sufficient information about RBF accountability in general in as much as they were aware of its existence in the facility. They particularly lacked knowledge on what percentage was meant on development and staff incentives. Regarding knowledge gaps, some participants were quoted saying, *"I know that RBF is in our health facility just like PHC. However, I don't know how much money comes and how it's to be used" (enrolled nurse- FGD)*

Payment is not commensurate with the level of effort

At the health facility level again, respondents pointed out that one of the challenges that hindered the implementation of URMCHIP-RBF program was payments not being commensurate with the level of effort of the different cadres, employees. A case in point was that some nursing assistants and data managers were perceived to be paid less than their actual efforts. This was mainly attributed to the fact that they had lower qualifications than other staff. This consequently demoralized some of the staff involved in the delivery of RBF funded programs/interventions.

"About 40% of the RBF funds are given for staff incentives. However, this is distributed according to the level of qualification rather than effort. Some categories of people like askaris, nursing assistants and data managers are paid less than clinicians, yet they put in more effort. That demoralizes the staff a lot. I think they should improve on that" (FGD).

Infrequent funding for the EDHMT to carry out routine support supervision

Lack of supervision for the RBF programs was cited as one of the main challenges hindering the implementation of accountability mechanisms. The district RBF staff acknowledged that they had, for instance, failed to undertake verification of the lower healthcare units. This consequently made it difficult for such healthcare units to benefit from the RBF program.

The foregone feedback is in agreement with one quarterly progress report which highlighted that the EDMHT had received funds twice since the rollout of RBF by the time of the study. The EDHMT could not carry out regular support supervision/ verification visits, which is key in accountability. [20].

"The district health team has failed at verification and organization of invoices which makes it impossible for lower healthcare facilities to benefit from the RBF program." (KI- district level).

"There is poor supervision of the RBF program. The RBF verification team has neither ever supervised us nor have we received any accreditation. I would also want to point out that supervision of the RBF program should be intensified." (KI -health facility).

Heavy workload

Respondents mentioned that heavy workload curtailed implementation of accountability mechanisms such as conducting meetings to discuss the implementation of the RBF programs. It was pointed out that staff were often busy to the extent that they could not attend such meetings. A heavy workload due to competing activities was mentioned by one of the district managers at the district level. He particularly pointed out that apart from RBF, administrative responsibilities require attention and sometimes involve travels outside the district for meetings. A respondent was quoted saying; the following was mentioned by respondent,

"There are times we cannot attend meetings because the wards are very busy. Obviously, when all of us get busy, meetings cannot proceed". (KI-health facility). "The challenge we have is that we have a heavy workload which makes it difficult to attend meetings" (FGD). "I hold other responsibilities in the district, which range from administrative and managerial in addition to RBF related work. This sometimes tends to be overwhelming; however, if the facilitation for RBF was timely, then it would be okay with me" (KI- district)

Procurement and supply chain management difficulties

This agrees with one of the progress reports (Q2 2019/2020 RBF Progress report) which highlighted delays by JMS to do deliveries of health materials on time as one of the challenges frustrating all improvement efforts towards achieving targets for which payments are based. Nonuse of procurement committees in most facilities to guide and superintend over procurements is one of the key barriers to accountability mechanisms reflected in the reports. Along with the lack of regular update of business plans in most facilities, this issue was highlighted in the quarterly report reviewed [20].

"Most facilities reported delays in delivery of procured items by JMS hence frustrating their improvement initiatives" (KI-MOH).

Conflict of Interest

Conflict of interests and lack of shared understanding among the stakeholders, especially those supposed to carry out verification exercises, was one of the issues raised by the respondents. For example, an in-charge of an HC IV is sometimes among the verification team at the HC III in a sub-district, yet the HC III team is his/her friend. This reportedly leads to the question of objectivity in terms of enforcement and being compliant with standards. One of the respondents was quoted, *"You reach a health facility and you begin to debate among yourselves as verifiers on how to score a health facility within a particular Health sub-district due to conflict of interest brought about by friendship issues" (KI-district). "Sometimes there is no room for explanation or discussion with the supervisors due to them being bosses. In such cases, you have to keep quiet and just say yes to everything even when you are right' (FGD).*

8. Discussion

RBF is currently being implemented in Lira under the URMCHIP project. This study sought to examine accountability mechanisms in RBF and the factors associated with their implementation in Lira District . This section reflects on the available accountability mechanism enablers, and barriers to implementing accountability mechanisms for RBF programs in comparison to other scholarly information.

Existence and functionality of accountability mechanisms and their implementation in RBF

This study revealed that the available accountability mechanisms in the implementation of RBF in Lira were use of staff registers to track expenditures, documentation of patients records in registers and partographs to aid verification, performance appraisal, staff participation in budgeting and resource allocation, conducting regular financial audits, and verification of results based on the implementation plans, display of expenditures on public notice boards,

This study revealed that verification of results based on the implementation plans are critical in RBF programs. This mechanism is critical in implementing any RBF program since it helps the implementers to ascertain whether payment requests/invoices are made based on the services provided and that the services provided are of the desired quality and quantity [21]. On the other hand, verification of results ensures that both the funder and the recipient have confidence on how performance is measured [22]. Without an effective verification and accountability mechanism, some service providers could likely be paid without delivering any service or after delivering substandard services. The verification reported in the present study also enables healthcare facilities or individuals to be paid bonuses based on their level of effort and performance and fosters transparency which is central in RBF programs [21] . In cases where verification of results includes patient satisfaction surveys, it could be a voice for the communities, which would improve provider accountability [21]. The findings of the present study are similar to those reported by [23–25], in which the authors indicate that support supervision is critical in the tracking of funds and improving program effectiveness.

Progress reports plus KIs revealed that a lot of attention and effort is concentrated on internal accountability such as budgeting, planning, human resource management, etc. With little attention paid to external accountability, which entails being responsive to community needs and opinions. This is probably due to information asymmetry between the health workers and the community. These findings are similar to those reported by [26], which highlighted that bureaucratic accountability often constrained efforts of meeting external accountability, such as meeting the demands of patients and the community in general [26]

Enablers, Facilitators to Implementation of accountability mechanisms

A number of factors were pointed out as enablers to implementation of accountability mechanisms in the RBF programs namely; conducting staff meetings, continuous support supervision, and transparency in the expenditure of RBF funds. This study particularly reports that monthly staff meetings were used to discuss the different activities/ interventions supported by the RBF programs. Besides, staff meetings are important at setting objectives and expectations and taking corrective action where need be. Holding staff meetings also helps the different stakeholders report progress on specific indicators and assess how they are faring in achieving the RBF set targets [22]. Failure to conduct staff meetings makes it difficult to take collective action.

This study revealed that holding staff meetings related to RBF was crucial in the implementation of accountability mechanisms for RBF programs. Staff meetings allow for establishing and enforcing ground rules for self and others and assigning roles and responsibilities. Besides, holding staff meetings provides an important platform for obtaining feedback on the implementation of RBF programs, particularly how funds are spent and accounted for. Staff meetings were also reported to facilitate effective decision-making by obtaining views on how funds can be spent and accounted for from the different stakeholders. Staff meetings as a measure of accountability are widely documented. In line with the role of staff meetings in fostering accountability in RBF programs, [27] and [28] report that such meetings can be instrumental in clarifying roles and tasks of each actor and establishing a set of explicit contractual relations. Besides, meetings can be used to define rewards and sanctions and verification and enforcement mechanisms for RBF programs [27].

Continuous support supervision was also mentioned as an important enabler of the implementation of accountability mechanisms for RBF programs. It provided a platform to assess the staff's progress in attaining the set targets and could also provide an avenue for maximizing the health workers' potential to its success. It also provides an avenue to guide, monitor, and observe the employees while performing their duties. The supervisor makes sure that all the instructions are communicated to each and every employee, feedback sessions promote motivation and discipline, facilitates control, promote optimum utilization of resources, and creates group unity. Failure to have continuous supervision creates a feeling of insecurity, resentment, and displeasure.

The culture and practice of transparency in the expenditure of RBF funds was also a critical enabler of the implementation of accountability mechanisms for RBF programs. Transparency means offering a clear, concise, and balanced view of expenses to all the stakeholders and minimizing the chances of misuse. Transparency involves financial reports such as income statements, balance sheets, statements of cash flow, and statements of retained earnings. As funds are spent, everyone has an opportunity to know how and where the funds have been spent.

The implications of not having transparency in the expenditure of RBF funding can result in scandals.

Constraints to the implementation of accountability mechanism

A number of factors were reported as those that potentially constrain the implementation of RBF accountability mechanisms in Lira. These include Heavy work load, Knowledge gaps, corruption tendencies, delays in procurements processes among others, Details are as discussed below, The study revealed that heavy workload negatively impacted the implementation of accountability mechanisms such as conducting meetings to discuss implementation of the RBF programs. Due to the intensity of job assignments at healthcare facilities, staff are often busy to the extent that they cannot attend staff meetings. Yet, such staff meetings are vital in ensuring staff accountability and participation through visibility of results and progress reports and discussing challenges hindering service delivery at the healthcare facility. Therefore, this study highlights the need for stakeholders to understand other structural challenges to ensure that the system is functional enough to start demanding results [29]. The study also showed that the lack of transparency and corruption exhibited through people signing for monies that they have not received was one of the biggest challenges to implementing accountability systems in RBF. Similar findings were reported in a study conducted by [30] in Nigeria. Lack of transparency and corruption tendencies could lead to staff loss of confidence and trust in the RBF program, which can consequently impact their performance and the implementation of accountability mechanisms in RBF. This study revealed a lack of supervision for the RBF programs as one of the main challenges hindering the implementation of accountability mechanisms. The study revealed instances of failed verification and supervision of lower healthcare units by the district RBF staff, making it difficult for such healthcare units to benefit from the RBF program. Lack of supportive systems is not new in RBF programs. Besides, even when effective supervision systems exist, some of them lack enough resources to execute their work [31]. The study also revealed concerns related to diversion of funds based on convenience by the PNFP facilities. It was particularly found that PNFP sites diverted the 40% meant for staff incentives to pay salaries which caused a lot of dissatisfaction among staff hence need for a unified approach of financial management and accountability at both PHC and PNFP facilities. This notion is supported by a study by Muhittin Acar and his friends on "accountability when hierarchical authority is absent" which pointed out that accountability for managing expectations emphasizes the need for managers to anticipate, define and respond to accountability pressures by scanning environments and then devising effective solutions to the expectations generated in different environments.

9. Conclusions

This study sought to find out accountability mechanisms currently being implemented in RBF and the factors (enablers and constraints) associated with their implementation in Lira District. Some of the key highlights are summarized below, • The accountability mechanisms highlighted by the respondents between the Ministry and the district was MOUs and business plans, between the district and the health facilities included; data verification, documentation and financial audits. Those between the health facilities and the staff included use of staff attendence registers, performance appraisals and joint budget and resource allocation while display of results on notice boards, complaint boxes and clinic committees were highlighted as accountability mechanisms between the health facility and the community.

• Implementation of RBF was largely perceived to be suboptimal considering the intricate challenges affecting the different RBF accountability relationships among the different actors for example it was pointed out that verification/audits by the EDHMT were very irregular due to irregular funding .

• The majority of the respondents pointed out irregular support supervisions and verification exercises corruption and slow procurement processes as some of the key factors affecting the implementation of accountability mechanisms in RBF.

• Low cadre health workers such as nursing assistants and enrolled nurses were the least empowered in terms of information. The majority felt left out of the decision-making loop. The in-charges in some facilities are doing little to involve their subordinate staff in activities such as joint budgeting, hence causing unnecessary suspicion and disharmony, consequently affecting the smooth implementation of accountability mechanisms in RBF.

• Intrinsic health system arrangements such as regular staff meetings, support supervision visits, synergies between the different accountability mechanisms transparency in use of funds were highlighted as some of the enablers to implementation of accountability mechanisms in RBF in Lira.

• Some of barriers to implementation of accountability mechanisms in Lira included the following; Corruption tendencies especially in some facilities, knowledge gaps especially among low cadre staff, payment not commensurate with the levels of effort, infrequent funding to the EDHMT and delays in procurement processes.

Recommendations

• In the short and medium term, the MoH should rollout a sustained refresher training and mentorship program to all districts targeting stakeholders at all levels. This will go a long way in empowering all those involved in appreciating the cardinal objectives of RBF, thereby ensuring its smooth implementation as well as enforcement of accountability mechanisms in the districts and health facilities.

• There is a need to improve on verification and technical support supervision exercises to the health facilities to ensure adherence to accountability mechanisms enshrined in RBF implementation manual to achieve smooth implementation since RBF has very strict timelines that can affect accountability mechanisms. This can be achieved through timely provision of funds to facilitate the verification teams to carry out their mandated work.

• There is a need to review some structural aspects of RBF that tend to drug procurement processes. More suppliers, for example need to be accredited rather than relying on JMS alone, which was widely reported to cause unwanted delays.

• There is a need to strengthen external accountability, which requires providers to be responsive to community input, such as through patient complaint procedures and active involvement of key community stakeholders in the entire RBF program.

• At the facility level, all HUMC members and not only chairpersons should know every release, procurements and they should be part of the whole RBF process to ensure compliance and also eliminate chances for abuse. This particular issue needs to be strengthened and scaled up

to all RBF facilities.
• There is need to conduct regular audits in all RBF facilities because once facilities are aware of regular audits, they will always be compelled to adhere to prescribed accountability mechanisms such as ensuring that a minimum of 60% of the fund is used for service delivery while a maximum of 40% is for staff incentives and not alter-based on convenience.
• On a long term basis, there is a need to intensify strategies that address corruption tendencies in healthcare settings to ensure successful implementation of accountability mechanisms so as to optimize programs like RBF that are largely intended to improve health care delivery to the communities. This can be through increased awareness and vigilance by the public as well as put in place strong punitive actions for the offenders.
• Regarding the challenge of heavy workload, Government needs to address human resource shortages in the health sector so that staff have time to rejuvenate and as well attend and participate in staff meetings such as those related to RBF whenever they are scheduled.
• There is need to scale up RBF program to more health facilities through supporting such facilities to measure up to the required standards to be accredited. In this way majority of facilities will benefit from infrastructural developments and as well benefit from staff incentives provided for in the RBF program.
• Future research will certainly be helpful in exploring whether and how the five functions of accountability (i.e. mapping and manifesting expectations, mobilizing and motivating internally , monitoring and measuring progress/performance , modifying , mobilizing and motivating externally) may complement each other or conflict with one another e.g. the absence of a modifying function may also reduce the function of monitoring /measuring to merely a control tool (i.e. a tool used to assign rewards and or sanctions).

Acknowledgements: The authors would like to I ascribe greatness and praise to God almighty for enabling me study and write up my thesis successfully without any major impediment. In a special way, I would like to extend my sincere gratitude to my wife and children, my mother, brothers, sisters, and relatives for the financial and emotional support that they offered me during my thesis writing and indeed throughout my academic journey. Furthermore, I would like to thank my academic supervisors Dr. Aloysius Ssennyonjo, Dr Christine Tashobya Kirunga, as well as some of my lecturers such as Dr Elizabeth Ekirapa, and Prof. Freddie Ssengooba for the guidance, insightful comments, and support they accorded me during the write-up. I would finally like to thank my colleagues in the MPH – Distance class and friends for their academic support.

References

[1] D. Bloom and D. Cunning. *POPULATION HEALTH AND ECONOMIC GROWTH*. THE WORLDBANK, 2000.

[2] P. B. A. R. Biltran. Health system analysis for better health system strengthening. 2011.

[3] P. Basinga, M. Serge, and J. Condo. Performance-based financing: the need for more research. *Bulletin of the World Health Organisation*, 89:698–699, 2011.

[4] J. F. Levesque and K. Sutherland. What role does performance information play in securing improvement in healthcare? a conceptual framework for levers of change. *BMJ Open*, 7, 2017. Article e014825.

[5] P. Musgrove. *FINANCIAL AND OHER REWARDS FOR GOOD PERFORMANCE OR RESULTS. AGUIDED TOUR OF CONCEPTS AND TERMS AND A SHORT GLOSSARY*. THE WORLD BANK, 2011.

[6] S. Muccune. Rbf for health. *THE SCIENCE OF DELIVERY IN ACTION.*, 1:1–2, 2015.

[7] T. Besley and M. Ghatak. The economics of coperate social responsibility. 2007.

[8] C. Lowell, Tineke Keesmaati, Sorcha Mckena Phd, and Ben Richardson. *Apractical approach to health system strengthening in sub-saharan Africa*. BMJ, 2009.

[9] A. Maryse, S. El-Saharty, A. Stanciole, O. Jonas, F. Pascual, R. Oelrichs, M. Lorenzo, T. Villafana, F. Lavadenz, and M. Rock. Connecting sectors and systems for health results. 2012.

[10] I. Czarnowski and P. Jedrzejowicz. Agent-based approach to the design of rbf networks. *Cybernetics and Systems*, 44:155–172, 2013.

[11] C. G. Evelyn Waweru, Sarah Kedenge, Benjamin Tsofa, and Sassy Molyneux. Tracking implementation and (un)intended consequences: a process evaluation of an innovative peripheral health facility financing mechanism in kenya. *1-2*, 2015.

[12] D. Bryant-Lukosius, A. Dicenso, G. Browne, and J. Pinelli. Advanced practice nursing roles: Development, implementation and evaluation. *Journal of advanced nursing*, 48:519–29, 2005.

[13] MOH. Annual health sector performance report. *1*, 2016.

[14] H.-G Ridder. The theory contribution of case study research designs. *Business Research*, 10:281–305, 2017.

[15] MINISTRY OF HEALTH. Comprehensive support supervision (css) strategy for the health sector. 2020.

[16] MINISTRY OF HEALTH. Uganda reproductive maternal and child health services improvement project (urmchip): Phase i rbf quarterly assessment independent verification report for the quarter january to march 2019. 2019.

[17] MINISTRY OF HEALTH. Results based financing implementation manual; uganda reproductive maternal and child health services improvement project. 2019.

[18] MINISTRY OF HEALTH. Uganda reproductive maternal and child health services improvement project (urmchip) project implementation manual. 2021.

[19] MINISTRY OF HEALTH. Uganda reproductive maternal and child health improvement project; project readiness assessment report for the period july to december 2018. 2019.

[20] LIRA DISTRICT LOCAL GOVERNMENT. Internal audit report on results based financing. 2021.

[21] G. B. Fritsche, R. Soeters, and B. Meessen. Performance-based financing toolkit, the world bank. 2014.

[22] R. Perakis and W. Savedoff. Does results-based aid change anything? pecuniary interests, attention, accountability and discretion in four case studies. *CGD policy paper*, 52, 2015.

[23] B. Uzochukwu, E. Onwujekwe, C. Mbachu, C. Okeke, S. Molyneux, and L. Gilson. Accountability mechanisms for implementing a health financing option: the case of the basic health care provision fund (bhcpf) in nigeria. *International Journal for Equity in Health*, 17:100, 2018.

[24] J. Chinkhumba, M. De Allegri, S. Brenner, A. Muula, and B. Robberstad. The cost-effectiveness of using results-based financing to reduce maternal and perinatal mortality in malawi. *BMJ Global Health*, 5, 2020. Article e002260.

[25] L. Morgan. *Some days are better than others: lessons learned from Uganda's first results-based financing pilot*. World Bank, Washington DC, 2010.

[26] S. M. Cleary, S. Molyneux, and L. Gilson. Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. *BMC Health Services Research*, 13:320, 2013.

[27] M. Antony, M. P. Bertone, and O. Barthes. Exploring implementation practices in results-based financing: the case of the verification in benin. *BMC Health Services Research*, 17:204, 2017.

[28] R. Soeters, C. Habineza, and P. B. Peerenboom. Performance-based financing and changing the district health system: experience from rwanda. *Bulletin of the World Health Organization*, 84:884–889, 2006.

[29] F. Ssengooba, E. Ekirapa, T. Musila, and A. Ssennyonjo. Learning from multiple results-based financing schemes: An analysis of the policy process for scale-up in uganda (2003-2015). 2015.

[30] N. Gambo, I. I. Inuwa, N. Usman, I. Said, and U. S. Shuaibu. Factors affecting budget implementation for successful delivery of primary health care building facilities within nigerian health sector. *International Journal of Construction Management*, pages 1–14, 2019.

[31] S. Witter, M. P. Bertone, J. Namakula, P. Chandiwana, Y. Chirwa, A. Ssennyonjo, and F. Ssengooba. (how) does rbf strengthen strategic purchasing of health care? comparing the experience of uganda, zimbabwe and the democratic republic of the congo. *Global Health Research and Policy*, 4:3, 2019.