



Ministry of Health

# **HEALTH SECTOR STRATEGIC & INVESTMENT PLAN**

*Promoting People's Health to Enhance Socio-economic Development*

*2010/11 – 2014/15*

*July 2010*

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## FOREWORD

The Government of Uganda and partners in health concluded the implementation of the first ten-year National Health Policy (1999/2000 – 2009/10) and the second Health Sector Strategic Plan (2005/06 – 2009/10). During this time, the overall development agenda for Uganda was guided by the Poverty Eradication Action Plan revised every three years, the Millennium Development Goals and other international and regional health commitments. Over this period, the health sector investments in both the public and private sectors yielded modest successes including reduction in Maternal Mortality Ratio (MMR) from 505 deaths per 100,000 live births in 2001 to 435 deaths per 100,000 live births in 2006, a decline in the Infant Mortality Rate (IMR) from 89 deaths per 1,000 live births in 2001 to 75 deaths per 1,000 live births in 2006 and an increase in the Life Expectancy at birth from 46.9 years in 2001 to 51 years in 2006. Despite these successes, health systems and other challenges prevented attainment of key national and international targets.

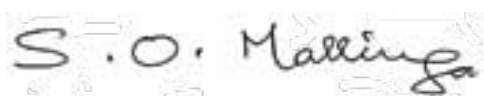
The National Development Plan (NDP) 2010/11 – 2014/15 has been launched and sets Uganda's medium term strategic direction, development priorities and implementation strategies. The NDP's theme is 'Growth, Employment and Socio-economic transformation for Prosperity' and the thrust is to accelerate transformation of Ugandan society from a peasant to modern and prosperous country within 30 years.

With this guidance, the health sector led by the Ministry of Health elaborated the second National Health Policy (2010/11 – 2019/20) and the Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15 to define the long and medium term health agenda and operationalise Uganda's aspirations as outlined in the NDP and the Public Investment Plan (PIP) 2010/11 – 2012/13. The development of HSSIP has been informed by lessons from the Mid Term Review of the second Health Sector Strategic Plan (2005/06 – 2009/10), the review of the Poverty Eradication Action Plan, health research in Uganda and in the Region and the Global Health Agenda. The process of development of the HSSIP was highly consultative, participatory and transparent. Stakeholders including public sector, line ministries, health service managers, District leaders, private not-for profit sector, private health practitioners, Civil Society Organizations and development partners were consulted on several levels and occasions. The process also benefited from the Joint Assessment of National Strategies (JANS) process which seeks to ensure that national strategies address the prevailing challenges, improve the focus and prioritization within national strategies and builds consensus among the partners in support on one national strategy for health development.

I am therefore certain that the HSSIP not only addresses the key challenges facing Uganda's health system but also sets out priorities and key areas on which to focus health investment in the medium term, for both public and private partners, in order to optimally contribute to the attainment of both the health sector goals and the national goals as outlined in the NDP. The implementation of the HSSIP shall be through a strong collaborative partnership guided by the principles outlined in the International Health Partnerships and related Initiatives (IHP+), the Paris Declaration on Harmonization and Alignment and the Accra Agenda for Action all to which Uganda is a signatory.

I wish to express my appreciation to all of you who worked tirelessly to develop the HSSIP on behalf of the people of Uganda. I look forward to the acceleration of the implementation of HSSIP interventions towards attainment of our national and international health goals.

For God and My Country.



Dr. Stephen Mallinga, MP  
Minister of Health



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## LIST OF ACRONYMS

ACSM	Advocacy, Communication and Social Mobilization
AHSPR(s)	Annual Health Sector Performance Report(s)
AIDS	Acquired Immuno-Deficiency Syndrome
AMREF	African Medical Research Foundation
ARI	Acute Respiratory Infections
ART	Antiretroviral Therapy
AT	Area Team
BEmoc	Basic Emergency Obstetric Care
CBR	Community Based Rehabilitation
CCM	Country Coordinating Mechanism
CDs	Communicable Diseases
CDC	Communicable Diseases Control
CDP	Child Days Plus
CDR	Case Detection Rate
CHD	Community Health Department
CMDs	Community Medicine Distributors
CMR	Child Mortality Rate
CDD	Community Drug Distributors
CDR	Contraceptive Prevalence Rate
CPT	Co-trimoxazole Preventive Treatment
CSO	Civil Society Organisation
CSW	Commercial Sex Workers
UDHS	Uganda Demographic and Health Survey
DHT	District Health Team
DOTS	Directly Observed Treatment, Short Course (for Tuberculosis)
DSC	District Service Commission
DTLS	District Tuberculosis and Leprosy Supervisor
FB-PNFP	Facility Based Private Not For Profit
EMHS	Essential medicines and Health Supplies
EML	Essential Medicines List
EMIS	Environnemental Management Information System
EmOC	Emergency Obstetric Care
ENT	Ear, Nose and Throat
FP	Family Planning
GBV	Gender-based violence
GAVI	Global Alliance for Vaccine Initiative
GET	Global Elimination of Trachoma
GHWA	Global Health Workforce Alliance
GoU	Government of Uganda
GFATM	Global Fund for the Fight against AIDS, Tuberculosis and Malaria
HBMF	Home Based Management of Fever
HC	Health Centre
HCT	HIV Counselling and Testing
HDI	Human Development Index
HDP	Health Development Partners
HIDM	Health Infrastructure Development and Management
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HPE	Health Promotion and Education
HR	Human Resource(s)
HRH	Human Resource for Health
HRIMS	Human Resource Information Management System
HSC	Health Services Commission

HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
HTR	Hard To Reach
HUMC	Health Unit Management Committee
ICC	Interagency Coordinating Committee
ICT	information Communication Technology
IEC	Information Education and Communication
IECC	Integrated Essential Clinical Care
IHP+	International Health Partnerships and other Initiatives
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ISS	Immunisation Systems Strengthening
ITN	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
JRM	Joint Review Mission
KDS	Kampala Declaration on Sanitation
KIDDP	Karamoja Integrated Disarmament and Development Plan
KIU	Kampala International University
KMC	Kangaroo Mother Care
LMIS	Logistics Management Information System
LTIA	Long Term Institutional Arrangement
MACIS	Malaria Childhood Illness NGO Secretariat
MB	Multibacillary Leprosy
MCH	Maternal and Child Health
MDG(s)	Millennium Development Goal(s)
MLG	Ministry of Local Government
MNCH	Maternal, Newborn and Child Health
MoE	Ministry of Education
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTR	Medium Term Review
NBH	New Born Health
NCD(s)	Non-Communicable Disease(s)
NDA	National Drug Authority
NDP	National Development Plan
NEPAD	New partnership for Africa Development
NFB-PNFP	Non-Facility Based Private Not For Profit
NGO	Non-Governmental Organisation
NHA	National Health Assembly
NHA	National Health Accounts
NHE	National Health Expenditure
NHP	National Health Policy
NHS	National Health System
NMR	Neonatal Mortality Rate
NMS	National Medical Stores
NRH	National Referral Hospitals
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
OAG	Office of the Auditor General
ORT	Oral Rehydration therapy
PAC	Public Accounts Committee
PB	Paucibacillary leprosy
PC	Partnership Committee
PER	Public Expenditure Review
PFP	Private for Profit

PHC	Primary Health Care
PHP	Private Health Practitioners
PIP	Public Investment Plan
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PNFP	Private Not for Profit
PPPH	Public Private Partnership in Health
PWD	Persons with Disabilities
QAD	Quality Assurance Department
RED	Reaching Every District
RBM	Roll Back Malaria
RRH	Regional referral Hospitals
SCHW	Sub-County Health Worker
SGBV	Sexual and Gender Based Violence
SHI	Social Health Insurance
SMC	Senior Management Committee
SM&R	Supervision, Monitoring and Evaluation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TB	Tuberculosis
TCMPs	Traditional and Complimentary Medicine Practitioners
TF	Task Force
TFR	Total Fertility Rate
TMC	Top Management Committee
TRM	Technical Review Meeting
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
U5MR	Under Five Mortality Rate
UBTS	Uganda Blood Transfusion Service
UCI	Uganda Cancer Institute
UHI	Uganda Heart Institute
UCMB	Uganda Catholic Medical Bureau
UFNP	Uganda Food and Nutrition Policy
UGX	Uganda Shillings
UMMB	Uganda Muslim Medical Bureau
UNCRL	Uganda National Chemotherapeutics Research Laboratory
UNEPI	Uganda National Expanded Programme on Immunisation
UNHRO	Uganda National Health Research Organisation
UNMHCP	Uganda National Minimum Health Care Package
UOMB	Uganda Orthodox Medical Bureau
UPE	Universal primary Education
UPMB	Uganda Protestant Medical Bureau
USE	Universal Secondary Education
UVRI	Uganda Virus Research Institute
VHT	Village Health Team
WHO	World Health Organisation
YSP	Yellow Star Programme
ZTLS	Zonal TB and leprosy Supervisor

## EXECUTIVE SUMMARY

The Health Sector Strategic and Investment Plan (HSSIP 2010/11-201/15) has been developed to guide the Health sector investments towards achieving medium term goals for health. This HSSIP provides the medium term strategic framework, and focus that the Government intends to pursue in regard to attaining the health goals for the country. It is anchored on the NHP II, the National Development Plan and the Public Investment Plan, aimed at achieving the overall goals and deliverables of the country.

### Introduction

The HSSIP has three sections consisting of 11 chapters; section one provides a background, situational analysis and the emerging issues with recommendations. The second section highlights the actual objectives and focus during the HSSIP while the third section outlines how the HSSIP will be implemented defining the key issues, structures and processes.

### Process of Developing the HSSIP

The development of the HSSIP took into consideration a wide range of policies, the new emerging diseases, the changing climatic conditions and issues of international health including consideration of the international treaties and conventions to which Uganda is signatory.

At the beginning of the process, the Ministry of Health (MoH) formed a Task Force (TF) chaired by the Director General of Health Services and composed of different Departments in the MoH, Academia, the private sector (including PHPs and PNFPs), Civil Society Organizations (CSOs) and Health Development Partners to oversee the development of the NHP II and the HSSIP. A JANS (Joint Assessment of the National Strategies) mission was undertaken to assess both the process and result of developing the HSSIP and recommendations from the JANS report have been used to enrich the final HSSIP.

## OVERVIEW OF THE HSSIP

### Situational analysis

Uganda has registered improvements in Health Nutrition and Population (HNP) outcomes, but the improvement in outcomes remain poor. The Maternal Mortality Rate (MMR) is estimated at 435 deaths per 100,000 live births, while the Infant Mortality Rate (IMR) is estimated at 76 deaths per 1,000 live births; stunting in children under five is estimated at 32 percent. Communicable diseases contribute over 50 percent of disability adjusted life years (DALYs) lost. HIV prevalence dropped from 18 percent in the early 1990s to 6.4 percent, where it has remained since 2002. With the exception of Millennium Development Goal (MDG) 6 on combating communicable diseases, the country will require extraordinary efforts to achieve MDGs 4 and 5. Although over the previous two HSSP periods, there has been a demonstrable decline in poverty levels, there remains unequivocal linkage between poverty and the incidence and prevalence of some disease conditions for example malaria, diarrhea and dysentery. The HSSP II defined the Uganda National Minimum Health Care Package as its priority interventions and the performance over the last 5 years has been as outlined below.

### Cluster 1: Health Promotion Education

This cluster aims at increasing health awareness and promoting community participation in health care delivery and utilisation of health services through the use of VHTs and mass media

- VHTs where functional (60 out of 112 districts have trained VHTs) have helped in increasing health awareness, demand and utilization of Health services, however a significant proportion of the country is yet to have trained and functional VHTs.
- The proportion of households with latrines has increased from 57% to 69.7% over the HSSP II period (HSSP II target was 70%)
- At the end of HSSP II, 100% of epidemics have laboratory confirmed diagnosis (68% at the start of HSSP II) however reporting of epidemic outbreaks within 24 hours was still below the target (76 % while HSSP II target was 80%)

### **Cluster II Maternal and Child Health**

Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda. The Road Map to accelerate Reduction of Maternal, The Reproductive Health Commodity Security Strategy and Neonatal Morbidity and Mortality and the National Child Survival Strategy were formulated in 2007, 2008 and 2009, respectively. The effective implementation of these strategies is what is needed to move towards achievement of MDGs 4 and 5 by 2015.

### **Cluster 3 Communicable Diseases**

Communicable diseases account for 54% of the total burden of disease in Uganda with HIV/AIDS, tuberculosis (TB) and malaria, being the leading causes of ill health. Some targets as set in the HSSP II have not been achieved: for example adult HIV prevalence in 2008/09 was estimated at 6.2% against a target of 3% in the HSSP II.

The burden of tuberculosis in Uganda is high and it is ranked 16th by the WHO Global TB Report of 2008. Trends over the past ten years show that Uganda still falls short of attaining the MDG target by 2015.

Malaria remains one of the most important diseases in Uganda in terms of morbidity, mortality and economic losses. The HSSP II agreed malaria interventions namely availability of ACTs consistently at all levels of the health system, strengthened use of RDTs for diagnostics and treatment, pre-referral treatment for severe malaria at community level, use of IRS, IPT, LLINs and early detection and treatment of malaria have not been fully implemented.

Uganda is on course for diseases that have been targeted for elimination namely guinea worm, trachoma, onchocerciasis, schistosomiasis, lymphatic filariasis and measles.

### **Cluster 4 Non Communicable Diseases**

Non Communicable Diseases (NCDs) are an emerging problem in Uganda, as is the case in all developing countries. The majority of the NCDs are preventable through a broad range of simple, cost-effective public health interventions that target NCD risk factors. The treatment of NCDs and their complications is costly. The Ministry of Health has undertaken to strengthen the planning, coordination and implementation of interventions targeted against NCDs in the Uganda population.

### **Management Systems for the Health sector**

There are three levels of supervision: (i) at the central level including central level institutions, (ii) local governments, and (iii) hospitals and lower level health units. While systems for supervision, monitoring and evaluation exist, there are enormous challenges. Monitoring, supervision and mentoring has been weak and irregular. Furthermore the capacity of the HMIS is still inadequate for example timeliness of reporting is currently estimated at 68%.

Although a lot of research is conducted in Uganda and the results of these studies are supposed to inform decision making, the conduct of research by various organisations in Uganda has so far been hampered by the lack of a policy framework, an uncoordinated priority setting of the research agenda, inadequate funding, shortage of human resource and inadequate logistics. As a result, research has mainly been donor driven.

### **Emerging Issues and Recommendations**

A critical analysis of the HSSP II above reveals the following;

1. Overall health of Uganda's population remains poor with a low level of life expectancy and high level of mortality
2. Although there has been an improvement in overall health this remains slow suggesting that some interventions are having a positive impact.
3. There remains significant disparities in the distribution of health services with some regions of country having poorer services compared to others

In view of the limited progress and stagnation and for more sustained and accelerated improvement in health impact the following recommendations have been made;

- Design different strategies, tailored to address the challenges to health in different parts of the country
- Propose a comprehensive approach to addressing health services is needed for any interventions that are chosen
- Work at a better understanding of the investments needed to achieve the health outputs being sought
- Pursue Scale up of health services.
- Undertake a comprehensive knowledge management approach in the sector
- Achieving equity in health should be prioritised by the sector
- Prepare a comprehensive Health Financing Strategy
- Agree to scale up sector coordination and partnership

## STRATEGIC DIRECTION

The HSSIP is the Medium Term Plan guiding sector focus, towards attainment of the policy objectives as outlined in the National Health Policy. The HSSIP, therefore, is aligned towards supporting attainment of these sector objective, and Government wide strategic approaches, informed by the situation of the sector at the end of HSSP II. The strategic framework takes cognizance of the comprehensive set of services needed to impact on the health of the people in a manner to contribute to overall National Development, and the Health policy focus.

The HSSIP puts the client and community in the forefront and adopts a 'client centred' approach and it looks at both the supply and demand side of health care. The key guiding principles as enshrined in the international covenants and the national guiding laws and policies will be used to guide the implementation of the HSSIP to progressively realize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. These principles include; equality and non –discrimination, participation and accountability and the right to health elements of availability, accessibility, acceptability and quality.

### Strategic Interventions for HSSIP

The priority areas of intervention in the HSSIP include;

#### **Cluster 1: Health Promotion, Environmental Health, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response**

- Promote individual and community responsibility for better health
- Contribute to the attainment of a significant reduction of morbidity and mortality due to environmental health and unhygienic practices and other environmental health related conditions.
- Reduct morbidity and mortality due to diarrhoeal diseases
- Improve the health status of the school children, their families and teachers and to inculcate appropriate health seeking behaviour among this population.
- Ensure equitable access by people in PRDP districts [in conflict and post-conflict situations] to Health Services
- Prevent, detect, and promptly respond to health emergencies and other diseases of public health importance.
- Scale up delivery of nutrition services

#### **Cluster 2: Prevention, Management and Control of Communicable Diseases**

- Prevent STI/HIV/TB transmission and mitigation of the medical and personal effects of the epidemic.
- Reduce the morbidity, mortality and transmission of tuberculosis.

- Sustain the elimination of leprosy in all the districts.
- Reduce the morbidity and mortality rate due to malaria in all age groups.
- Maintain the Guinea Worm free status of the country through maintenance of high quality post-certification surveillance.
- Eradicate onchocerciasis and its vector in all endemic districts in Uganda
- Achieve the global target for the elimination of trachoma.
- Reduce, and ultimately interrupt transmission of the disease in all endemic communities through the use of chemotherapy with Ivermectin and albendazole.
- Eliminate sleeping sickness as a public health problem in Uganda.
- Reduce morbidity caused by the worms by decreasing the worm burden among communities
- Reduce morbidity and mortality due to Leishmaniasis among the endemic communities

### **Cluster 3: Prevention, Management and Control of Non-Communicable Diseases**

- Prevent Type 1 and Type 2 diabetes and reduce morbidity and mortality attributable to diabetes and its complications.
- Prevent cardiovascular and related diseases and reduce morbidity and mortality attributable to CVDs
- Establish a national framework for cancer control with emphasis on cancer prevention
- Prevent chronic respiratory diseases and reduce morbidity and mortality attributable to COPD and asthma
- Reduce the morbidity and mortality associated with sick cell disease.
- Decrease the morbidity and mortality due to injuries, common emergencies and disabilities from visual, hearing and age-related impairments.
- Ensure increased access to primary and referral services for mental health, prevention and management of substance abuse problems, psychosocial disorders and common neurological disorders such as epilepsy.
- Improve the oral health of the people of Uganda by promoting oral health and preventing, appropriately treating, monitoring and evaluating oral diseases.
- Improve the quality of life of terminally ill patients and their families especially the home carers

### **Cluster 4: Maternal and Child Health**

- Reduce mortality and morbidity relating to sexual and reproductive health & rights
- Improve newborn health and survival by increasing coverage of high impact evidence based interventions, in order to accelerate the attainment of MDG 4.
- Scale up and sustain high, effective coverage of a priority package of cost-effective child survival interventions in order to reduce under five mortality.
- Prevent morbidity and mortality due to gender based violence.

### **HSSIP Investment Focus**

Six key areas for investment have been agreed as the main focus during the HSSIP and these include (a) human resources for health, (b) health infrastructure, (c) essential medicines, health supplies, and other health commodities, (d) health information systems, (e) preventive health / health promotion and education, and (f) management and coordination of sector activities.

The cost of the agreed interventions have been estimated for these key investment areas. These costs will be used to guide the sector in resource mobilization and resource allocation.

#### **1. Health Promotion, Education, Environmental Health & Nutrition**

The health promotion and education component has planned activities for the 5-year period, and on average, the activities relating to nutrition would take up the biggest proportion (51%) of the total cost (Uganda shillings 669 billion over the 5-year period). VHT activities relating to community and household supervision would take up about 22%, while environmental health would take about 7% of total cost.



## 2. Essential Medicines and Health supplies.

About 940 billion is required to cover the national need for pharmaceuticals, health supplies and commodities annually. Of this, 65.5% would be spent at community and district level

As result we see, HIV/AIDS drugs and commodities take up significant proportion (23%) of the total costs of pharmaceuticals, as does malaria drugs and related commodities which altogether take up 22% of total costs. Contraceptives, condoms and other reproductive health commodities take up 16.3%, vaccines and related costs take up 13.4% and essential medicines and health supplies take up 12.5% of total costs.

The increase between 2010/11 and 2011/12 in cost of ARVs and OIs is mainly due to adopting a new treatment policy that involves providing ARVs for people whose CD4 count is 350 and below. Similarly, there are significant increases, in the same period, in the cost of vaccines, mainly due to the introduction of new vaccines (Rotavirus + PCV) in 2011/12. The projected increase in the investment in Long Lasting Insecticide Treated Nets in 2010/11 and in 2014/15, is attributed to meeting the targets of universal coverage and replenishing LLINs in 2014/15

## 3. Human Resources for Health

The total investment costs for the Human Resources for Health current salary scales and projected targets from 52%-84% during the 5 year period for current staffing norms requires Uganda shillings 471bn-918bn with an estimated annual increment of 8%. The detailed costing for HSSIP provides options for different resource scenarios.

## 4. Health Infrastructure

Out of an estimated total of Uganda Shillings **3,712 billion** for the 5-year period, about 24% would be required for district level health facilities (i.e. from community to general hospital level), 8% would be required for RRH and 33% for NRH (including the proposed expansion of Mulago and the radiotherapy facilities, and the upgrading of Mbarara and Gulu hospitals). About 24% of total cost is required for the 3 key institutions (Uganda blood Transfusion Services, Uganda Cancer Institute and Uganda Heart Institute), and 5.4% of total cost would be required for maintenance of all buildings and equipment for the entire sector. The high proportion of the infrastructure investment costs at the national level are due to the high cost of specialized equipment used at the tertiary level.

## 5. Management costs

Over the 5-year period, a total of Shillings 1,657 billion will be required for operational costs, to cover expenses relating to strategic planning and policy development, administrative items, utilities, travel, relevant meetings and workshops. Of this total, 35% is required at lower level units (HC I – HC IV), 19% for MOH headquarters, 15% at national referral hospitals, 11.5% is required at general and regional referral hospitals, and 10% for autonomous institutions.

## IMPLEMENTATION ARRANGEMENTS

### Governance and coordination of the Health sector

Coordination of service delivery will be central to maximize the outputs and deliver services to the people of Uganda. Improvement in coordination and management of the delivery of Health and Health related services is therefore a key strategic deliverable. Guidance on coordination and governance will be provided through three oversight structures namely; the management structure, the governance structure and the partnership structure. The existing partnership instrument – the compact – will serve as the formal instrument to guide the functioning of the partnership in health and is guided by the principles of the 2005 Paris Declaration on Aid Effectiveness. Specific structures for coordination of the sector will be made functional, to guide

implementation of the HSSIP. Key among the innovations of HSSIP is the regional level structure being discussed to ease coordination, quality assurance and support for decentralized health service delivery. This will be implemented in line with a law that has been passed by parliament establishing the regional tier.

### **Supervision, Monitoring & Review of HSSIP**

The SM&ER Technical Working Group is developing an M&E plan that for the HSSIP. The supervision and mentoring of the various levels in the health sector including the Ministry of Health headquarters, Central Level Programmes, Regional and General Hospitals, Local Governments / Districts, will be revamped in the implementation of HSSIP. The roles and obligations of different players at the various levels shall be clearly spelt out in the M&E plan and the schedules of the supervision and mentoring sessions with the expected outputs will be outlined. Members from Top Management Committee shall continue conducting support supervision, mentoring and inspection visits to both national and lower levels on a regular basis to iron out issues identified by other routine supervision mechanisms. In addition there will be other forms of supervision such as Technical support supervision by technical programmes and emergency support supervision like in case of epidemics and disasters Feedback to supervisees shall be provided. A list of core indicators for program monitoring has been agreed and included as part of the HSSIP.

### **Financing of the HSSIP**

Costing of the HSSIP has been undertaken using the ingredients approach. This means that all inputs required or used in the process of 'producing' and delivering health services have been considered in the costing. The methodology to be used followed the international standards for costing. The standard costing procedures involve: identification, quantification and valuation of inputs. More specifically, the costing covered only the "supply" side of the equation which involves the production and delivery of health services. The costs generated shall help guide resource mobilization and allocation. A comprehensive Health Financing Strategy is being developed to identify sustainable sources and strategies for financing the HSSIP.

### **Accountability & Risk Analysis**

Successful implementation the HSSIP is premised on several factors. Technical accountability, and risk analysis for HSSIP implementation therefore outline responsibilities and risks during implementation of the HSSIP. Strengthening governance and tackling corruption in the Health Sector has been identified as being key to the attainment of the Minimum Health Care Package (MHCP) and health sector goals as contained in the HSSIP.

The Implementation of the HSSIP will be guided by a compact which reflects commitment of all parties to national goal of reducing morbidity and mortality through the implementation of the Health Sector Strategic and Investment Plan (HSSIP).

## HSSIP CORE PERFORMANCE INDICATORS

No:	Indicator	Baseline, (year)	Target
	Health Impact		
1	Maternal Mortality Ratio (deaths per 100,000 live birth)	435 (2006)	131
2	Neonatal Mortality rate (deaths per 1,000)	70	23
3	Infant Mortality Rate (deaths per 1,000)	76 (2006)	41
4	Under 5 Mortality Rate (deaths per 1,000)	137 (2006)	56
5	% of households experiencing catastrophic payments	28%	60
6	% clients expressing satisfaction with health services	-	
	Coverage for Health Services		
7	% pregnant women attending 4 ANC sessions	47 (09/10)	60
8	% deliveries in public and PNFP health facilities	38 (2006)	60
9	% children under one year immunised with 3rd dose Pentavalent vaccine	74	85
10	% one year old children immunised against measles	72 (09/10)	90
11	% pregnant women who have completed IPT2	42 (09/10)	80
12	% of children exposed to HIV from their mothers accessing HIV testing within 12 months		80
13	% UFs with fever receiving malaria treatment within 24 hours	70	85
14	% eligible persons receiving ARV therapy	53	75
	Coverage for Health Determinants		
15	% of households with a pit latrine	67.5	72
16	% U5's children with height /age below lower line (PR)	38 (2006)	
17	U5's children with weight /age below lower line (PR)		
	Coverage for Risk Factors		
18	Contraceptive Prevalence Rate	24 (2006)	35
	Health System Outputs (availability, access, quality, safety)		
19	% of new smear+ cases notified compared to expected (case detection rate)	56	70
20	Per capita OPD utilisation rate (m/f)	$\frac{m}{f}$ (09/10)	-
21	% of villages with trained VHT, by district	31 (09/10)	100
22	% of health facilities without any stockouts of six tracer medicines	28 (2010)	80
23	% HCs IV with a functioning theatre (providing EMOC)	(09/10)	?
24	Annual reduction in absenteeism rate	-	20
	Health Investment		
25	% of approved posts filled by trained health workers	54	75
26	General Government allocation for health as percentage of total Government budget	9.6 (09/10)	10



# **SECTION 1:**

## **DESCRIPTION OF THE HEALTH CONTEXT**



# 1. BACKGROUND

**H**ealth Sector Strategic Plans (HSSPs) guide the health sector investments by all health sector actors (public and private) towards attainment of medium term health goals. Uganda has completed implementation of two five-year Health Sector Strategic Plans; HSSP I (2000/01 – 2004/05) and HSSP II (2005/06 – 2009/10). During the implementation of the HSSP II, various lessons were learnt in consolidation of the achievement of the overall health sector goals in the country. This Health Sector Strategic and Investment Plan (HSSIP) shall:

- Provide continuity in terms of strategic planning for the Health Sector
- Capture critical lessons in implementation of the HSSP II, to guide the sector strategic focus, and investments in the medium term, and
- Align the sector priorities with all Government policy and strategic documents in terms of the health agenda.

The HSSIP provides the overall strategic and implementation framework for the health sector priorities and aims to contribute towards the overall development goal of the GoU of accelerating economic growth to reduce poverty as stated in the 5 year National Development Plan (NDP) 2010/11-2014/15. The HSSIP operationalises the second 10 year National Health Policy (NHP II) 2010/11-2019/20 and the health component of the 3 year Public Investment Plan (PIP) 2010/11 – 2012/13.

## 1.1 Outline of the HSSIP

The HSSIP is organized in 3 sections, consisting of a total of 10 chapters.

Section 1 presents the contextual issues that provide the guidance to the focus, priorities, and thrusts of the HSSIP. These are presented in Chapters 1 – 3, which are:

- Background
- Situation analysis
- Emerging issues, and recommendations

Section 2 represents the core of the HSSIP. It highlights the framework, objectives, and focus of the sector during the period of the HSSIP. This is presented in Chapters 4, 5 and 6 of the document, which are:

- Strategic framework
- Strategic focus, and
- Investment focus

Section 3 outlines how the HSSIP will be implemented. It defines the key issues, structures and processes that the sector will focus on putting in place, to ensure adequate implementation of the HSSIP as defined in the Section 2 above. These are presented in Chapters 7 to 10 of the document, which are:

- Governance, and coordination of the health sector
- Supervision, monitoring and review of HSSIP
- Financing of services
- Technical Accountability and Risk analysis

## 1.2 Introduction

### 1.2.1 Population and demographics

Uganda has an area of 240,038 km<sup>2</sup> of which 197,323 km<sup>2</sup> is covered by land. The Uganda Bureau of Statistics

(UBOS) estimates the population in 2009 at 30.7 million and by the end of the HSSIP in 2014/15 Uganda's population will be approximately 37.9 million, increasing the average population density from 133, to 156 persons per square km. 48.5% of the population are male while 51.5% are female; with 88% of the population resident in rural areas. The population growth rate is estimated at 3.2% per annum translating into annual increments of approximately 1 million people. In 2005, an estimated 31% of the population were living below the poverty line, 34.2% from rural areas and 13.7% from urban areas with northern Uganda having the highest proportion of people classified as poor. Although most of the country is physically accessible, there are some areas whose geographical landscape presents a challenge in terms of access, in particular, the mountainous areas and the islands on Lake Victoria.

It is estimated that 49% of Uganda's population constitutes of persons under the age of 15. Over the next 5 years the Ugandan population will remain a young population with 18.5% of the total population being under-five. The population structure will change, with the elderly (65+) slowly increasing from about 2.1% in 2010 to 2.3% of the total population in 2015. There shall be an increase in the number of females in reproductive years (from 7 million in 2009 to 8.3 million in 2014) which will put a strain on all reproductive health services.

### **1.2.2 Political and administrative factors**

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

As a way of improving the efficiency and effectiveness of service delivery, the GoU decentralized delivery of services guided by the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997). Both NHP I and II support the decentralization of services to districts and Health Sub-Districts (HSDs). Each level of the decentralized health delivery system has specific roles and responsibilities. With changing leadership and creation of new districts, the district leadership needs to be periodically oriented in the roles and responsibilities. Supervision both from central level to districts and districts to lower levels is inadequate; inadequate funding and weak logistics management constrain the delivery of quality health services. Over the period of the HSSIP, the sector shall continue reviewing the strategies and adopt the ones that will give optimum outcomes.

### **1.2.3 The National Development Plan**

Uganda's economy has been boosted by macroeconomic and political stability resulting from the macroeconomic reforms. For almost a decade now, Uganda has experienced robust economic growth rates averaging 7% in real terms. A stronger export sector; increased foreign direct investment into various sectors; growing fixed private investment, driven by construction; large concessional inflows from donors; and a stable macroeconomic environment have contributed to the steady growth of the Uganda's economy. Further economic growth has been constrained by inadequate infrastructure, limited capacity in the energy sector, high interest rates and extreme weather conditions (drought, flooding etc). With a GDP of US\$430 per capita<sup>1</sup> Uganda remains among the poorest countries in the world. Poverty is still wide spread in the country especially in rural areas.

The National Development Plan (NDP) provides an overall development framework for the GoU for the period 2010/11-2014/15. It highlights the strategic agenda for development and further details priority interventions in all sectors of the economy including health and nutrition. The current NDP is part of a 30 year development vision for the country and this is the first of the 6 such national development plans. The overall goal of the NDP is to accelerate economic growth to reduce poverty. The NDP seeks to achieve 7 development objectives as follows:

- Increasing household incomes;
- Enhancing the quality and availability of gainful employment;

<sup>1</sup> UBOS Statistical Abstract 2008.



- Improving the stock and quality of economic and trade infrastructure;
- Increasing availability and access to quality social services;
- Promoting innovation and competitive industries;
- Harnessing natural resources and the environment for sustainable development; and
- Strengthening good governance and improving human security

The NDP therefore acknowledges that social and human development is a critical component of economic development. Over the period of the NDP GoU will increase availability and access to quality social services including health services delivery. The chapter on health and nutrition in the NDP prioritises the implementation of the UNMHCP. While the NDP, the Constitution of the Republic of Uganda and the NHP II avail the right to progressively realise the right for everyone to the enjoyment of the highest attainable standard of physical and mental health in Uganda there are constraints such as shortage of HRH and inadequate funding for the health sector that will make this unattainable.

According to the NDP, the Health Service focus over the next 5 years will give priority to strengthening of health systems and implementation of programs of national interest namely reproductive health and child survival, HIV, AIDS and tuberculosis, malaria and nutrition. The ultimate aim will be to ensure that Uganda achieve the targets of the health related MDGs by 2015. The delivery of health services will, if not addressed urgently, greatly be affected by shortage of HRH, inadequate funding to the health sector, poor infrastructure, unavailability of medicines in the facilities, and inadequate planning, management and leadership. Unless these issues are addressed, the goals of the NDP and the MDGs will not be achieved.

### **1.3 Description of the Health Sector in Uganda**

The health services provision in the country has always been guided by a clear strategic framework, to ensure all actions are aimed at improving the health of the people, in a manner that is responsive to their legitimate health needs, and ensure fairness in financing of services being accessed. This

This HSSIP provides the medium term strategic framework, and focus that the Government intends to pursue in regard to attaining the health goals for the country. It is developed, with the prevailing socio-economic, and development context in mind. It is anchored on the NHP II, and the National Development Plan, ensuring its goals and deliverables are aimed at achieving the overall goals and deliverables of the country.

#### **1.3.1 Description of the National Health System**

The National Health System (NHS) is made up of the public and the private sectors. The public sector includes all GoU health facilities under the MoH, health services of the Ministries of Defense (Army), Education, Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of Private Not for Profit (PNFPs) providers, Private Health Practitioners (PHPs), and the Traditional and Complementary Medicine Practitioners (TCMPs). This section describes the organization and management of the health sector and delivery of health services in Uganda.

The provision of health services in Uganda is decentralised with districts and health sub-districts (HSDs) playing a key role in the delivery and management of health services at those levels. The health services are structured into National Referral Hospitals (NRHs) and Regional Referral Hospitals (RRHs), General Hospitals, Health Centre (HC) IVs, HC IIIs, HC IIs and Village Health Teams (HC Is).

#### **MoH Headquarters and national level institutions**

The core functions of the MoH headquarters are as follows:

- Policy analysis, formulation and dialogue;
- Strategic planning;
- Setting standards and quality assurance;

- Resource mobilization;
- Advising other ministries, departments and agencies on health-related matters;
- Capacity development and technical support supervision;
- Provision of nationally coordinated services including health emergency preparedness and response and epidemic prevention and control;
- Coordination of health research; and
- Monitoring and evaluation of the overall health sector performance.

Several functions have been delegated to national autonomous institutions including Uganda Cancer Institute, Uganda Heart Institute, Uganda Blood Transfusion Services, Uganda Virus Research Institute, National Medical Stores, Central Public Health Laboratories, Professional Councils, National Drug Authority (NDA) and research institutions. The Uganda National Health Research Organisation (UNHRO) coordinates the national health research agenda, whilst research is conducted by several institutions including the Uganda Natural Chemotherapeutic Research Laboratory. The Health Service Commission (HSC) is responsible for the recruitment, and deployment of HRH at Central and Regional Referral Hospital levels. In the districts, this function is carried out by the District Service Commissions. The Uganda AIDS Commission (UAC) coordinates the multisectoral response to the HIV/AIDS pandemic.

### **National, Regional and General Hospitals**

The National Hospital Policy (2005), operationalized during HSSP II, spells out the role and functions of hospitals at different levels in the NHS. Hospitals provide technical back up for referral and support functions to district health services. Hospital services are provided by the public, private health providers (PHPs) and private not for profit (PNFPs). The public hospitals are divided into three groups

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

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

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

The national standards for availability of health facilities towards achievement of overall goal of the health sector are given below:

**Table 1.1: National Health Facility Availability Standards and 2009 situation**

Type of facility	Indicator	
	Health Facility Population Ratio standard	Current Situation
1. National Referral Hospital	1: 10,000,000	1: 30,000,000
2. National Referral Hospital	1: 10,000,000	1: 30,000,000
3. Regional Referral Hospital	1: 3,000,000	1: 2,307,692
4. General Hospital	1: 500,000	1: 263,157
5. Health Centre IV	1: 100,000	1: 187,500
6. Health Centre III	1: 20,000	1: 84,507
7. Health Centre II	1: 5,000	1:14,940
8. Health Centre I/ VHT	1: 1,000 or 1 per 25 HH's	

Source: MoH, HMIS 2009

Except for general hospitals, all facilities currently provide for more people than they are supposed to.

All hospitals are supposed to provide support supervision to lower levels and to maintain linkages with communities through Community Health Departments (CHDs). Currently, there are 65 public hospitals: 2 NRHs, 11 RRHs and 52 general hospitals. There are 56 PNFP and 9 PHP hospitals. With decentralisation, the public general hospitals are managed by the local governments. The RRHs have been granted self accounting status and remain under MoH oversight. The NRHs, namely Mulago and Butabika, are semi-autonomous All PNFP hospitals are autonomous as granted by their respective legal proprietors.

### ***District health systems***

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

### ***Health Sub-District system***

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

### ***Health Centres III, II and Village Health Teams (HC I)***

HC IIIs provide basic preventive, promotive and curative care. They also provide support supervision of the community and HC IIs under their jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HC IIs provide the first level of interaction between the formal health sector and the communities. HC IIs only provide out patient care, community outreach services and linkages with the Village Health Teams (VHTs). A network of VHTs has been established in Uganda which is facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health services. The VHTs are responsible for:

- Identifying the community's health needs and taking appropriate measures;
- Mobilizing community resources and monitoring utilization of all resources for their health;
- Mobilizing communities for health interventions such as immunization, malaria control, sanitation and promoting health seeking behaviour;
- Maintaining a register of members of households and their health status;
- Maintaining birth and death registration; and
- Serving as the first link between the community and formal health providers.
- Community based management of common childhood illnesses including malaria, diarrhoea and pneumonia; and management and distribution of any health commodities availed from time to time.

While VHTs are playing an important role in health care promotion and provision, coverage of VHTs is however still limited: VHTs have been established in 75% of the districts in Uganda but only 31% of the districts have trained VHTs in all the villages<sup>2</sup>. Attrition is quite high among VHTs mainly because of lack of emoluments.

### **1.3.2 Health service delivery in Uganda**

The delivery of health services in Uganda is by both public and private sectors with GoU being the owner of most facilities. Over the past decade, Government has focused on expanding its health infrastructure through construction of health facilities in an effort to bring services closer to the people. The GoU owns about half of

<sup>2</sup>AHSPR. (2009).

the health facilities in Uganda, followed by the PNFPs. The number of private facilities has dropped from 858 in 2004 to 277 in 2006 but increased to 998 in 2010 as can be seen below.

**Table1.2: Health Facilities (2004 - 2010)**

Year	2004				2006				2010			
	GOVT	PNFP	PRIVATE	TOTAL	GOVT	PNFP	PRIVATE	TOTAL	GOVT	PNFP	PRIVATE	TOTAL
Hospitals	55	42	4	101	59	46	8	114	64	56	9	129
Health centre IV	151	12	2	165	148	12	1	161	164	12	1	177
Health centre III	718	164	22	904	762	186	7	955	832	226	24	1082
Health centre II	1055	388	830	2273	1332	415	261	2008	1562	480	964	3006
Total	1979	606	858	3443	2301	659	277	3237	2622	774	998	4394

Source: AHSPR (2009).

### ***The public health delivery system***

Public health services in Uganda are delivered through VHTs, HC IIs, HC IIIs, HC IVs, general hospitals; RRHs and NRHs. Currently, there are 27,000 employees in the health sector. The range of health services delivered varies with the level of care. In all public health facilities curative, preventive, rehabilitative and promotive health services are free, having abolished user fees in 2001. However, user fees in public facilities remain in private wings of public hospitals. Although 72% of the households in Uganda live within 5km from a health facility (public or PNFP), utilisation is limited due to poor infrastructure, lack of medicines and other health supplies, shortage of human resource in the public sector, low salaries, lack of accommodation at health facilities and other factors that further constrain access to quality service delivery. The MoH acknowledges that 75% of the disease burden in Uganda is preventable through improved hygiene and sanitation, vaccination against the child killer diseases, good nutrition and other preventive measures such as use of condoms and insecticide treated nets (ITNs) for malaria. Health Promotion and Education (HPE) and other health social marketing strategies promote disease prevention, uptake and utilization of services, care seeking and referral. Other players in service provision and promotion include the media, CSOs and community structures such as the village health team VHT.

A study conducted in 2008 on user's satisfaction and understanding of client experiences showed that in general clients were satisfied with physical access to health services (66%), hours of service (71%), availability and affordability of services including the providers' skills and competencies among other things. However, they were dissatisfied with a wide range of issues such as long waiting times and unofficial fees in the public sector, quantity of information provided during care and other behavioural problems relating to health workers. The clients were also more satisfied with community health initiatives because they provide free services and it gives them an opportunity to participate in health services management<sup>3</sup>. Some of the recommendations from this study included improvement of service availability, improving staffing levels, sustaining a reliable drug supply and removal of unofficial fees, among other recommendations.

### ***The private sector health care delivery system***

The private sector plays an important role in the delivery of health services in Uganda covering about 50% of the reported outputs. The private health system comprises of the Private Not for Profit Organisations (PNFPs), Private Health Practitioners (PHPs) and the Traditional and Complementary Medicine Practitioners (TCMPs), the contribution of each sub-sector to the overall health output varies widely. The PNFP sector is more structured and prominently present in rural areas. The PHP is fast growing and most facilities are concentrated in urban areas. TCMPs are present in both rural and urban areas, even if the services provided are not consistent and vary from traditional practices in rural areas to imported alternative medicines, mostly in urban areas. The GoU recognizes the importance of the private sector by subsidizing the PNFP, a few private hospitals and PNFP training institutions.

#### ***(a) Private Not-For-Profit Sub-Sector (PNFPs)***

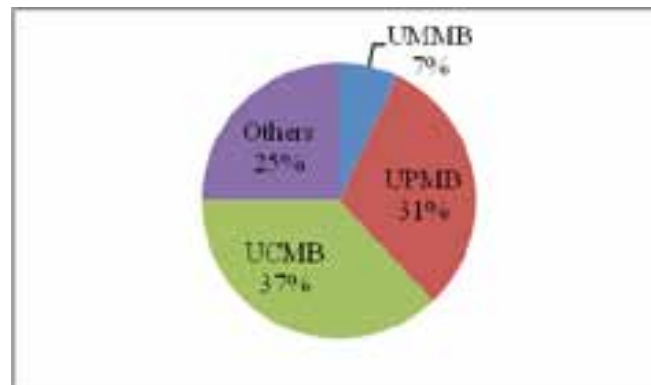
The PNFP sub-sector is divided into two categories: Facility-Based (FB-PNFPs) and the Non-Facility Based (NFB-PNFPs). The FB-PNFPs provide both curative and preventive services while the NFB-PNFPs mainly

<sup>3</sup> Jitta, J., J. Arube-Wani and H. Muyiinda. (2008). *Study of Client Satisfaction with Health Services in Uganda*.

provide preventive, palliative and rehabilitative services. The FB-PNFs account for 41% of the hospitals and 22% of the lower level facilities complementing government facilities especially in rural areas. It is estimated that there are about 12,000 employees in the PNFs. In 2007/08 PNFP hospitals handled over 1.5 million outpatients, 360 thousand admissions and 70 thousand deliveries.<sup>4</sup> After several years of expansion in number and scope of their facilities, the sub-sector has now opted for a phase of consolidation of its services. The PNFs currently operate 70% of health training institutions. More than seventy five percent (75%) of the FB-PNFs exist under <sup>4</sup> umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB). Nearly 70% of the facilities are owned by the UCMB and UPMB.

The NFB-PNFP sub-sector is diverse and less structured comprising of hundreds of NGOs and Community Based Organisations (CBOs) that mainly provide preventive health services which include health education, counselling, health promotion and support to community health workers. Although the diversity makes it challenging to achieve the desired goal of a coordinated voice from the community, the sub-sector remains critical in channelling concerns of communities where the CSOs are strategically positioned.

**Figure 1.1: Distribution of health facilities, amongst PNFP service providers**



### **(b) Private Health Practitioners (PHPs)**

As of 2010 it is estimated that the PHPs constitute 22.5% of health care providers. Dual employment is common. While 54% of the doctors working in the private sector also work in the government sector, more than 90% of the nurses, midwives and nursing assistants in the private sector work full time in this sector. A total of 9,500 health professionals were estimated to be working exclusively in the private sector, including more than 1,500 doctors. More than 80% of these doctors are employed within the central region and the major municipalities nation-wide. The PHPs have a large urban and peri-urban presence and provide a wide range of services, mainly in primary and secondary care. Few PHPs provide tertiary services. Curative services are widely offered; preventive services are more limited, with the exception of family planning offered by three-quarters of PHP facilities. While more than 90% of PHP facilities offer malaria and STD treatment, only 22% offer immunization services. About 40% of the PHPs provide maternity, post abortion care and adolescent reproductive health services. Difficulties in accessing capital and other incentives have limited the development of certain aspects of service delivery in the private sector.

### **(c) Traditional and Complementary Medicine Practitioners (TCMPs)**

Approximately 60% of Uganda's population seek care from TCMPs (e.g. herbalists, traditional bone setters, traditional birth attendants, hydro-therapists, spiritualists and traditional dentists) before and after visiting the formal sector. TCMPs practice in both urban and rural areas with varying and inconsistent service provision. Many traditional healers remain unaffiliated. Most TCMPs have no functional relationship with public and private health providers. This results into late referrals, poor management of various medical, surgical, obstetric conditions and high morbidities and mortalities. Non-indigenous traditional or complementary

<sup>4</sup>AHSPR. (2008).

practitioners such as the practitioners of Chinese and Ayurvedic medicine have emerged in recent years. A regulatory bill and policy framework for TCMPs is awaiting cabinet approval which is intended to establish functional relationship between the TCMP and the rest of the health sector.

### **1.4 Process to develop the HSSIP**

The development of the HSSIP has taken into consideration a wide range of policies, new emerging diseases, changing climatic conditions and issues of international health. The process also took into consideration the international treaties and conventions to which Uganda is a signatory more especially (i) The Millennium Development Goals (MDGs), three of which are directly related to health and most others address determinants of health; (ii) The International Covenant on Economic, Social and Cultural Rights (ICESCR); (iii) the Convention on All forms of Discrimination Against Women (CEDAW); (iv) the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa and (v) the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness; among others. The aim of reviewing policies and plans during the development of the HSSIP was to harmonise the strategic plan with the other existing sector and inter sectoral documents.

At the beginning of 2009 the MoH formed a Task Force (TF) to oversee the development of the NHP II and the HSSIP. The membership of this TF was drawn from different Departments in the MoH, universities, the private sector (including PHPs and PNFPs), Civil Society Organizations (CSOs) and HDPs. The involvement of the different stakeholders was important in order to ensure ownership of the plan. The TF was chaired by the Director General of Health Services in the MoH. In order to facilitate the drafting of the NHP II and the HSSIP, 12 TWGs namely Sector Budget Support Working Group (SBWG), Hospitals, Nutrition, Human Resource (HR), Maternal and Child Health (MCH), Environmental health, Health Promotion and Education (HPE), Public Private Partnerships in Health (PPPH), Health Infrastructure, Medicines and Health Supplies, Communicable Diseases, Non-Communicable Diseases (NCDs) and Supervision, Monitoring, Evaluation and Research (SMER) were tasked to develop the NHP and HSSIP.

TWGs were responsible for the development of objectives, strategies and interventions as contained in this HSSIP. A Lead Consultant was recruited to facilitate the process of developing the HSSIP. In addition, other consultants were recruited to work with the TWGs. The TWGs met separately to discuss issues that should be contained in the HSSIP. There were two workshops, in October 2009 and March 2010, where all TWGs met and discussed HSSIP content. There were also consultations with a wide range of health experts in order to get their inputs into specific issues related to the development of the HSSIP. A review of a wide range of health sector documents was done to provide an in-depth analysis and understanding of the sector such as the HSSP I and its final evaluation report, HSSP II and its MTR report and the thematic paper on health and nutrition of the National Development Plan. There were also consultations with local Governments during National Health Assembly (NHA) and Joint Review Mission (JRM) in November 2009, district planning workshops in January and February 2010 and also the April 2010 Technical Review Meeting. Health Development Partners and Civil Society Organizations and other Ministries have expressly been consulted and involved during the development of HSSIP. The process was also informed by the Joint Assessment of National Strategies (JANS) which provided useful guidance in improving the focus of the document.

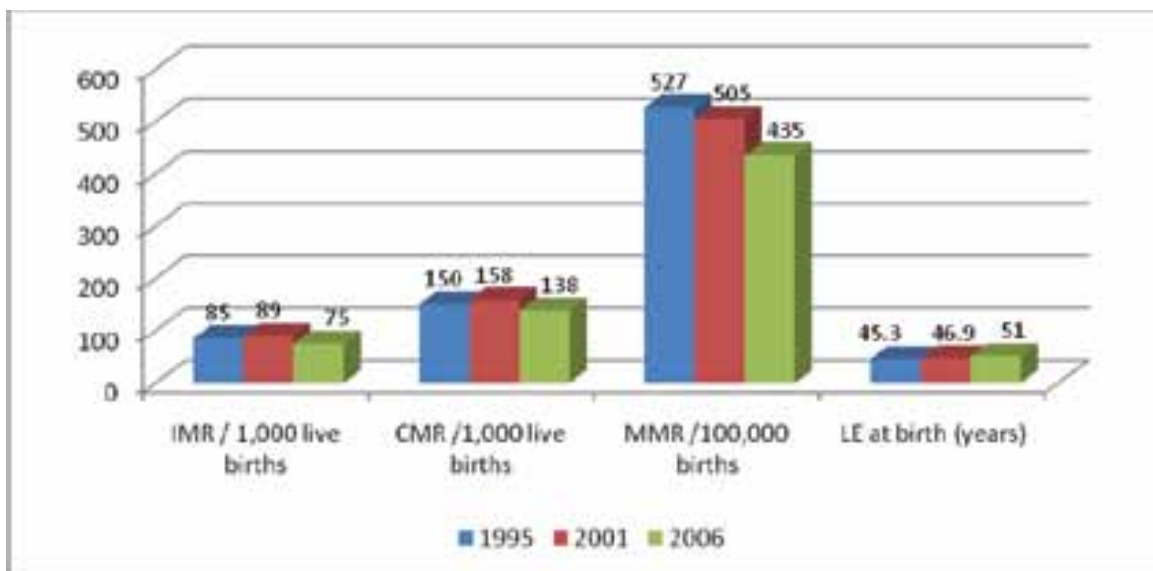
## 2. SITUATION ANALYSIS

Over the last decade economic growth rate has on average been at 7%. The proportion of people living below the poverty line was recorded as 31% in 2005. Far more people live below the poverty line in Northern Uganda (64.8%) than in other regions. A direct relationship has been demonstrated between poverty and incidence and prevalence of some conditions, such as malaria, dysentery and diarrhoea as they are more prevalent among the poor compared to the rich. The lack of a comprehensive social security system makes the poor more vulnerable in terms of affordability and choice of health provider.

### 2.1 Overall Health Status

The health status is a function of the information provided from the health impact indicators. Indicators used to monitor trends in overall health status therefore are Life Expectancy at birth (LE), Adult Mortality rate (AMR), neonatal mortality rate (NMR) infant mortality rate (IMR), child mortality rate (CMR), maternal mortality ratio (MMR). The figure below shows the trends on these indicators between 1995 and 2006

Figure 2.1: Trends in Health Impact indicators, 1995 – 2006

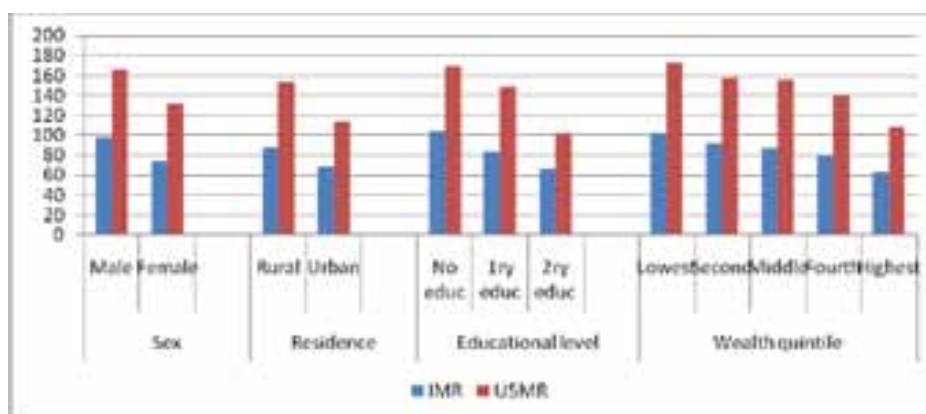


Source: UDHS 1995, 2001, 2006

Between 1995 and 2006, CMR declined from 156 to 137 deaths per 1,000 live births; IMR decreased from 85 to 75 deaths per 1000 live births; MMR reduced from 527 to 435 per 100,000 live births. The trend in the distribution of health by key socio-economic variables is illustrated in the figure below, using 2 representative indicators.

Sex, residence, socio-economic status and educational level are important determinants of health. These indicators are better off in urban areas, among the wealthy and those with secondary school plus level of education. The results also show that male children are more likely to die in childhood compared to females.

Figure 2.2: Trends in selected impact indicators in Uganda by residence, educational level and wealth



(Source: UDHS 2006)

The UDHS further shows that IMR, CM and U5MR are highest in South West, North, West Nile and Central compared to other regions. Kampala has the lowest under-five mortality rates. The disparities in some regions such as Northern Uganda could have been due to insecurity resulting from the prolonged insurgency. These indicators, although unsatisfactory, generally demonstrate that the health status of the people of Uganda improved over the reference period.

## 2.2 Coverage with Health Services

The HSSP II defined the Uganda National Minimum Health Care Package (UNMHCP) into four clusters namely:

- (i) Health Promotion, Disease Prevention and Community Health Initiatives;
- (ii) Maternal and Child Health;
- (iii) Prevention and Control of Communicable Diseases; and
- (iv) Prevention and Control of Non-Communicable Diseases (NCDs).

This section summarizes progress that has been made in reaching targets as were set in the HSSP II for each of the clusters of the UNMHCP.

### 2.2.1 Cluster 1: Health Promotion, Disease Prevention, Community Health Initiatives and Environmental Health

Cluster 1 aims at increasing health awareness and promoting community participation in health care delivery and utilisation of health services through the use of VHTs, mass media and Environmental Health Officers. This is expected to increase demand and utilisation of health services and adoption of healthier lifestyles. The implementation of the VHT strategy has, however, not been satisfactory: as of November 2009 VHTs were established in 60 of the 80 districts but only 31% of the districts have trained VHTs in all the villages<sup>5</sup> mainly because of inadequate funding and trained health educators. Where VHTs are functional such as in Mpigi District, they have contributed to increasing health awareness, demand and utilisation of health services and significantly led to decongestion at health facilities as they timely treat minor illnesses. VHTs have further helped to increase community participation in local health programmes.

The 1997 Kampala Declaration on Sanitation (KDS) guides the promotion of hygiene and sanitation in Uganda but indicators are still poor and the targets for some indicators were not achieved. For example: while the target was that by 2008/09 70% of the households at national level would have a pit latrine, 67.5% recorded as having a pit latrine although this was an improvement from 62.4% the previous year. The increase was

<sup>5</sup> AHSPR. (2009).



attributed to development and enforcement of ordinances and bye laws by local governments<sup>6</sup>. Latrine coverage is worse in some districts such as Abim, Kaabong, Kotido, Nakapiripirit, in some rural and slum areas. Some regions for example Karamoja which have nomadic populations have on average 7% latrine coverage. 21.4% of the districts were implementing water quality surveillance and promoting safe water consumption by 2008/09 against a target of 100%. Almost all districts have water and sanitation coordination committees.

Housing conditions are also poor with three quarters of the households having floors made of earth, sand or dung. The incidence and prevalence of diseases such as acute respiratory infections and diarrhoea in such environments is high; hence the need to promote better housing structures. Only 14% of the persons wash hands with soap against a target of 70%. Overall, during the HSSP II period there was a decrease in the incidence of diarrhoeal diseases. The annual incidence of cholera fell from 15/100,000 in 2005 to 3/100,000 in 2009 and that of dysentery decreased from 288/100,000 in 2005 to 254/100,000 in 2009. There was also a decrease in case fatality rate of diarrhoeal diseases. Cholera Case Fatality Rate (CFR) fell from 2.5% in 2005 to 2.1% in 2009; Dysentery CFR fell from 0.11% in 2005 to 0.08% in 2009; and Acute watery diarrhoea CFR fell from 1.2% in 2006 to 0.9% in 2009; but persistent diarrhoea CFR increased from 0.7% to 1.3%. This demonstrates that the targets had not yet been reached. Inadequate resources, high levels of poverty, inadequate awareness, poor enforcement of public health bye-laws and cultural factors in some regions (e.g. in Karamoja) are major challenges that have affected the implementation of environmental health programmes.

The school health programme ensures that school children and staff are healthy and creates an environment conducive for learning, growth and development of children. In 2008/09 the School Health Policy was finalised but not yet approved by Cabinet; and the school health manuals have since been developed and distributed. The new Policy covers public and private schools, from early childhood development centres up to secondary and technical schools, and clearly defines the roles of various ministries, parents, students and other stakeholders. The main responsibilities are with the MoES, including the implementation of the Health Promoting School Initiative (HPSI) by the teachers, recruitment and employment of school health nurses –and the establishment of basic health and nutrition services through these nurses-, the construction of toilets and pit latrines etc. However, in the absence of school health nurses, health centre staff is expected to provide both curative services (at health centres) and promotive and preventive services, including immunisation (at schools). Successes have been limited: Sanitation in schools has improved, but 57% of primary and secondary schools combined meet the recommended criterion of 40 pupils to one toilet (target: 75%). Only 25% of the primary schools implement the main components of HPSI including sex education, counselling and life skills against a target of 75% at the end of the HSSP II. The proportion of primary and secondary schools with safe water sources within 0.5 km to the school were at 61% and 75% respectively in 2007/08 against a target of 75% and 95%, respectively. The proportion of schools with hand washing facilities and those providing basic school health and nutrition services also remains off target<sup>7</sup>. The implementation of comprehensive school health programmes has been hampered by the lack of some standards (e.g. in nutrition), enforcement of guidelines by local governments, insufficient ownership by the MoES, the absence of a MoU between the MoH and MoES, absenteeism of teachers and health workers, and the lack of financial resources at school level. The latter factors probably explain the relative successes seen in private schools and in urban public schools.

With regard to epidemics and disasters, a comprehensive surveillance and reporting system has been put in place. A multisectoral epidemic preparedness and response committee has been formed in all districts and it has proved useful in managing epidemics. Since 2004/05 weekly epidemiological newsletters are produced. Quarterly IDRS reports are not being produced. As of 2008/09, 82% of the districts submitted timely weekly surveillance reports to MoH against a target of 80% while 92% (against a target of 80%) were submitting weekly surveillance reports to MoH. These figures represent an improvement from the previous years including at baseline. All investigated outbreaks include case based data compared to 50% at baseline. All epidemics have laboratory confirmed diagnosis compared to 68% at baseline. While there has been an improvement in the proportion of outbreaks notified to MoH within 24 hours of detection from 65% at baseline to 76% in 2008/09, this still falls short of the target of 80% at end of HSSP II. 62% of the suspected outbreaks are

<sup>6</sup>AHSPR. (2009).

<sup>7</sup>AHSPR. (2009).

responded to within 48 hours of notification and this represents an improvement from 30% at baseline. Challenges exist with regard to epidemic and disaster prevention, preparedness and response: the shortage of staff with requisite skills especially at district level to effectively manage epidemics still exists and follow up community interventions especially during epidemics and disasters; the lack of transport for district staff; inadequate resources and the delayed release of funds constrain the epidemic/disaster response.

Some progress has also been made in occupational safety and health. The Occupational Health and Safety Policy has been finalised. The guidelines for mainstreaming occupational health and safety have also been finalised. Both the policy and guidelines have been launched and are awaiting wider dissemination. The 2008/09 does not provide any data on the progress Uganda has made with regard to access to services. The major challenge in the implementation of the occupational safety and health program was the inadequate financial and human resources allocated both centrally and at district level for implementation of the occupational safety and health interventions. The occupational safety health policy and guideline are yet to be operationalised.

### **2.2.2 Cluster 2: Maternal and child health**

Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda<sup>8</sup>. Some progress has been made in the improvement of the health of mothers and children in Uganda over the implementation of the HSSP II. The Road Map to accelerate Reduction of Maternal and Infant Mortality, the Reproductive Health Commodity Security Strategy and Neonatal Morbidity and Mortality and the National Child Survival Strategy were formulated in 2007, 2008 and 2009, respectively. The effective implementation of these strategies will contribute significantly towards achievement of MDGs 4 and 5 by 2015.

Sexual and reproductive health (SRH) core interventions (such as community mobilisation and capacity building for RH at district and lower levels to deliver RH services, provision of EmOC services at HC IIIs, HC IVs and hospitals, provision of FP services especially to adolescents, maternal health audits, advocacy and IEC focussing on importance of RH services) were rolled out during the HSSP II. Despite expansion of these services, the proportion of pregnant women delivering in GoU and PNFP facilities is still low at 34% in 2008/09 dropping from 40% in the previous year against a target of 35% at the end of the HSSP II. The proportion of facilities providing appropriate EmOC is still low and so is access to postnatal care within first week of delivery which stands at 26%. About 15% of all pregnancies develop life threatening complications and require EmOC, more so in those that conceived too early (under 18) or too late (above 35 years). The national met need for EmOC is 40%<sup>9</sup>. Only 11.7% of women deliver in fully functional comprehensive EmOC facilities. Although the MMR for Uganda has reduced from 505 deaths per 100,000 live births in 2001 to 435 deaths per 100,000 live births in 2006, the rate of reduction is slow, as per the set MDG target of 131 (by 2015). The leading direct causes of these deaths are haemorrhage (26%), sepsis (22%), obstructed labour (13%), unsafe abortion (8%) and hypertensive disorders in pregnancy (6%). The proportion of pregnant women receiving two doses of IPT was at 47% in 2008/09 against a HSSP II target of 75%. The main factors responsible for maternal deaths relate to the three delays – delay to seek care, delay to reach facilities and intra-institutional delay to provide timely and appropriate care, while those related to abortions arise mainly from unwanted or unintended pregnancies. The referral mechanism has also faced challenges of poor road networks or terrain in some areas (the hard-to-reach), insufficient funding for operating and maintenance of ambulances, and lack of relevant emergency medicines and supplies including blood at the endpoint of referral.

Unmet need for Family Planning stands at 41%, with poor coverage of Family Planning services especially in the hard-to-reach areas. There have been efforts to increase funding for procurement of Family Planning supplies however, it has been insufficient to meet the requirements.

With regard to newborn health, during the HSSP II a detailed framework on newborn health was developed to operationalise the newborn health component of the Child Survival Strategy, the national steering committee on newborn health was instituted, newborn service audit standards were piloted in some districts and some perinatal death audits were conducted in some selected districts with the help of development

<sup>8</sup> UBOS. (2002). *Uganda Demographic and Health Survey*.

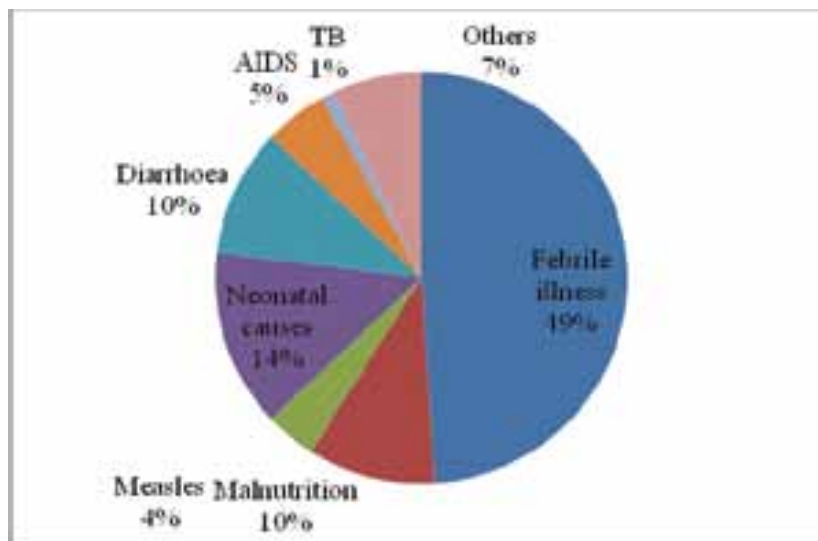
<sup>9</sup> AHSPR. (2009)

partners. Slow progress in addressing maternal health problems in Uganda is due to inadequate funding of the interventions, lack of HR, medicines and supplies and appropriate buildings and equipment including transport and communication equipment for referral<sup>10</sup>. The lack of decision making at household level by women affects their health seeking behaviour including during pregnancy. The HSSIP will address such gender and human rights issues through awareness creation targeting men to for example delegate authority to their wives and to be involved full on issues to do with birth preparedness.

Most of the HC IVs are not providing comprehensive SRH services yet there are a number of reproductive health challenges at that level. The current high fertility of women with an average of 7 children per woman predisposes women to high risk pregnancies and subsequently increases chances of morbidity and mortality. Early sexual involvement of girls has sometimes led to unplanned and unwanted pregnancy with evidence of high incidence of unsafe abortions and its related complications in the age group. HIV prevalence among pregnant women attending ANC is estimated at 6.5%. Child morbidity and mortality are still high in Uganda. Neonatal deaths contribute 38% of all infant deaths, which is a significant proportion given that these deaths occur in one month out of the twelve months of infancy. This proportion has largely remained the same over the past 15 year (36.7% in 2000, 36.8% in 1995).

It is evident from the figure below that febrile illness is the major cause of under-five mortality in Uganda followed by neonatal causes. Over a half of the total newborn deaths occur during the first week of life, mainly in the first 24 hours of life. The majority of newborn deaths result from infections, asphyxia, birth injuries and complications of prematurity. Low birth underlines 40-80% of newborn deaths. Over the past years some achievements in child health have been recorded: e.g. Vitamin A supplementation increased from 60% (2004/05) to 69.5 % in 2008/09. The proportion of sick children under 5 seen by health workers using IMCI guidelines has increased to 63% in 2008/09 from 45% in 2004/05. Child Days Plus are being implemented which have contributed to an increase in immunization coverage. The promotion of infant and young child feeding (IYCF) has been integrated into different programmes such as PMTCT, reproductive health and EPI and appropriate guidelines have since been developed. The proportion of children under 5 with fever, diarrhoea and pneumonia seeking treatment within 24 hours, those with acute diarrhoea receiving ORT and those with pneumonia receiving appropriate antibiotics increased over the period 2004/5-2006/7 when the last DHS was conducted. The new malaria policy provides for HBMF but the challenge is the availability of drugs for HBMF. The implementation of MCH interventions is hampered by inadequate human resource at service delivery outlets and inadequate supervision.

**Figure 2.3: Causes of under 5 mortality in Uganda**



Source: MoH 2008

During the implementation of the HSSP II the number of static service delivery points for immunisation increased from 1,950 to 2,100 and contributed to high accessibility of immunisation services: the proportion

<sup>10</sup>AHSPR. (2009).

of the children under-1 who received 3 doses of DPT/pentavalent vaccine according to schedule was at 79% and 78% in 2008 and 2009, respectively. This was against a target of 95%. Countrywide social mobilisation campaigns have helped to increase demand for immunisation services specifically during Supplemental Immunization Activities (SIA). In 2007, a cold chain and vaccine management assessment showed insufficient storage at national and district levels and this led to the development of a 5 year replacement and expansion plan. With support from GAVI the GoU provides all the country requirements for the vaccines. Measles morbidity and mortality has been reduced by 90% over the period and in 2009, the country experienced a re-importation of WPV 1, after 13 years of non-polio circulation. Eight cases were confirmed polio in two districts of Amuru and Pader. The major challenges with regard to immunisation have been the declining funding for operational costs which was worsened by the suspension of GAVI ISS funding. An aging fleet of vehicles, irregular distribution of gas, vaccine and injection materials from the national level to the districts and peripheral units, shortage of gas cylinders, irregularities of outreaches, lack of child health cards and tally sheets for recording child immunisation and lack of supportive supervision are some of the challenges that hamper the effective implementation of the immunisation programme in Uganda.

The 2006 DHS also highlighted health challenges related to Sexual Gender Based Violence in all the regions of the country. In general more women tend to experience gender based violence compared to men. In 2006 about 60% of the women aged 15-49 reported that they had ever experienced physical violence since age 15. Among men it was slightly lower at 52.7%. More women in rural areas reported experiencing physical violence at 61% compared those in urban areas at 54.1%. The corresponding proportions among men were 53.2% and 50.2%, respectively. Of the women who reported having ever experienced physical violence since age 15, 63.3% of those who were married reported that it was their husband/partner who perpetrated the violence and this was followed by those who reported that it was their former husband/partner at 22.5%. Among men 34.1% mentioned that it was their current wife/partner who perpetrated the violence and this was followed by other relative at 22.8%. The experience of physical violence among women who ever been pregnant and were married was reported by 15.7% of the women. About 40% of the women aged 15-49 reported that they have ever experienced sexual violence compared to men at 10.9% and for both men and women who experienced sexual violence it was mainly the spouses who perpetrated this. The DHS further shows that violence is mainly practised in rural areas<sup>11</sup>.

During HSSP II, a baseline survey on gender-based violence in Northern Uganda was done, a campaign to raise awareness about GBV amongst health workers was undertaken, change agents in communities were sensitized, support to agencies and organizations that work to address SGBV was undertaken and partnerships with other sectors created. The control of SGBV is still hampered by limited financial and transport resources and poor social and economic status of women in the society. These factors have also hampered the rolling out of capacity building for health workers to more districts. Poor multi-sectoral coordination weakens the response to SGBV. The law requires that survivors of SGBV be examined by medical doctors and this is a major limitation. The lack of equipment in health facilities to appropriately manage SGBV survivors and the limited number of medical officers to endorse Police forms hampers complete access of services to SGBV survivors.

### **2.2.3 Cluster 3: Communicable diseases control**

Communicable diseases account for 54% of the total burden of disease in Uganda with HIV/AIDS, tuberculosis (TB) and malaria, being the leading causes of ill health. The HSSP II prioritised the prevention and control of HIV/AIDS, malaria, tuberculosis and diseases targeted for elimination. Most of these diseases are aggravated by poor nutrition hence nutrition services should be prioritized in the treatment and prevention of these conditions.

#### **(a) HIV/AIDS**

Sectors and line ministries continued conducting IEC and community mobilisation campaigns with emphasis on abstinence, faithfulness and condom use. As a result, HIV/AIDS awareness has remained high. In addition to HIV/AIDS awareness programmes, HIV/AIDS interventions in HSSP II have also included provision of HCT, PMTCT, ART, promotion of condoms, safe blood transfusion, management of STIs and home-based care management. The Modes of Transmission (MoT) study conducted in 2008 showed that 135,000 new infections occurred in 2007. Eighteen percent (18%) of the new infections occurred through mother to child transmission

<sup>11</sup>UBOS. (2006). *Uganda Demographic and Health Survey*. Kampala

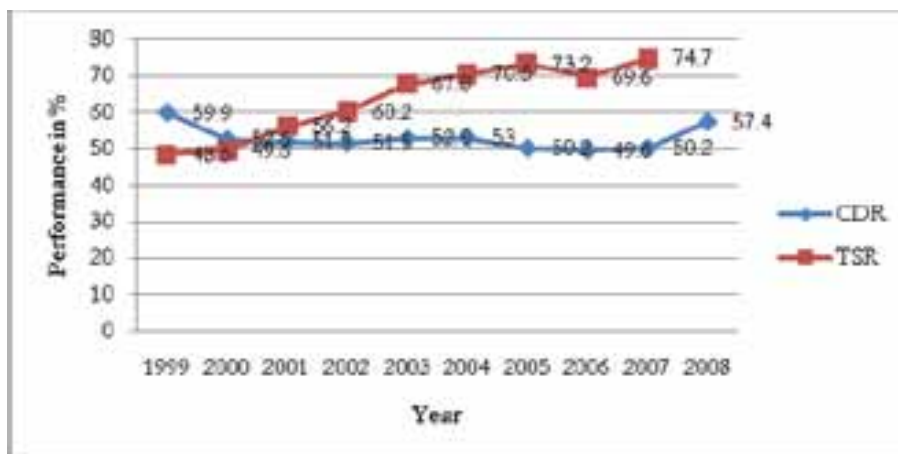
(MTCT), 37% were due to multiple partnerships, 34% occurred among monogamous discordant couples while 9% arose from commercial sex networks<sup>12</sup>. There is need for an increased focus on HIV prevention among couples and other high risk groups such as commercial sex workers (CSWs). Some targets as set in the HSSP II have not been achieved: e.g. adult HIV prevalence in 2008/09 was estimated at 6.2% against a target of 3% in the HSSP II; HIV prevalence among women attending ANC was estimated at 6-7% in 2008/09 against a target of 4.4%; and that only 50% of the HC IIIs were offering HCT services against a target of 100%. Some targets for 2008/09 were achieved e.g. 68% of the HC IIIs were offering PMTCT services against a target of 50% and 90% of the HC IV were offering comprehensive HIV/AIDS care with ART against a target of 75%<sup>13</sup>. When the last UDHS was conducted in 2006 the proportion of the general population with comprehensive knowledge about HIV/AIDS was at 36% and the HSSP II target was at 95%. HIV/AIDS is responsible for 20% of all deaths and a leading cause of death among adults. A total of 373,836 PLHIVs (by September 2008) in Uganda required ART but only 160,000 (52%) were on ART. As of September 2009 a total of 200,213 patients were on ARVs of which 8.5% were children. While a number of interventions are being implemented the concern however is that the epidemic appears to have reversed from the previous declining trends.

Condom distribution has increased to about 10 million per month, the number of health facilities providing HCT has increased and the uptake of ART, HCT and PMTCT services have increased even though as stated earlier some targets have not been reached. Various guidelines and standards for the prevention and control of HIV/AIDS have since been produced and disseminated while a public health approach was used to build capacity of health workers. While there has been an increase in uptake of HIV/AIDS services, procurement and logistics problems, lack of monitoring of HIV/AIDS care and treatment services, high costs of drugs and commodities and high reliance on donor support, including GFATM, for such commodities have slowed down the scaling up of priority services. This has been exacerbated by the limited physical infrastructure and human resource capacity at district and facility level for the delivery of comprehensive care. The verticalisation of the HIV/AIDS programme in a context where HRH is a major challenge has brought in problems such as the creation of parallel information systems.

**(b) Tuberculosis and Leprosy**

The burden of tuberculosis in Uganda is high and it is ranked 16<sup>th</sup> by the WHO Global TB Report of 2008. WHO estimates put incidence of infectious TB cases at 136 and all TB at 330 new infections per 100,000 populations annually. The HSSP II aimed to expand CB-DOTS to all districts as a means of attaining global case detection and treatment success targets of 70% and 85%, respectively, while minimising emergence of drug resistant TB. In the past one year the case detection rate (CDR) increased from 50.3% to 57.4% and treatment success rate (TSR) improved from 68.4% to 75.1%. Figure below shows trends over the past ten years.

**Figure 2.4: Trends in NTLP performance, 1999 – 2008**



**Source:** NTLP annual surveillance reports 1999 – 2008.

Uganda still falls short of attaining the MDG target by 2015. Underperformance is due to a combination of

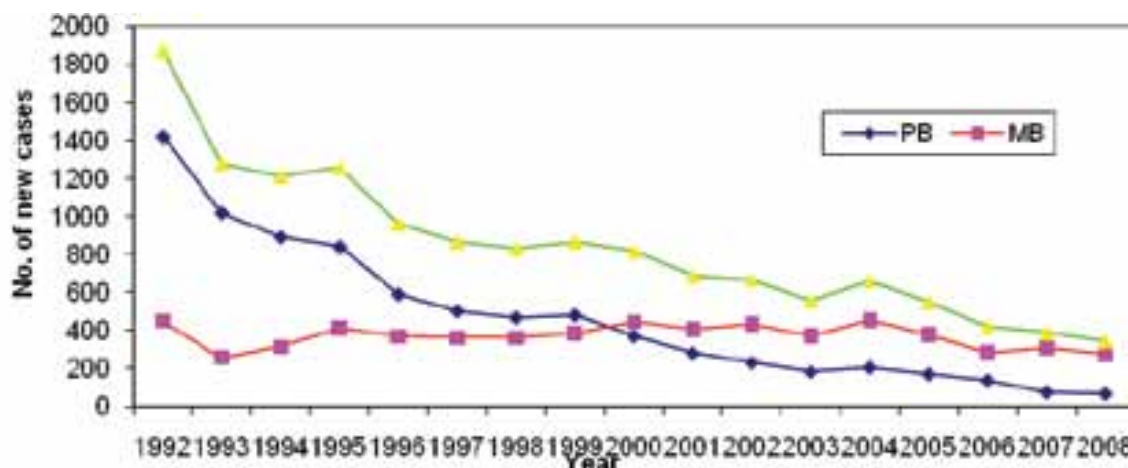
<sup>12</sup>AHSPR. (2009).

<sup>13</sup>AHSPR. (2009).

factors including poor access to TB services; shortage of human resources especially laboratory and ZTLs; poor quality of DOTS services including poor recording and reporting, stock outs due to weak LMIS capacity, inadequate facilitation to SCHWs leading to inappropriate implementation of CB-DOTS strategy; high HIV prevalence; low community awareness and a weak ACSM strategy among others. Persistent high default rates of over 20% in large districts such as Kampala, Mbarara and Masaka are other factors. During 2008, 4.7% of the newly registered smear positive cases died and this was far short of the HSSP II target for Year 4 (FY 2008/09) of 3.1%. It is difficult to reduce case fatality in the midst of HIV and late health seeking behaviour. Uganda has adapted WHO generic TB/HIV collaborative guidelines to the country setting to address the dual TB-HIV epidemic. In 2008/2009, 63.6% (target 80%) of TB patients were counselled for HIV testing while 60% of them were tested. This was an improvement from 38% of the TB patients tested in 2007/08. Of the TB patients tested, 60% of them were co-infected with HIV. CPT was provided to TB/HIV patients with an improvement from 53% to 59.2%. There was slight improvement of ART to TB/HIV patients from 13% to 14.2%. HIV testing and provision of CPT and ART are constrained by inaccessibility of the services, especially ART, and frequent stock out of test kits and co-trimoxazole and associated poor recording and reporting.

In Uganda, the elimination of leprosy as a public health problem was achieved at the end of 2004. At the moment, leprosy is not considered an eradicable disease. CDRs are showing a gradual downward trend most marked in the MB types as can be seen in the Figure below.

**Figure 2.5: Trends of new leprosy case detection in Uganda, 1992 -2008**



During 2008, 345 new Leprosy cases were notified implying a CDR of 1.2/100,000 population. Seventy percent of the new cases were notified by only 13 out of the 80 districts. About 8% of the new cases were children below the age of 14 years; 18% of new cases had visible disabilities attributable to leprosy (Grade 2) at the time of detection. Data from the districts to NTLP suggest the continuing presence of pockets of the undetected leprosy cases in the country and a significant delay in case detection. Of the cohort of MB cases who started MDT in 2006, 82% completed the treatment as compared to 90% for the cohort of PB patients that started in 2007.

An increased rate of decline in new case detection may simply be symptomatic of decreasing quality of leprosy control services rather than a rapid decrease in disease occurrence. Awareness of the symptoms and signs of leprosy is dwindling both in the public and among health care providers. At national level, information about the identification and management of complications especially leprosy reactions remains scanty; most complications were still referred to and managed in the old leprosy referral centres. Other actions for prevention of disability are also poorly documented. The coverage of protective footwear requirements for people with impaired sensation in their feet is estimated to be about 50%. There is need to sustain on-going efforts to enable people living with disabilities after leprosy treatment to access the mainstream Community Based Rehabilitation (CBR) services in their respective areas.

**(c) Malaria**

Malaria remains one of the most important diseases in Uganda in terms of morbidity, mortality and economic losses. The goal of malaria control in Uganda is to control and prevent malaria morbidity and mortality, as well as to minimize social effects and economic losses attributable to malaria. In order to achieve this, the Malaria Control Programme endeavours to implement at a national scale a package of effective and appropriate malaria control interventions. The major interventions include the use of Long Lasting Insecticide-treated Nets (LLINs), early and effective case management, in-door residual spraying (IRS), Intermittent Preventive Treatment of pregnant women (IPTp) with antimalarial tablets and IEC/BCC. A nearly 20% reduction in malaria outpatient cases observed over the years has been attributed to improvement in IPTp coverage, early home and community treatment of children with fever, ITN coverage and the IRS consolidation and expansion programme. The proportion of children with malaria who receive effective treatment within 24 hours after the onset of symptoms has increased from 25% at the end of HSSP I to 71% in 2007/08 falling short of the 80% target for 2009/10. The proportion of pregnant women who receive IPT has increased to 42% in 2007/08 against the HSSP II target of 80%. Only 42% of the households have at least one ITN against a target of 70%. IRS approved in 2006 has since been consolidated and expanded in malaria endemic areas and 85%-100% household coverage in targeted areas for IRS in both endemic and epidemic areas against a target of 80% in 2009/2010 which shows that the target has been reached. These initiatives have resulted into a rapid decline in malaria admissions. Major challenges that affected malaria prevention and control are shortages of ACTs due to inadequate procurement and delivery to health facilities and CMDs, irregular and inadequate expansion of IRS, inadequate capacity for malaria diagnosis, understaffing and inadequate partner coordination. The percentage of health facilities without stock outs of first line antimalarial drugs worsened from 35% to 26% in 2006/07 and 2008/09, respectively<sup>14</sup>. There is a need therefore to strengthen logistics management and other malaria interventions namely use of IRS, IPT, LLINs and early detection and treatment of malaria.

**(d) Diseases targeted for elimination**

Uganda is on course to eliminate diseases targeted for elimination namely guinea worm, trachoma, onchocerciasis, schistosomiasis, lymphatic filariasis and measles. WHO has certified Uganda as free of guinea worm transmission; however due to the threat of importation of cases from South Sudan the programme has to maintain high quality post-certification surveillance. Mass distribution of azithromycin and tetracycline for the control of trachoma is on-going. Integrated mass drug administration against onchocerciasis, schistosomiasis, lymphatic filariasis and soil transmitted helminths is ongoing and has been scaled up to most endemic districts. Programmes for Neglected Tropical Diseases (NTDs) are still being implemented towards their elimination. Challenges mainly revolve around the lack of adequate funding for these programmes. The number of people who are at risk of getting onchocerciasis is 3,049,838. Onchocerciasis is endemic in 29 districts. Bi-annual treatment and vector elimination are being done in 14 districts with the overall aim of eradicating onchocerciasis in those districts. Measles control through vaccination remains one of the strategies for reduction of childhood morbidity and mortality by 2015 as stipulated in the Millennium Development Goals. Two integrated Measles SIAs were conducted in 2006 and 2009 thereby increasing the proportion of the population that is protected against measles. Measles confirmed cases decreased from 580 cases in 2006 to 22 cases in 2009. There has been a general decline in the number of confirmed Neonatal Tetanus (NNT) cases by 86% since the implementation of the high risk approach. Busoga region, 2nd phase and 3rd phase districts have shown a decline by 97%, 94% and 90%, respectively. The reported national annual NNT incidence decreased from 0.35/1,000 live births in 2006 to 0.06/1,000 live births in 2009

**2.2.4 Cluster 4: Non- Communicable Disease (NCDs) Prevention and Control**

NCDs are an emerging problem in Uganda, as is the case in all developing countries. NCDs include cardiovascular diseases, diabetes, chronic respiratory diseases, cancers, injuries and disabilities, oral diseases, genetic diseases and mental health conditions. The increase in NCDs is due to multiple factors such as adoption of unhealthy lifestyles, increasing ageing population and side effects resulting from lifelong antiretroviral treatment for HIV/AIDS. The majority of the NCDs are preventable through a broad range of simple, cost-effective public health interventions that target NCD risk factors. The treatment of NCDs and their complications is extremely costly. Uganda does not have nationally representative data on NCDs and also lacks a comprehensive NCD

<sup>14</sup>AHSPR. (2009).

Policy, strategic plan, standards and guidelines for managing NCDs. In 2006, the MoH established a Unit for NCD Prevention and Control to spearhead the planning, coordination and implementation of interventions targeted against NCDs in the Uganda population. The MoH has initiated a process to upgrade this unit to a division and to resource it adequately to enable it to execute its mandate. The NCD Unit has planned, as its first step, to conduct a national NCD Survey which will generate community based data on the magnitude of NCDs; the prevalence of NCD risk factors; the social determinants of NCD risk factors; and the capacity of existing health facilities to prevent and control NCDs. The data and information obtained from this survey will be utilized to formulate evidence based National NCD policies and strategies as well as developing comprehensive and integrated NCD prevention and control interventions in the population.

Health facilities at all levels are conducting treatment and care for individual NCD conditions. There are insufficient numbers of adequately trained health workers to provide NCD screening, early diagnosis, and treatment services; appropriate screening and diagnostic equipment is not generally available at the health facilities; and there is an insufficient supply of medicines and supplies for treating NCDs particularly at lower level health facilities. The above factors are undermining the population's access to quality NCD care.

Regarding disabilities, 300,000 (1%) people in Uganda have hearing impairments while 250,000 are blind, the causes of which are largely preventable. The population of 60 years and above increased from 4% to 6% between 1991 and 2002. Despite increasing demand, geriatrics services are non-existent. Currently, only 2% of the 25% of People with Disabilities (PWDs) have access to rehabilitation services. Uganda has adopted community based rehabilitation (CBR) as the main strategy to reach PWDs with services. Death from road traffic accidents has more than doubled over the past 10 years from 992 in 1993 to 1,996 in 2003. Uganda has the second highest accident burden, with over 20,000 road accidents annually and 2,334 fatalities in 2008 alone. In 1998, Uganda lost UGX 151.7 bn through road traffic crashes accumulated from the costs of fatalities, injuries and vehicle damage. The cost for 2003 is estimated at over UGX 300 bn. During HSSP II, sensitisation of the general population and school children about road traffic accidents was undertaken. Black spots on some of the major highways continued to be identified and marked. The programme strengthened orthopaedic workshops in 4 RRHs for production of assistive devices. Six orthopaedic technicians were trained in wheelchair technology and have been deployed in the RRHs. A wheelchair provision project was inaugurated. The MoH with support from partners established ENT and Eye Units in five districts and developed a Communication Strategy on hearing impairment. There was enhanced collaboration with the social development sector with respect to the Community Based Rehabilitation initiative. In collaboration with stakeholders, a data collection tool on landmine survivors has been developed and surveillance activities conducted in five districts. In addition, a cataract survey was conducted in one district.

Mental health is a major health problem in Uganda contributing 13% to the national disease burden. Butabika Hospital is the only national referral mental health hospital. In 2008/09, 2,707 patients were first time admissions while 3,341 were re-admissions. Data from supervision reports shows that about 75% of attendances at Mental Health Clinics have some form of neurological problem commonly epilepsy, with cases of dementia on the increase especially among persons living with HIV/AIDS. So far, 6 Regional Mental Health Units have been constructed; the Mental Health Policy has been revised and other policies such as the Alcohol policy, the Tobacco Control Policy and the Tobacco Control Bill have been drafted. The implementation of mental health programmes is hampered by inadequate staffing, inadequate resource allocation and the lack of mental health drugs at the health facilities.<sup>15</sup>

### **2.3 Coverage with other Health Determinants**

The critical health determinants affecting the health of the population relate to the following

- Sustainable population and high fertility
- Safe hygiene and sanitation
- Gender norms
- Education
- Housing and Urbanization

<sup>15</sup>AHSPR. (2009).



Key Ministries relating to health are illustrated in the table below.

**Table 2.1: Health related Ministries**

No.	Health related sector	Role of health related sector
1.	Ministry of Finance, Planning and Economic Development	<ul style="list-style-type: none"> <li>- Mobilization of resources</li> <li>- Rational allocation of resource to different sectors according to government priorities</li> </ul>
2.	Minister of Lands, Water and Environment	<ul style="list-style-type: none"> <li>- Mapping availability of water sources for all health facilities.</li> <li>- Development of water sources (drilling bore holes, provision of piped water in urban areas, protection of springs, water for production – valley dams, rain water harvesting)</li> <li>- Provision of sanitation services in rural growth centres &amp; urban areas and communal toilets.</li> <li>- Control and enforce sustainable use of the environment (EIA, avoid pollution, ensure sustainability use of wetlands)</li> <li>- Support communities to plant trees (forestation)</li> </ul>
3.	Ministry of Agriculture, Animal Industry and Fisheries	<ul style="list-style-type: none"> <li>- Production of food – (both plant and animal sources of food)</li> <li>- Preservation and storage of food items (food security)</li> </ul>
4.	Ministry of Gender, Labour and Social Development	<ul style="list-style-type: none"> <li>- Community mobilization for health promotion</li> <li>- Mainstreaming gender in plans and activities of all sectors including engendering the budget.</li> <li>- Advocacy and prevention of gender based violence</li> <li>- Develop policies for social protection of the vulnerable groups</li> </ul>
5.	Ministry of Works, Housing and Communication	<ul style="list-style-type: none"> <li>- Setting and enforcing standards for buildings</li> <li>- Construction and maintenance of roads for accessing to health facilities to facilitate access and referral of patients</li> <li>- Establishment of communication network to facilitate communication (e-governance, telemedicine, telephone, radio call)</li> </ul>
5.	Ministry of Education and Sports	<ul style="list-style-type: none"> <li>- Education of the population to read, write and interpret information for healthy life styles, e.g. education of the women very critical for improving the maternal and child health.</li> <li>- School Health Education Program</li> <li>- Training of health workers</li> <li>- Research and Development</li> </ul>
6.	Ministry of Public Service	<ul style="list-style-type: none"> <li>- Maintenance of payroll of civil servants (health workers inclusive)</li> <li>- Provide hard-to-reach allowances</li> <li>- Ensure entry on to the payroll of new recruits</li> </ul>
7.	Ministry of Local Government/ District Local Governments	<ul style="list-style-type: none"> <li>- Recruitment, deployment and retention of health workers (PHC and general hospital) at district level</li> <li>- Delivery of health services</li> <li>- Supervision and monitoring of health service delivery</li> </ul>
8.	Ministry of Trade and Industry	<ul style="list-style-type: none"> <li>- Setting and enforcing standards for manufactured and imported goods e.g. enforcing salt iodination</li> </ul>

Each Ministry will therefore have to play its role in order to address social and economic determinants of health.

### 2.3.1 Population and fertility

The country is still faced with a high population growth rate. In addition, the fertility rates have consistently remained high, recorded at 6.9 in 1995 and 6.5 in 2006<sup>16</sup>. If the current population growth rate of 3.2% continues unabated, it is expected that the population size will double by the year 2032. This makes delivery of

<sup>16</sup>UBOS. (2006). *Uganda demographic and health survey*. Kampala.

services more difficult, as there are significantly more people to provide services to, and increasing population density makes spread of some conditions more favourable.

### **2.3.2 Safe hygiene and sanitation**

Achieving acceptable safe hygiene and sanitation remains a challenge for Uganda with a significant proportion of the population of up to 32.5% with no latrines. The Sanitation MDG target of 72 % has been achieved by 40 % of the districts, with 25 % on course to meet the goal. According to the 2006 UDHS, 77% of the population has access to safe water. Addressing social determinants of health will help improve the health status of the people of Uganda. Continued security, economic growth and stability are assumed necessary conditions for the successful implementation of the NDP, NHP II and the HSSIP.

### **2.3.3 Gender norms and relations**

Decision making ability is an important determinant of health care seeking behaviour and in contexts where decisions are made by men this may delay or deny seeking appropriate health care. Gender norms, roles and relations also have other effects on the incidence and ability to adequately respond to ill health. It is important that the gender dimensions of the incidence and also response (including the organization and delivery of health services) to ill health be considered and addressed in policies and programmes not only to enhance the effectiveness of policies and interventions, but also to ensure that unintended discrimination is avoided and the “right to health” of the various members of the population is realized.

In most cases married women may not be able to make decisions on their own regarding how resources in the home can be spent. The UDHS shows that about 55 percent of the women mainly decide by themselves how their earnings are to be spent, 32% report that they make the decision jointly with their husband/partner while 13 percent report that the decision is mainly made by their husband/partner. There are variations in the proportion of women who make independent decisions about their earnings ranging from 24% in Eastern region to 79% in Kampala. This shows that women in urban areas are more likely to make independent decisions compared to those in rural areas.

### **2.3.4 Education**

The 2006 DHS shows that level of education attained constitutes one of the major determinants of health; e.g. prevalence of diarrhoea, ARIs and fever among under-five children decreases the higher the educational level of the mother. In order to increase access to education the GoU introduced Universal Primary Education (UPE) programme in 1997 to offer free education at the primary level while Universal Secondary Education (USE) was introduced in 2007. Since the introduction of UPE, enrolment in primary schools in Uganda increased to 7.6 million in 2005/06 compared to 3 million in 1997.

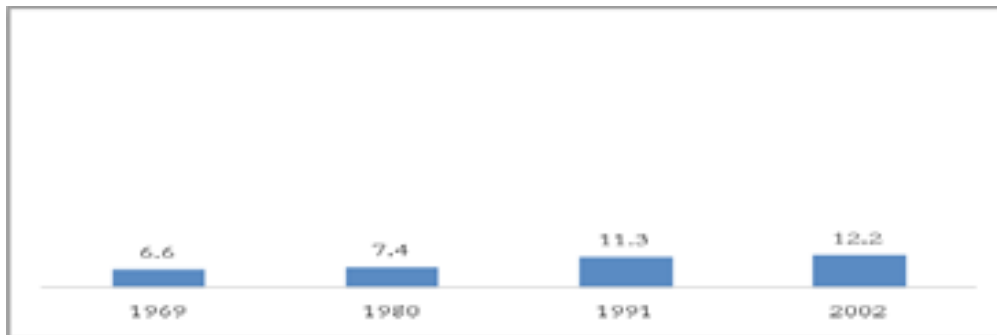
The literacy level among women is quite low at 56.1% among those aged 15-49 compared to men at 82.8%. The situation in rural areas is worse: the literacy rate among women aged 15-49 in rural areas is 51.5% compared to 81.5% in urban areas. Improving access to education especially for girls will help to improve on the health impact.

Although the net enrolment ratio in primary education is high and virtually the same for girls as boys (approx. 82%), the literacy rate among 15-24 year old girls (58%) is substantially lower than among boys (70%) and ensuring that children remain in school is a major challenge as the school dropout rate is high: only 49% reach Grade 5. This difference in literacy levels between males and females is also seen in other age categories, resulting in an overall literacy rate among males of 76% compared to females at 63%; it is also higher among urban residents at 86% compared to rural residents at 66%. In 2005/06, Northern Uganda had the lowest literacy rates at 59%.

### **2.3.5 Housing and Urbanisation**

Uganda is also experiencing rapid urbanization within the context of widespread poverty and the failure of local authorities to effectively provide social services. The figure below shows the proportion of Uganda’s population in urban areas:

Figure 2.6: Trends in urbanization in Uganda, 1969 – 2002 (source UBOS 2002)



Source: UBOS 2002

The proportion of Ugandans living in urban areas almost doubled between 1969 and 2002. The UN Habitat estimates that currently 15% of Uganda's population live in urban areas. In terms of absolute figures in 1,966 634,952 people lived in urban areas in 1,969 and this increased to nearly 3 million in 2002. The UN Habitat estimates that at a rate of urban growth of 5.1% per annum Uganda's population will increase to 68.4 million in 2035 and 30% of these will live in urban areas. This will have serious implications on demand for land, housing, water, health, education and other basic services.

Most of the settlements in Uganda towns have sprung up without proper planning and development controls. Due to their informal status urban authorities have ignored them in the provision of basic services such as water, refuse collection, electricity and sewerage disposal<sup>17</sup>. The remarkable economic growth over the last decade as well as political stability have led to the expansion of existing urban centres especially Kampala. According to the MoLG, there are several consequences of urbanisation. They include proliferation of slums, haphazard developments, increased crime, traffic congestion, increased poverty, unemployment, poor solid waste management, environmental degradation and pollution. The growth of urban areas for example Kampala exceeds the ability of the city administration to provide the needed infrastructure to combat pollution and reduce the incidence of diseases related to the environment<sup>18</sup>.

### 2.3.6 Changing lifestyles, and climate change

Uganda is experiencing important changes in disease patterns. For example, NCDs are an emerging problem and their increase is due to multiple factors such as adoption of unhealthy lifestyles, increasing aging population and metabolic side effects resulting from lifelong antiretroviral treatment. The treatment of NCDs is very expensive and if they are not effectively prevented they will constitute a major expenditure in Uganda's health budget.

In addition to NCDs, Uganda has also experienced the negative consequences of climate change on the health of the people of Uganda for example floods in Eastern Uganda in 2007 resulted in a humanitarian crisis. Higher temperatures and rainfall associated with El Nino may increase transmission of malaria leading to epidemics in highland areas in Uganda. Prolonged drought may lead to food insecurity and malnutrition, further predisposing populations to illnesses. Better systems for weather forecasting, disease surveillance and public health planning offer some protection for the affected populations. Given the current situation, there is a need to emphasise mitigation of adverse effects of climate change and ensuring the implementation of interventions that will control the spread of NCDs.

### 2.3.7 Food and nutrition

According to the Constitution, the state shall encourage and promote nutrition through mass education and other appropriate means in order to build a healthy state. The Constitution mandates the MoH and the Ministry of Agriculture to set minimum standards to ensure quality and develop relevant policies in the area of food and nutrition. Following this mandate, the Uganda Food and Nutrition Policy (UFNP) has been developed which provides a framework through which minimum standards, strategies and guidelines have

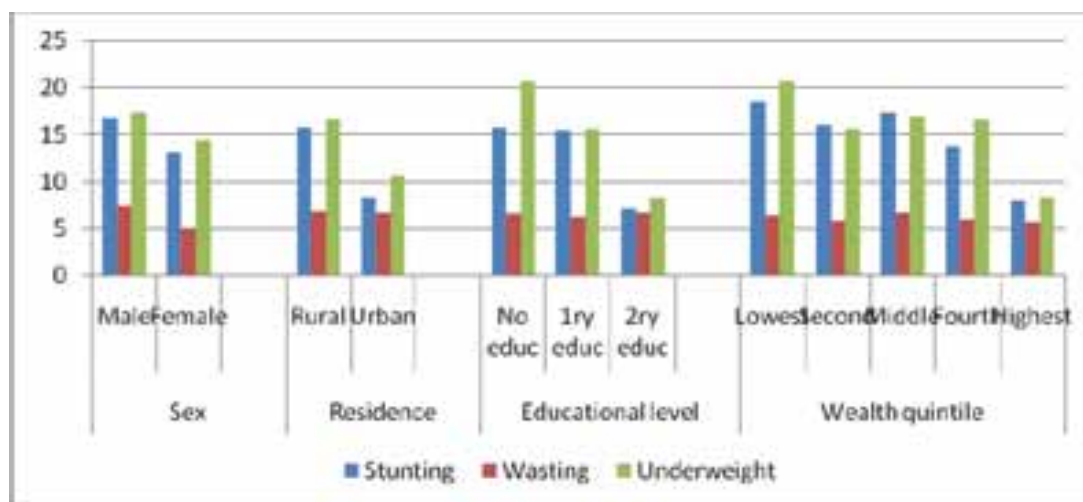
<sup>17</sup> UN Habitat. (2008). *Country programme document 2008-2009: Uganda*. Nairobi: UN Habitat.

<sup>18</sup> Mukwaya, P.I. (2004). *Urban change in Uganda: The challenge of managing urban areas in a global environment*. Paper for the College of Urban Planning and Public Affairs (CUPPA) conference at the University of Illinois Chicago USA 22-24 July 2004.

been developed by the relevant ministries. The UFNP provides for the establishment of the National Food and Nutrition Council which will have the responsibility of coordinating food and nutrition activities in Uganda<sup>19</sup>.

Adequate nutrition has internationally been recognized as one of the key factors in human development and economic productivity. The previous three UDHSs show high levels of child and maternal under nutrition that have persisted over the past 15 years. According to the 2006 UDHS, 38% of children under five in Uganda are stunted, 16% are underweight and 6% are wasted. The figure below shows the prevalence of stunting, wasting and underweight among under-five children in Uganda:

**Figure 2.7: Status of malnutrition among under-five children in Uganda**



Source: UDHS 2006

According to UDHS 2006 male children are more likely to be stunted, wasted or underweight compared to female children and that malnutrition is less likely to be a problem among mothers with secondary school level of education and wealthy households. The UDHS further shows that prevalence of malnutrition is highest in South West, North, West Nile and Central compared to other regions with Kampala having the lowest. Between 2001 and 2006, there was a reduction in underweight and stunting among under-five children from 23% to 16% and 41% to 39%, respectively. Between 2004 and 2009, Vitamin A supplementation uptake increased from 60% to 69.5% and household salt iodisation was maintained at around 96%; 49% of women, 27.8% of the men aged 15-49 and 73% of children aged under 5 years were anaemic. Twenty percent of the children and twenty percent of the women are vitamin A deficient<sup>20</sup>. While the target for the HSSP II was that the prevalence of exclusive breastfeeding should reach 80%, it actually dropped from 70% in 2004/05 to 61% in 2008/09. 80% of the children under-five receive complementary foods which is often not adequate in terms of quality and quantity<sup>21</sup>. The Infant and Young Child Feeding policy guidelines have since been finalised, printed and disseminated. The ready-to-use Therapeutic Feeds (RUTF) have been introduced to manage acute uncomplicated malnutrition at community and facility levels. The food fortification programme is also underway with companies to participate in the programme already identified.

Although food and food supplements are the primary medicines used in promotive nutrition, prevention and therapeutic treatment of acute malnutrition, therapeutic products are not included in essential drug packages. Anthropometric and other pieces of equipment for managing and monitoring nutrition programmes are also found in very few health facilities. The low prioritization and commitment for nutrition in the health sector in the past has led to inadequate resource allocation, both financial and human (especially nutritionists and dieticians) to implement nutrition interventions at all levels. There is now increasing recognition for nutrition as reflected in the NHP II and NDP. The causes of malnutrition are multi-dimensional including poor feeding practices emanating from lack of knowledge and shortage of food; hence it requires an integrated approach involving line Ministries including MoH, MAAIF, MoES, MTTI, MoJCA, Universities, NGOs and CBOs.

<sup>19</sup>Ministry of Health. (2003). *The Uganda Food and Nutrition Policy*. Kampala

<sup>20</sup>UBOS. (2006). *Uganda Demographic and Health Survey*. Kampala

<sup>21</sup>AHSPR. (2009).

## 2.4 Management systems

Management systems relate to the processes that the sector institutes, to translate its inputs / investments into desired outputs. These are processes of

- Planning, Supervision, monitoring and evaluation
- Health Information, research, and evidence generation
- Management of health inputs, which include
  - o Human Resources Management,
  - o Infrastructure maintenance processes
  - o Commodity and Supply management
- Procurement, and Financial Management systems
- Partnership, and sector governance

### 2.4.1 Planning, supervision, monitoring and evaluation (M&E)

The HSSP II spells out the systems for supervision, monitoring and evaluation of the health sector. There are three levels of supervision: (i) at the central level including central level institutions, (ii) local governments, and (iii) hospitals and lower level health units. The HSSP II recommended having quarterly Area Team (AT) reports, quarterly District Health Teams (DHTs) supervision reports, technical and support programme specific reports and HSD monthly supervision reports. The responsibilities of each level are clearly spelt out<sup>22</sup>. During the implementation of the HSSP I the AT supervision approach was adopted. ATs consist of officials from various departments in the MoH and other central and regional institutions and they have responsibility to provide integrated technical support and supervision to a group of districts. DHTs and HSDs supervise service delivery at government and PNFP facilities at different levels, except the national and RRHs. In addition to this, there are also clinical specialists outreach programmes from NRH and RRH to district and lower level facilities. TMC and SMC supervise central level institutions while the QAD ensures availability of standards and guidelines. The Yellow Star Programme (YSP), started in 2001, has been introduced in 54 districts and aims at strengthening supervision of lower level health units by districts but there are issues of sustainability that have to be addressed.

While systems for supervision, monitoring and evaluation exist, there are enormous challenges. AT visits have been irregular due to late release of funds, insufficient funds and inadequate transport arrangements. They have also been ineffective due to insufficient feedback to the districts. Also for other supervision and monitoring visits, transport was often inadequate. In general, there is also a lack of supervision skills at all levels of the system. The implementation of the YSP is irregular and supervision of community programmes is limited<sup>23</sup>. The MTR of HSSP II points out that the supervision mechanism for community health programmes is less well known except in districts which have active VHTs. The envisaged joint supervision with PNFP partners is yet to be implemented and efforts at national level to organize and support clinical supervision of RRHs by NRHs and general hospitals by RRH clinicians have been limited. In general, technical supervision is weak and this has affected quality of service delivery. The Professional Councils are expected to inspect all facilities.

The Annual Health Sector Performance Reports (AHSPRs) produced annually since 2000 detail annual health sector performance and form the basis for discussions during the National Health Assembly. These annual reports are verified by the Joint Review Missions (JRM) during field visits. HPAC is expected to discuss quarterly performance reports and performance of agreed upon undertakings. The operations of the HMIS are affected

<sup>22</sup>HSSP II (2005).

<sup>23</sup>Ministry of Health. (2008). *Review of the supervision mechanisms in the health sector*

by inadequate human and financial resources as well as excessive volumes of data collection that may not be relevant to the different levels of care and programme. Timeliness of reporting is currently estimated at 68%. The existence of parallel data collection systems for vertical programs such as HIV/AIDS puts a strain on HRH. Data analysis and utilisation for planning purposes is low and the private sector's contribution to the HMIS is modest. The capacity of the HMIS is still inadequate. Some nutrition data is being collected within the HMIS however this data is insufficient and systems need strengthening for reporting and action based on that data. The 2007/08 Auditor General's report also observes that there is poor reporting by districts, HSDs and HCs on their performance to higher levels and even where they report it is not timely.

#### **2.4.2 Health Information, research and evidence generation**

The MTR of HSSP II noted that a lot of research is conducted in Uganda. The results of these studies are supposed to inform decision making hence contribute to improving delivery of and access to health care and nutrition services. Several institutions conduct health and nutrition research in Uganda e.g. universities, autonomous institutions and other public institutions with diverse affiliations and districts. The Uganda National Health Research organisation (UNHRO) is the Secretariat for health and related research in Uganda and its Bill was passed by Parliament in 2009 and assented to and approved by the President (UNHRO Act 2009). The Act gives the UNHRO the mandate to coordinate health research activities. UNHRO will provide guidance to ensure that research data is disaggregated by sex, residence and wealth quintile among other variables. A gender analysis of the research findings will also be helpful in terms of contributing to development of policies and interventions. There is a drive by the MoH to set up Health Economics and Systems Institute which will boost the link between health systems research and policy.

The conduct of research by various organisations in Uganda has so far been hampered by the lack of a policy framework, an uncoordinated priority setting of the research agenda, inadequate funding, shortage of human resource and inadequate logistics. As a result, research has mainly been donor driven. Other challenges include the translation of research findings into policy and the dissemination of results. There are no regular meetings of researchers and policy makers to turn research findings into policy. There is lack of a national database for research done hence rendering it difficult to access.

#### **2.4.3 Financial management, and procurement in the health sector**

In the past five years, Procurement and Disposal Plans have been developed as required, and the procurement process is improving with additional recruitment and capacity building in the Procurement Unit of MoH. Nevertheless, challenges remain:

- Procurement processes remain long and protracted thus causing undue delays and affecting the entire procurement and supply chain.
- Implementation of a Sector-wide Procurement Plan has not been consistent resulting into periodic emergency procurements to address issues of stock outs of essential medicines and health supplies

#### **2.4.4 Management of Health inputs**

##### ***Health infrastructure investments***

The 2008/09 annual health sector performance report records that only 40% of available equipment were in good condition and about 17% needed replacement. Rehabilitation of buildings and maintenance of medical equipment is not regularly done. Nutrition units which were attached to health units are functioning with limited essential equipment. Accommodation for staff remains a big challenge and is a major reason for low staff numbers, especially in hard to reach areas. ICT remains a challenge with prevalence among health facilities being at 6.4% mostly comprising of mobile phone, radio, TV and computers to a smaller extent.

The MoH developed the National Health Infrastructure Development and Maintenance Plan in 2002 to

harmonise planning, development and maintenance of health infrastructure. The plan is outdated and cannot address the health needs of modern Uganda; hence the need for a new infrastructure development strategic plan. The National Medical Equipment Policy and Guidelines are currently being revised. Despite the existence of an Essential Medical Equipment list, problems exist relating to procurement delays and the lack of funds. Inadequate staffing to effectively manage maintenance of infrastructure and allocation of inadequate funds for maintenance of infrastructure and equipment hamper the rehabilitation and maintenance of equipment and infrastructure.

### ***Human resource management and development***

Although significant steps have been taken in the development of the HRH Policy and Strategic Plan 2005-2010, HRH development, deployment and utilization are still not rigorously directed in a sustainable manner, neither at national nor district level. Overall 40% of the HRH are working for the private sector, and there is no clear policy and guidelines to coordinate and optimise their use.

In terms of training, emphasis for most curricula of health workers is on curative care. Despite the PNFP subsector producing the majority of PHC staff, recognition and inclusion of the PNFPs in national and district level decision-making fora for health training under MoES remains limited. Training of medical doctors and other health staff is governed by several institutions (MoH, MoES, PNFP training institutions, Professional Councils), with weak coordination mechanisms. There is lack of a functional integrated HRH Information System (HRIS) able to generate up to date information for HRH planning and management.

The sector still faces insufficient training capacity, low remuneration and poor working conditions in the public and PNFP sectors, making it difficult for the sector to recruit and retain staff. The process of recruitment is complex, lengthy and involves several stakeholders. The lack of coordination and joint planning between the training schools, MoH and the Health Service Commission causes long delays between completion of training and absorption into the workforce. As a result of weak planning and coordination, some interventions fall short of addressing the HRH challenges. For example the position for nutritionists was created by the Health Services Commission in 2002 at only RRH level, and yet this cadre is needed at General Hospitals and HCIVs. In-service training and capacity building interventions are also poorly coordinated thus affecting quality service delivery.

In the public sector, productivity is low due to high rates of absenteeism and rampant dualism. A recent study of the MoH, MoFPED and the World Bank estimates the cost of absenteeism at UGX 26 bn annually. Absenteeism is the single largest waste factor in the public health sector in the country<sup>24</sup>. The poor attitude of health workers to clients affects utilisation of services. Leadership and management of human resources are also weak at all levels.

### ***Medicines and other health supplies***

The National Drug Policy, operationalised through the Uganda Pharmaceutical Sector Strategic Plan, aims at ensuring the availability and accessibility at all times of adequate quantities of affordable, efficacious, safe and good quality essential medicines and health supplies to all who need them. This is a basic requirement for the delivery of the UNMHCP. Public sector national medicines procurement is mainly through National Medical Stores (NMS), a parastatal organization, while the Joint Medical Stores (JMS) is the major PNFP sector supplier for medicines and health supplies. The National Drug Authority (NDA) is responsible for regulating the pharmaceutical market, licensing premises, drug information, pharmacovigilance, quality assurance, import permissions and disposal of expired medicines but has a limited capacity with insufficient outreach.

Over the period of implementing HSSP II, all efforts were geared to improving availability of medicines. Absolute funding for medicines has increased. Training of health care workers of all levels of care was done. Support was provided to NMS and JMS to improve their business processes, management information systems and enterprise resource plans. Storage capacity at NMS and JMS was significantly expanded. A tool or framework to support integration of EMHS inputs and harmonise procurement was developed. The plan to operationalise

<sup>24</sup>World Bank, MoH, MoFPED; 2009, Fiscal Space for Health in Uganda

the NDP was reviewed and the second NPSSP developed. A tool to guide interventions to promote rational use of medicines was developed. Mechanisms to integrate EMHS resources in form of a dedicated Essential Medicines Account were put in place. Support was provided to build institutional capacity of NDA. A modern school of pharmacy at Makerere University was constructed and equipped to address the acute shortage of pharmaceutical human resources. Pharmacy Section was upgraded to a Division (with four persons instead of 1) at the MoH Headquarters. The operationalization of medicines and therapeutic committees is ongoing in hospitals and HSDs. Tools for promoting rational use of medicines like the Essential Medicines List and the Uganda clinical guidelines were updated and are available in more than 90% of facilities.

The private sector is poorly regulated and comprises of hospitals and clinics, retail pharmacies and both legal and illegal drug stores. Irrational use of medicines is widespread due to prescribing and dispensing by untrained or insufficiently trained personnel. Despite increased capacity to train pharmacists and dispensers, output is still insufficient to meet demands from both the public and private sectors.

There is an emerging pharmaceutical industry in the country, with a limited production far below their installed capacity. As a result about 90% of all medicines are imported; and close to 95% of these are generic products. The challenge of counterfeit products on the market is becoming an increasing problem which needs to be urgently addressed.

With regard to laboratory services, the Central Public Health Laboratories has the responsibility of coordinating health laboratory services in Uganda, developing policies and guidelines and training and implementing quality assurance schemes for laboratories. A comprehensive National Health Laboratory services policy was developed and this provides a framework for the future development of laboratory services in the country. The provision of good laboratory services laboratory support for disease surveillance is affected by low levels of funding for laboratory services, a weak regulatory framework and the limited number of laboratory professionals in the country.

#### **2.4.5 Partnership, and sector governance**

The Health Sector defined a clear mechanism for bringing together health sector partners, to ensure coordinated implementation. A good working relationship continues to exist with the HDPs, other government ministries and the communities. As a result, a number of successes have been attained:

- A number of health sector reforms were successfully implemented during this period including sustaining of the Sector Wide Approach in health (SWAp). The sustained functioning of structures such as HPAC, Health Sector Budget Working Group (HSBWG), the National Health Assembly (NHA), TRM and JRM are all aimed at ensuring the effective delivery of the UNMHCP.
- Decentralization of the delivery of health services in Uganda, with more focus on enabling communities to participate in health planning and management, especially in those areas where the VHTs have been trained and are fully functional.
- Continued development of a clear strategic direction for the sector through health strategic plans, policies and guidelines are available and are reviewed periodically as need arises. These are informed by international agreements such as the RBM, the Stop TB Strategy and Global TB Plan (community DOTS) among others.
- The MoH and stakeholders have also defined a set of health services that should be delivered at each level of health care. In the context of a limited resource envelope, the sector strategic plans define a minimum health care package that should be delivered to all Ugandans and the indicators and targets in the health sector have since been aligned with the NDP and the MDGs.

However, in spite of the above successes, a number of challenges still exist.

- There is still limited implementation of sectoral policies and strategies and weak enforcement of existing legislation. While health sector policies and strategic plans exist, implementation is a major challenge. The lack of implementation and enforcement might be due to the critical shortage of HRH, inadequate funding to the health sector making it difficult to effectively deliver the UNMHCP; and train, recruit, deploy and maintain and adequately motivate health care workers.
- While the number of health facilities has increased significantly over the years, nearly a third of the people in Uganda still live more than 5 kilometres from the nearest health facility; and the referral system



is weak and this, combined with staff shortage and lack of medicines, forces many Ugandans to seek treatment from TCMPs.

- Even though the private sector provides a significant proportion of health care the partnership with MoH is rather weak especially at district and lower levels due to lack of coordination and representative body for the sub-sectors. Since the National Policy on PPPH has not yet been approved, there is no institutional framework for the public private partnership.
- While a SWAp mechanism has been established in Uganda and is relatively functioning well and most donors have aligned their support to SWAp, there still exist some HPDs who resist such a funding arrangement and this is a threat to successful implementation of the HSSIP.
- Resistance to change or adapting to new ideas e.g. the development of an effective partnership with the private sector is hampered by the resistance from some sector of the GoU as a reliable means to increase access to health services.

## **2.5 Financing of Health Services**

The Public financial management in Uganda is supported by the constitution, legislations, regulations, instructions, procedures and standards. The key legislations and standards include:

- The Constitution 1995
- The Budget Act 2001
- The Public finance and accountability Act 2003
- Local Government Finance Act 2007
- Public Finance and Accountability regulations 2005
- Treasury Accounting instructions 2003
- Local Government Act 2007
- Local Government financial and accounting regulations 2007
- Public Procurement and Disposal of Assets Act 2003
- The National Audit Act 2008
- International Public Sector Accounting standards

Treasury Accounting Instructions 2003 cover offers guidance on Appointment of Accounting Officers, Payments, Procurements under Commitment Control System, Advances to staff, Opening and Closing bank accounts, Treatment of losses, fraud and thefts, Accounting basis for donor-funded projects, Stores and Record of Assets under the Accounting Officer.

### **2.5.1 Overall financing, and financial management**

#### ***Planning and Budgeting.***

The approach of the Government of Uganda (GoU) to national planning has evolved over the last decade, with reforms of the country's public expenditure management resulting in new institutional arrangements for planning and budgeting, which include: SWAps, the medium-term expenditure framework (MTEF), the Poverty Action Fund (PAF), the fiscal decentralization process and the National Development Plan (NDP). The NDP provides a national medium-term planning framework. The budget process is characterized by relative transparency and openness and broad participation. Important components of this process are the Budget Framework Papers (BFPs), which are prepared at the national, sectoral and local government levels. They are three-year rolling frameworks used to streamline and guide the budget process, setting out planned outputs and their associated expenditures in the medium term.

#### ***Off budget funding***

Development assistance continues to play a major role in financing health services but a bigger proportion of

this is off- Budget. There is high expenditure of donor funding for off-budget activities. MOH has information on general budget support and project support to the Health sector but not sufficient information on off-budget support. According to MoFPED 2009 report, In FY 2008/09, off budget funding constituted USD \$440 m, while the overall health budget stood at US \$628 m<sup>25</sup>.

Ministry of Health has had a challenge tracking donor off-budget support. Programming of off-budget support is not harmonised and may or may not be directed towards health sector priorities. Reports from about 7 HDPs in FY 2008/09 indicated that about UGX 64.5 bn was provided as off-budget support to the health sector. Most of the funds from partners are directed towards the three disease areas; HIV/AIDS, TB, and Malaria.

**Table 2.2: Health sector DP expenditure for FY 2008/09-2009/10**

	Name of Development Partner	Project support to health sector for FY 2008/09 in Million USD		Project support to health sector for FY 2009/10 in Million USD	
		On Budget	Off Budget	On Budget	Off Budget
1	DANIDA	12.50	5.85	9.92	7.61
2	Sweden	1.95	2.16	1.35	2.10
3	Germany	2.72	2.43	1.19	3.75
4	World Food Programme	9.30	-	-	-
5	African Development Bank	20.16	-	15.75	-
6	Ireland	0.54	2.60	0.54	3.2
7	JAPAN	4.03	-	-	-
8	Belgium	-	-	1.76	-
9	Italy	-	2.30	2.16	4.46
10	European Union	-	2.81	-	1.54
11	UNICEF	1.10	-	0.88	-
12	UNFPA	1.10	-	0.88	-
13	WHO	8.50	-	6.72	-
14	World Bank (IDA)	-	-	4.80	-
15	DFID	0.45	5.05	0.36	6.03
16	USAID	-	152.9	-	147.99
17	Austria	-	0.1	-	-
18	PEPFAR	-	255.0	-	285
19	Norway	-	0.58	-	-
20	GAVI	22.00	-	18.00	-
21	GFATM	89.98	-	71.99	-
22	Netherlands	1.77	-	-	-
	GRAND TOTAL	176.12	440.25	136.30	463.55

Source; MoFPED Budget Speeches FY 2008/09-2010/11.

### Challenges in Budgeting

- Resources for curative and preventive medicines are still inadequate.
- Remuneration of health workers is still very low and has not created sufficient motivation to attract qualified health workers to work in hard to reach areas.
- Investments for basic infrastructure have not met the need for quality service provision in the health facilities.
- Increased alignment of Donor funds through Budget support may reduce the level of engagement between MOH and donors on resource allocation in the Health sector .Most discussions on funding health sector by HDP may occur between Ministry of Finance, Planning and Economic Development and the Donors.
- Growth of essential medicines budget is not in line with the increasing needs for medicines of the population.
- Only a PHC Non wage budgetary allocation in the sector is based on clear rationale (formula) leaving out capital development allocation which is based on needs assessment.

<sup>25</sup> MoFPED Budget Speech FY 2008/09-2010/11.

### 2.5.1 Health financing Mechanisms

This section provides a review of HSSP I and HSSP II Health financing mechanisms, in line with set objectives.

#### (a) Sources of health financing and trends in financing to the health sector

Households constitute a major source of health financing (50%) followed by donors (35%) and then government (15%). Households spend about 9% of their household consumption expenditure on health<sup>26</sup>. The private sector charge user fees and patients pay under-the counter fees in public institutions. Recent studies show that not less than 65% of all ACTs are actually paid for. Catastrophic health expenditure actually increased from 8% to 28% between 1996 and 2006, despite the elimination of user fees in 2001. Private health insurance, which is largely subsidized by employers on behalf of employees, is for a few. The establishment of the National Health Insurance Scheme as a health financing mechanism, which is in advanced planning stages, will gradually attempt to address the above issues.

In recent years, government's expenditure to health as a percentage of total government expenditure has fluctuated between 8.3% and 9.7% (see Table below). The HSSP II target of allocating 13.2% of the GoU budget on health by 2009/10 was not achieved.

**Table 2.3: Health financing trends over HSSPI and HSSPII (2000/01-2009/010) funding (nominal terms)**

Year	GoU Funding	Donor Projects and GHIs	Total	Per capita public health exp (UGX)	Per capita public health exp (US \$)	GoU health expenditure as % of total government expenditure
2000/01	124.23	114.77	239.00	10,349	5.9	7.5
2001/02	169.79	144.07	313.86	13,128	7.5	8.9
2002/03	195.96	141.96	337.92	13,654	7.3	9.4
2003/04	207.80	175.27	383.07	14,969	7.7	9.6
2004/05	219.56	146.74	366.30	13,843	8.0	9.7
2005/06	229.86	268.38	498.24	26,935	14.8	8.9
2006/07	242.63	139.23	381.86	13,518	7.8	9.3
2007/08	277.36	141.12	418.48	14,275	8.4	9.0
2008/09	375.46	253.00	628.46	20,810	10.4	8.3
2009/10*	435.8	301.80	737.60	24,423	11.1	9.6

Source; PER 2006, and AHSPR 2008/09. \*Provisional Budget outturn 2009/10

The table above shows the trends in public (GoU and donor projects in MTEF) health expenditure during HSSP I and II in nominal terms. It is evident that overall funding to the health sector from both the GoU and donors has been increasing. In general funding to the health sector is inadequate. The estimated per capita cost was US\$41.2 in 2008/09 and will increase to US\$47.9 in 2011/12<sup>27</sup> yet the health budget according to the MTEF was estimated at US\$12.5 per capita in 2008/09, demonstrating a shortfall of almost US\$29. Some development partners namely DANIDA, SIDA, DfID, the EU and Belgium channel the majority of their development assistance through budget support and in addition fund some projects. Others such as the GFTAM, GAVI, WHO, UNICEF, UNFPA and USAID channel funds through projects. USAID assistance remains outside the MTEF. GAVI and Global Fund resources are captured on-plan and uses government systems.

Over the period 2005/06 to 2006/07, on-budget and off budget external funding increased from UGX507 bn to UGX540 bn, respectively. During the same period external funding within MTEF decreased from UGX 269 billion to UGX189 billion while that outside the MTEF increased from UGX238 billion to UGX351 billion. This has created challenges of unpredictability and continues to be a big constraint to comprehensive planning and prioritisation at both national and district levels. The 2006 PER highlighted challenges with off-budget development assistance as; poor alignment resulting in expenditure on inputs not included in the HSSP; and delayed reporting<sup>28</sup>.

<sup>26</sup>World Bank, MOH, MoFPED, Fiscal space for Health in Uganda 2010.

<sup>27</sup>HLSP Africa Limited. (2008). *Development of the minimum service standards in Uganda's health sector*. Kampala: Ministry of Health.

<sup>28</sup> MoH, Public Expenditure Review, 2007, 2004/05 – 2006/07

### 2.5.3 Financial reporting;

Health institutions (Public and Private not for profit) receiving public funding prepare monthly and quarterly and annual financial reports and statements in accordance with the existing government rules and regulations.

The Accounting officers of health institutions are responsible for the following:

- Maintaining efficient and transparent system of financial management and internal controls
- Ensuring use of financial and other resources for the purpose for which they are voted
- Managing and controlling commitments and expenditures within the approved budgets

Introduction of the Output Budgeting Tool (OBT) and the requirement of accounting officers to enter into performance contracts in order to deliver agreed upon outputs has been a milestone in improving the planning and budgeting process, particularly linking work plans and procurement plans to the cash flow. This will address delays in procurement, low absorptive capacity issues and timely reporting

There is still a major challenge with reporting at the districts level. This is manifested in delays in reporting and sometimes submission of poor quality reports. Several factors account for the delays i.e., lack of commitment, weak capacity and poor attitude towards work. This situation usually creates serious challenges for the decentralised Health service delivery since releases are tied to timely submission of performance reports on quarterly basis.

#### *Integrated Financial Management System (IFMS).*

GoU introduced IFMS, a computerised financial management system to promote efficiency, secure management of financial data and comprehensive financial reporting. IFMS is currently operational in central MoH, Regional Hospitals and some Local Governments. An IFMS is a fiscal and financial management information system for government that bundles all financial management functions into one suite of applications, it assists the government and MoH to initiate, spend and monitor the budget, initiate and process payments and manage and report on financial activities.

It is a core component of financial management systems reforms which promotes efficiency, security of financial data, management and comprehensive financial reporting. The IFMS system has significantly revitalised the budgeting and accounting system on which to undertake public sector accounting and financial management. In MoH the IFMS has greatly;

- Increased the ability to undertake central control and monitoring of receipts and expenditure
- Provided up to date and online information on the cash position, financial and operational performance
- Tightened internal control to prevent and detect potential fraud
- Facilitated cost management of group of activities and tasks
- Improved the monitoring and evaluation systems especially for financial reporting
- Enhanced the ability to demonstrate accountability to the public and development partners.

#### **Challenges of the IFMS**

- The system is not rolled out to all Government public health facilities
- Limited access by vote controllers to the system and limitations in terms of tools
- Extending the IFMS system to all public health facilities
- Occasional systems unavailability
- Dealing with un-budgeted contingencies.

Ideally, realization of the full benefits of the IFMS, hinges on ensuring that all transactions are captured on real-time basis. Extension of the IFMS system has therefore been a major point of focus. However, in cases where the User departments are geographically dispersed e.g. health facilities, the MoFPED is faced with the prospect of substantially increased costs for the communication and information infrastructure required. In such cases, the MoFPED have had to opt for a manual data transmittal as a stop-gap measure

**External Auditing:**

The functions of the auditor general are:

- a) To audit and report on all public accounts of Uganda Government and Projects co funded by GOU and Donors.
- b) To conduct financial, value for money and other audits such as gender and environmental audits.
- c) To audit classified expenditure
- d) Audit all government investments
- e) Carry out procurement audits and assessment of the soundness of the financial management systems.
- f) Audit treasury memoranda

The auditing of all GoU funds and Donor support funds is done in accordance with GOU procedures and regulations as stipulated in the Public Finance Act and more specifically the National Audit Act 2008, as well as other donor specific procedures. Financial Audits are conducted annually and Value for money audits and the other types of audit may be conducted any time.

In the audit report of FY 2008/09 for the health sector, out of the 17 health institutions audited 9 had unqualified opinions<sup>29</sup> and 8 qualified- except for opinions. There has been a significant increase in unqualified reports during the HSSP II period for Local Governments from FY 2007/08. Though there has been improvements in the final audit reports and in giving relevant information to auditors, Major observations and cross cutting issues arising from the audits included;

- delays in preparation of comprehensive procurement plans and non compliance to some procurement regulations,
- lack of proper guidelines for prioritisation and standardisation of the infrastructural developments undertaken in Local Governments and regional referral Hospitals,
- It was observed that there has been minimal progress in curbing accumulation of domestic arrears,
- board of surveys are very weak,
- There are poor drug storage facilities and untimely disposal of expired medical drugs.
- During the period it was noted that there is lack of clarity regarding the responsibility of valuation of government properties
- Some donor funds experienced shortfalls in GOU counterpart funding
- Expiry of slow moving drugs and Perpetual stock deficiency of essential drugs at health facilities

**Internal Audit.**

Scope: On regular basis, internal audit

- Identifies and evaluates significant exposures to risk and contribute to the improvement of risk management and control systems.
- Assist in maintaining effective controls by evaluating their effectiveness and efficiency. Assess and makes recommendations for improving the governance process in accomplishment of objectives.
- Conducts Value for Money audits on key activities to ensure that value (economy, efficiency, effectiveness) is obtained. Internal Auditors may need to be trained in value for money auditing to further improve on their performance.

**Independence of internal audit:**

- Internal audit reports to the Audit Committee of Health Sector on technical matters and administratively to the Accounting Officer.

<sup>29</sup>There are four kinds of opinion issued;

- Unqualified; is where the financial statements contain no material misstatements or errors.
- Qualified-except for; is where the financial statements contain material misstatements or errors but are not pervasive.
- Disclaimer; is where the financial statements contain material misstatements based on limitation of scope on the work of an Auditor to the extent that there is un certainty on the fairness and truthfulness of the financial statements and therefore the auditor is unable to give an opinion.
- Adverse; is where the financial statements contain material misstatements or errors and the Auditor has disagreed with management and as such concludes that the financial statements do not represent a true and fair position.

- Has a separate program for funding in the budget. This makes it easier for internal audit to have access to its funding.
- The purpose, authority and responsibility of internal Audit is formally defined in a charter, consistent with the Standards, national laws, rules and regulations.
- Internal Audit has adopted Standards for Professional Practice of Internal Auditing of Institute of Internal Auditors.

#### **Internal Controls:**

System of controls, financial, organisational structure and management control systems have been established to manage financial records, define responsibilities and reporting channels, manage budgetary controls, performance appraisals and review systems. Other control procedures such as accounting controls (approval and control of documents) and administrative controls (quality, performance indicators, performance statistics) have been put in place for purposes of risk management and internal controls.

The objectives of internal controls include;

- encouraging compliance with policies and procedures laid down by management
- safe guarding of assets
- prevention and detection of fraud
- accuracy and completeness of records
- Segregation of duties.
- Timely accountability
- Timely auditing

Limitations of internal controls included; delayed corrective action and lack of feedback information.

#### **Ensure effectiveness, efficiency and equity in resource allocation and utilisation.**

During the first three years of HSSP II, overall GoU budget performance (Releases vs. Budget) was well above 90% for wages and development grants and 100% for non-wage recurrent. The approved budget for PAF Programmes was 85% of the entire sector budget and actual releases were 84% of the entire sector releases. In 2006/07, 94.5% of the funds were reported to have been timely released against a target of 100%.<sup>30</sup>

##### ***2.5.3.1 Efficiency in Health financing***

Efficiency is currently not well addressed in the way resources are mobilized, allocated and used in the health sector. A recent study conducted by the World Bank, MoH and MoFPED<sup>31</sup> highlighted some efficiency challenges in the health sector in Uganda. The same study estimated the health sector loses at UGX 36.7 bn annually due to waste through health worker absenteeism, expired drugs and poor payroll management. The 2010 World Bank study further noted that significant fiscal space can be created by improving efficiency and effectiveness of health spending through: (i) improving management and performance of health workers; (ii) linking funding to results and avoiding resource wastage; revising the health financing strategy; and (iv) better programming and management of development assistance for health. During implementation of the HSSIP, the aim will be to improve the efficiency of health service delivery through health sector reforms, donor coordination in the spirit of the Paris Declaration on aid effectiveness and the Accra Agenda for Action which specifically mention emphasis on results, improved allocation of resources to the health sector and better reporting. The HSSIP will also aim at ensuring equity in delivering health care services. This is of particular importance given the human rights and gender concerns as mentioned in the NDP.

##### ***Allocation by administrative and service delivery level***

During the HSSP II period, 45-54% of the GoU budget allocations were directly disbursed to district health services with MoH headquarters getting 18-27% and other national level institutions getting between 2-3%. At district level 70-80% of the district funds were allocated to district PHC, 4-11% to district hospitals, and 0-7% to PNFP facilities as shown in the table below.

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<sup>30</sup> MoH, Health Sector Strategic Plan 2005/06-2009/10, Mid-Term Review Report, October 2008

<sup>31</sup> World Bank, MoH, MoFPED, 2010, Fiscal Space for Health in Uganda

**Table 2.4: Allocation of GoU funds by level of care 2005/06 – 2008/09**

	2005/06		2006/07		2007/08		2008/09	
	Bn UGX	%	Bn UGX	%	Bn UGX	%	Bn UGX	%
MOH Headquarters	41.23	18%	40.75	16%	64.69	24%	99.87	27%
Central hospitals	37.36	16%	36.51	14%	40.96	15%	52.61	14%
Others Agencies -1	6.11	3%	5.71	2%	5.87	2%	6.59	2%
Regional hospitals	21.27	9%	24.73	10%	25.75	10%	44.56	12%
District health services	123.9	54%	146.3	58%	131.6	49%	165.7	45%
District PHC - 2	96.83	42%	101.8	40%	106.1	39%	165.7	45%
PNFP – 3	16.69	7%	16.78	7%	15.93	6%	0	0%
District hospitals	10.37	5%	27.73	11%	9.61	4%	0	0%
<b>TOTAL</b>	<b>229.9</b>	<b>100%</b>	<b>254</b>	<b>100%</b>	<b>268.9</b>	<b>100%</b>	<b>369.3</b>	<b>100%</b>

Sources: MoH, AHSPRs.

It is evident that a substantial proportion of the MoH funds are transferred Districts and hospitals. These allocations are however inadequate to effectively deliver the minimum package and this is exacerbated by delays in financial disbursement to Districts and lower levels which further slows down delivery of services. During HSSIP financial allocations to the districts should be increased and correspondingly funds should be timely disbursed to districts.

### 2.5.3.2 Equity in financing of health care

Every Ugandan should access basic health services according to need irrespective of ability to pay or geographical location. According to the 2007 household survey, there remains a significant inequality in access to health care. These inequalities occur due to differences in socio-economic status and geographical location. Twenty eight percent (28%) of the households in Uganda are experiencing catastrophic payments. The incidence of catastrophic health<sup>32</sup> expenditure ranges from 24.8% in the richest quintile to 28.3% in the poorest quintile and between 23.4% in the eastern region and 38.1% in the western region<sup>33</sup>. In an effort to increase access to health care, GoU subsidizes PNFPs and its training institutions and a few private hospitals that should in turn reduce user fees. The reduction of user fees could further enable the poor to access services in PNFPs and PHCs.

### 2.5.3.3 Resource allocation

There are two levels of resource allocation, inter sectoral allocation of resources within the MTEF to all sectors is done by MoFPED based on the NDP, policy priorities and macroeconomic frameworks. Attempts are made to increase the discretionary powers of Local Governments in the allocation of resources through ensuring that all LG needs and priorities identified during the budget process feed back into the budget process at the national level.

Although funds allocated to the health sector have steadily increased from UGX 236 bn in FY 2006/07 to UGX 735 bn in FY 2009/10; these are not enough to fund the UNMHCP. An estimated UGX 1.5 Trillion is required annually to deliver the UNMHCP<sup>34</sup>. Whereas resources allocated to health have been increasing steadily, the public per capita expenditure has been fluctuating from USD 8.4 in FY 2007/08 to USD 10.4 in FY 2009/10. The government budget for health is allocated at the Central and Local Government levels. About 52 % of the health sector budget is decentralised. Most of the budget is used to fund preventive and curative care.

The MoH handles intra-sectoral allocation of resources within the health sector based on the resource allocation formulas. Among the key considerations in the RA allocation formula is ensuring financial risk protection of poor households and improving equity and efficiency in resource allocation and use. The resource allocation formula for PHC Non wage recurrent grant has most of the ingredients of needs based resource allocation formulae i.e. population size mortality indicators and number of live births in the district as a proxy for health

<sup>32</sup> Defined as health expenditures in excess of 10% of total household consumption.

<sup>33</sup> World Bank, MoH, MoFPED, 2010, Fiscal Space for Health in Uganda

<sup>34</sup> Commission for Macroeconomics and Health.

need<sup>35</sup>, a special and fixed allocation for hard to reach areas and, a basic amount allocated to all Districts for health service delivery.

A technical appraisal (Cost benefit Analysis) allocation criteria is largely used for huge capital infrastructure projects. Other PHC capital development grants is allocated based on a needs assessment, perceived health care needs, other funding sources and level of health infrastructure development. The wage component is allocated based on available health workers in a given district/facility/institution. One of the challenges in Health sector is inequitable distribution of available resources and obvious differences exist between districts and localities country wide in levels of per capita health expenditure.

### **Shortcomings of the resource allocation criteria.**

There are various shortcomings pertaining to the allocation of funds for health care both in terms of funding gaps to meet need and limitations in use and management of the funds allocated. Although the formula for PHC non-wage recurrent grant is based on some measure/indicator of socio-economic deprivation and factors related to the cost of service provision and other funding sources, factors such as hard-to-reach areas, border districts and levels of service delivery have not been taken as variables in the resource allocation criteria. Some of the factors in the resource allocation formula are not clearly defined and the weights attached to them not explicitly stated. For example; eventuality factors. By and large, there is no accurate needs based allocation formula. There is no rational allocation of capital development funds under PHC conditional grant. The concept of needs assessment and perceived health care needs normally offers technical guidance for allocation of capital development grants. However with infrastructure and services often poorly distributed this can mean significant inequity in the allocation of resources and in access to services. Other challenges include;

- Border districts have a higher population than that computed in the resource allocation formula.
- At hospital level, allocation premised on number of beds is a gross under estimate of the volume of services provided by hospitals.
- Allocation of resources between departments and programmes at central level MOH needs to be refined and formula developed and or refined.
- No guidelines on allocation of resources to hard-to-reach areas and for emergencies
- Infant mortality is included in the resource allocation formula as a main indicator of deprivation (and by implication the need for health care). However, given the poor vital registration systems, under/over reporting may be a problem, hence a true picture of the Districts deprivation may not be assessed.
- Lack of investment plans by most health sector institutions to guide allocation of capital development grants.
- Resource allocation is premised on physical health facilities. There are regions, like the Karamoja region that have devised mechanisms of reaching nomadic populations through use of mobile health centres, these are not carted for in the resource allocation.

### **Transparency and accountability in resource allocation and management**

There is a formula that is used to allocate resources in the sector and it takes into consideration the population size, infant mortality rate, poverty index and geographical location (such as border Districts, islands and mountainous terrain) when allocating resources within the health sector. The GoU provides subsidies to the PNFP Sector and allocation to NGO lower level units is based on the level of service delivery by a unit, Human poverty index of the District where the facility is based. These subsidies contribute 20% of the of service delivery in the PNFP Sector. The MoH, MoFPED and stakeholders will from time to time review this formula and ensure that resources are allocated according to priorities in the sector. In terms of financial management,

<sup>35</sup> Number of deaths in the District between birth and first birthday anniversary; Infant mortality rate of the District; Crude birth rate of the District; number of live births in the District



the health sector follows the Public Finance and Accounting regulations 2003 and Local Government Finance and Accounting Regulations 2007. These regulations are comprehensive to ensure that there is transparency and accountability in utilisation of public resources.

The PER for the period FY 2003/04-2005/06 showed that, at the district level, about 80% of funds reach the intended entities, with variations across districts and entities. PNFP facilities tended to receive the least proportion of their budgets. The PER also reported delays in the transfer of funds from District general fund accounts to the health sector accounts.

#### **2.5.4 Procurement in the health sector**

In the past five years, Procurement and Disposal Plans have been submitted as expected, and the procurement process is generally improving. Nevertheless, challenges remain:

- Weaknesses in procurement processes remains long especially for contracts requiring advice from stakeholders outside the health sector
- 'Sector-wide Procurement and Disposal Plan' in which all procurement is centrally coordinated by the MoH Procurement and Disposal Unit has been developed but the procedures are not closely enforced and or adhered to.

#### **2.5.5 Health Insurance**

Currently there are over 15 community based health insurance schemes in Uganda coordinated by an umbrella organisation Uganda Community Based Health Financing Association and overseen by MoH. Analysis shows that these schemes have yielded members and housing institutions to uphold solidarity as a principle and improve financial access to health care despite being beset by a number of challenges. On the other hand Private Commercial health insurance arrangements exist and together contribute less than 1% to the total health expenditure because of their coverage plans. With introduction of a Health Insurance Plan practical measures will be undertaken to guide future actions of these schemes in line with the overall health sector financing goal of efficiency and equity. The gradual introduction of the health insurance plan to provide universal health care will help reduce current inequalities in access to care and contribute to reduction of catastrophic health expenses that impoverish households.

#### **2.5.6 Trends in investments**

##### ***Health infrastructure investments***

The objective for the health infrastructure in the HSSP II was to ensure a network of functional, efficient and sustainable health infrastructure for effective health services delivery closer to the population.

The number of health facilities in the public sector and the PNFPs has been growing. The establishment of more facilities ensures that people access health services within 5 km of their residence: at the beginning of the HSSP I this was at 49% and it has since increased to 72% at the end of HSSP II against a target of 85%. The health facilities are being mapped to update the geographical access data.

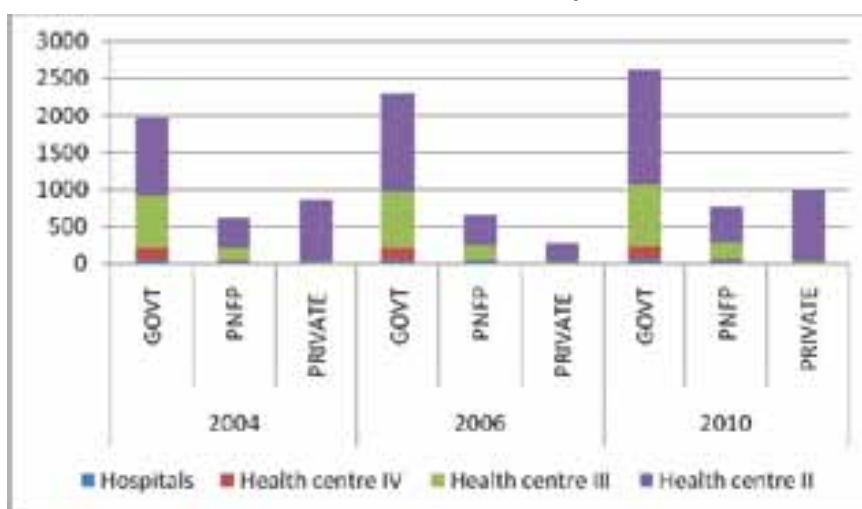
Over the period of the HSSP II some HC were upgraded to higher levels and this necessitated the construction of OPDs, theatres, maternity wards, staff houses as well as rehabilitating and equipping health centres. While this is the case, most facilities and equipment are in a state of disrepair. The 2008/09 annual health sector performance report says that only 40% of available equipments were in good condition and about 17% needed replacement.

Rehabilitation of buildings and maintenance of medical equipment is not regularly done. Nutrition units which were attached to health units are functioning with limited essential equipment. Accommodation for staff remains a big challenge and is a major reason for low staff numbers, especially in hard to reach areas. ICT remains a challenge with prevalence among health facilities being at 6.4% mostly comprising of mobile phone, radio, TV and computers to a smaller extent.

The existing infrastructure is therefore insufficient to ensure that the core functions of the health sector are

carried out. Infrastructure therefore needs to be refurbished.

**Figure 2.8: Trends in numbers of health facilities, by level of care and ownership**



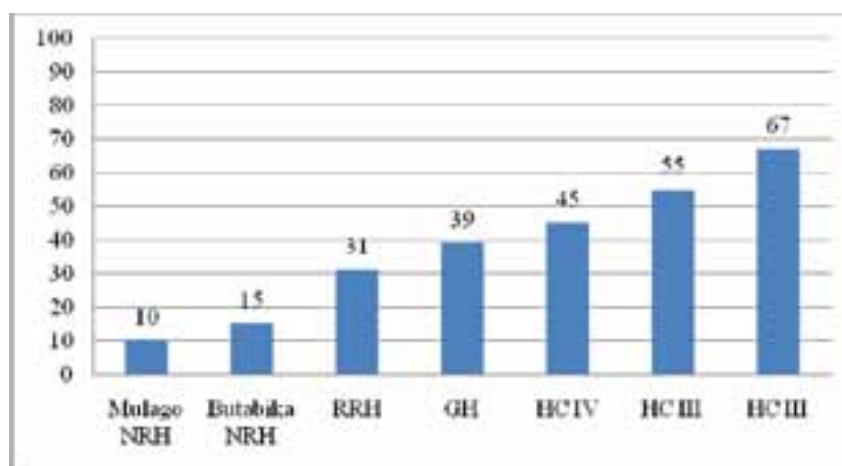
**Human resource availability**

Human Resources for Health (HRHs) remain in short supply, both in numbers and in skills mix, to effectively respond to the health needs in Uganda. The HIV/AIDS epidemic has increased demand on HRHs because of the special skills required for HIV/AIDS prevention and treatment. In addition many health workers have themselves being exposed to the disease.

The total number of health workers available in the country, including the PNFP sector, amount to about 40,000<sup>36</sup>. It is estimated that 22% of these categories of health workers in the health sector is currently contracted by the PNFP sector and 21% by the private sector. Overall 40% of the HRH are working for the private sector, and there is no clear policy and guidelines to coordinate and optimise their use.

The figure below shows the proportion of established posts filled at different levels of health care (HC II-NRHs). The majority of the vacancies in the public health sector are at HC II level at 67%. HC IIs are located in rural communities and the absence of staff impacts on population health seeking behaviour. Most of the vacancies for nurses are at HC II, III and IV (53%, 54% and 37%, respectively). In November 2008 to-date, only 51% of the approved positions at national level are filled<sup>37</sup>. For all levels of health care and all cadres the HRH situation is critical.

**Figure 2.9: Percentage of vacant positions in public health facilities (MoH, 2009)**



There is inequitable distribution of health workers among districts, between rural and urban areas and

<sup>36</sup>This is far below the recommended WHO minimum standard, which considers countries with less than 1 doctor, nurses or midwife per 439 people, in critical shortage of health workers.

<sup>37</sup>MoH (2009). Human Resources for Health Bi-annual Report. Kampala: Ministry of Health.

between public and private providers. Nearly 70% of medical doctors and dentists, 80% of pharmacists and 40% of nurses and midwives, are in urban areas serving 13% of the population<sup>38</sup>. Internal migration from rural to urban areas, from PNFP to public sector following increase in remuneration of civil servants and from public and PNFP sector to (government and non-government funded) health projects is often observed. External migration is prompted by poor working conditions and more attractive salaries in the region and abroad. For example the average monthly salary for a senior Nurse/Midwife is \$341 in Uganda compared to \$630 in Tanzania and \$1,384 in Kenya. This is of particular concern given the coming into force of the East African Common Market Protocol on 1 July 2010. The critical shortage of health workforce especially in locations where the poor live namely rural and underserved areas need to be urgently addressed within the context of human rights and gender equality and to better achieve targets of health outcomes.

### ***Medicines and other health supplies***

Availability of and access to medicines in Uganda continues to be a major problem. Only 30% of the EMHS required for the basic package are provided for in the national budget. Global Initiatives provide the bulk of resources needed for malaria, HIV/AIDS, tuberculosis, vaccines and reproductive health commodities e.g. in 2006/7 the contribution from the global initiatives was US\$2.39 per capita out of the US\$4.06 per capita spent on EMHS. The Medicines Credit Line budgets have stagnated while PHC grants for EMHS only slightly increased with low utilisation at approximately 55%. Delays in procurement, poor quantification by and late orders from facilities and poor records keeping are among the management issues that contribute to shortage and wastage of medicines in the public sector.

For many people, medicines in the private sector are not affordable and this constitutes a major obstacle to households accessing medicines<sup>39</sup>. Medicines are 3-5 times more expensive in the private sector compared to the public sector procurement costs.

Another study shows that only 45.7% of the public health facilities had key essential medicines; the situation was a bit better in mission facilities at 57.5% and private facilities at 56.3%. The length of stock-out duration in public health facilities is at 72.9 days compared to 7.6 days per year for the mission facilities. Mean availability of originator and generic medicines on the EML is at 3.5% and 45.7%, respectively<sup>40</sup>. A recent WHO review highlights the fact that women incur more out of pocket expenditure than men in many countries. One of the factors contributing to the increased spending may be women's specific health needs related to pregnancy, childbirth and contraception among others. The higher prevalence of a number of chronic diseases among women would also be a contributory factor. Paying for delivery care and other reproductive health services places a high financial burden on women. Out of pocket expenses may prevent more women than men from utilising essential health services<sup>41</sup>.

<sup>38</sup>UBOS. (2002). Uganda Population and Housing Census. Kampala: UBOS.

<sup>39</sup>MoH. (2008). *Access to and use of medicines by households in Uganda*. Kampala

<sup>40</sup>MoH. (2008). *Pharmaceutical situation assessment*. Kampala

<sup>41</sup>WHO. (2010). *Gender and Primary Health Care Renewal: a discussion paper, soon to be published*



### 3. EMERGING ISSUES & RECOMMENDATIONS

It remains imperative that the Health Sector, through its interventions, is able to address the critical health needs of the population in Uganda. The activities being carried out are all aimed at this. As highlighted in the previous chapter, the health impact sought is a function of the health services, together with risk factors to health, contextual factors, and other health determinants.

#### 3.1 Emerging issues

The roles of different determinants of health to this emerging picture are discussed in the proceeding sections.

- Firstly, the overall health of the persons in Uganda is still low. Health impact indicators show a low level of expectation of life, and a high level of mortality.
- Secondly, the indices suggest there is improvement in overall health, though at a very slow pace. All indices indicate positive improvements are occurring across all age groups. This suggests some interventions are having a positive impact on the available health stock in the country, albeit at a very slow pace.
- Third, there are significant disparities in the distribution of the available health stock. Some regions of the country, particularly in the northern regions, are having significantly lower levels of health as compared to other regions.
- Contextual factors appear to influence, particularly, the distribution of health stock seen. The worse the levels of poverty (multidimensional), the lower the health stock.

This picture is contributed to by issues relating to different services available, to address interventions impacting on health. These interventions are addressing health services, health determinants, or risk factors to health. Regarding health services,

- Strategic approaches to addressing the challenges in different intervention areas were agreed upon for most of the priorities in the UNMHCP. As a result, the direction towards addressing the different interventions is now better elaborated, suggestive of improvements in stewardship in addressing the different health services
- Improvements in coverage's for many interventions has stagnated. Some critical coverage's, such as skilled birth attendances, have actually reduced (40% to 35%). A number of reasons can be attributed to this
  - o Inadequate financial resources are made available, to enable adequate improvements in coverage.
  - o Implementation of many public health interventions is not comprehensively done to achieve the impact sought. Various system capacity gaps exist, limiting the translation of the interventions into actual improvements in coverage. This partly explains the reductions in coverage attained for some interventions.
  - o For some interventions, the methods of measuring of impact is affected by changes in numbers of administrative units, when these are used as denominators. The increased number of districts leads to dilution of achievements for these services, not just in measurement, but even in existing management capacity to coordinate intervention delivery.
  - o For achievement of impact, it is critical to understand the Human Resource, Infrastructure

(including equipment, transport, and ICT), commodities (& supplies) and operational financing (for management functions) investments required. The outputs sought, and the investments being made to achieve these outputs are not linked. Many programs only focus on the commodities, and management investments. Some programs are attempting to address all the investments vertically, leading to some improvements in coverage's. This is, however, not an efficient, or sustainable strategy.

- Management systems for health services appear to be comprehensively defined. Systems for planning, supervision, monitoring, and service management exist. However, their adequate utilization at the different levels of care is still weak. As a result, the quality of outputs from these management systems is not yet up to expectation.
- While extensive information is generated by the sector, there are still many weaknesses in overall information management. Information is generated on an adhoc basis, based on existing needs at the time. As a result, there are many critical areas of the sector with information gaps. Analysis of information is not carried out in a comprehensive manner, and communication of information is not tailored to the recipients of information – this is primarily left in reports, or scientific paper. The result of this is that information is not adequately guiding decision making in the sector, and the sector is not able to adequately communicate its progress to different stakeholders.
- Resources for health appear to improve in nominal terms, with year by year increases seen in Government, and donor resources. However, these increases are too small, to have a real increase in available resources. Even though per capita public health expenditure (Government and donor) shows increases in UGX, the exchange rate changes in the UGX are enough to erode any increases seen in financing for health, leading to a stagnation of per capita public health expenditure (when expressed in US\$, a currency with less devaluation). This is significant as a significant portion of health expenditure relies on importation (drugs and supplies). Government health expenditure as a % of General Government Expenditure, and the Total Health Expenditure as a % of GDP all have stagnated, suggesting no real increases in health expenditure.
- Some improvements in some of the health inputs is seen during the period of HSSP II, though this is largely nominal. Distribution of these improvements is also poor. Only financing for operations, and drug commodities are subject to an equitable resource allocation criterion. Other inputs are not subject to this.

Looking at other health determinants, on the other hand, there appears to be limited progress in addressing other health determinants in the country. Many of the required coverage's are still too low to significantly impact on health of the population. Strategies to manage population growth, improve safe water and sanitation, literacy, adequate housing, environmental management are still not achieving the levels of improvements needed to impact significantly on the health status. Nutrition levels are still rather poor in the country.

Finally, there appears to be little progress being made towards addressing the risk factors to health. Evidence of safer sexual practices exists, though due to interventions pre-dating the HSSP II. The impact of the health promotion activities targeting other risk factors is still weak. As a result, suboptimal breastfeeding, alcohol / tobacco use, high blood pressure, high blood glucose, zinc / iron deficiencies, and physical inactivity still remain major risk factors that are limiting the health impact.

### **3.2 Recommendations for HSSIP**

The stagnation of health impact being seen is expected, given the limited progress made in addressing the issues contributing to it. The progress in improvement of health services is limited in some areas of intervention. This should show improvements in overall health impact, which will however not be sustainable, and will be limited to population cohorts, and areas of the country where the interventions are targeted. For more sustained, and accelerated improvement in the health impact, it is important for the sector to strategically focus on the following issues:

1. **Put in place different strategies, to address the challenges to health in different parts of the country.** This is because the causes, and therefore expected focus is different for different parts of the country. Contextual factors, risk factors, health services and other health determinants all interact differently, to produce the health impact seen.
2. **A comprehensive approach to addressing health services is needed.** Focus only on a small set of interventions will not deliver the results required in a cost efficient, and sustainable manner. Investments made in health are not done by program, but rather by required inputs. These inputs are Human Resources. Infrastructure (including equipment transport and ICT), Medical Products, vaccines and technologies, and operational financing.
3. **A better understanding is needed of the investments needed to achieve the health outputs being sought.** This needs to be done in a sector wide manner, and not by program areas. Financing for health is guided by these investments.
4. **Scale up of health services should be prioritized.** The current situation, with limited improvement in health services should be reversed. Innovative strategies should be introduced to guide organization and management of health services that focuses on improving health outcomes
5. **A comprehensive knowledge management approach is needed in the sector.** This should guide a comprehensive look at information needs, analysis and use to better guide decision making for health. This will require definition of a comprehensive performance monitoring approach for the sector, which uses input, output, outcome and impact indicators to generate information for analysis and use.
6. **Achieving equity in health should be prioritised by the sector.** This calls for equity in allocation of all sector investments, including HR, equipment, facilities – not just drugs and operations. In addition, monitoring and follow up of sector achievements should be carried out with an equity perspective. Disparities in health are a reflection of the disparities seen in investments.
7. **A comprehensive Health Financing Strategy is needed.** This should guide the sector in looking at ways to improve the stagnating financing situation for health in the country. Innovative strategies are needed to make available resources from all the different sources of financing.
8. **Scale up sector coordination and partnership.** All factors impacting on health in the country should be engaged in addressing the health challenges. These include those actors addressing other health determinants. In addition, the partnership and coordination process needs to be strengthened at the sub national level.





# **SECTION 2:**

## **STRATEGIC DIRECTION**



## 4. STRATEGIC FRAMEWORK

The Health Sector focus during HSSIP is directly informed from the previous section, which defines the situation. It is designed to elaborate the approach the sector will take to address the challenges to promoting health to enhance socio economic development – the goal of the National Health Policy – in the Medium Term (2010/11 – 2014/15).

The HSSIP represents the Health Sector’s Medium Term plan, outlining its focus towards supporting attaining the objectives of the country’s National Development Plan. The HSSIP also is the Medium Term Plan guiding sector focus, towards attainment of the policy objectives as outlined in the National Health Policy. It’s strategic approach is therefore defined to respond to the imperatives outlined in these 2 documents, guided by the situation analysis for the HSSP II.

### 4.1 Review of strategic approach guiding HSSIP

#### 4.1.1 Review of the National Development Plan

The 2010/11 – 2014/15 National Development Plan represents the first 5 years of a strategy for the socio-economic transformation of Uganda to a modern and prosperous country from a peasant economy within 30 years. The plan addresses structural bottlenecks in the economy in order to accelerate socioeconomic transformation for prosperity. The development approach of the NDP intertwines economic growth and poverty eradication. This will be pursued in a quasi-market environment where the private sector will remain the engine of growth and development. The Government, in addition to undertaking the facilitating role through the provision of conducive policy, institutional and regulatory framework will also actively promote and encourage public-private partnerships in a rational manner.

The overall theme for the National Development Plan is ‘**Growth, Employment and Socio-Economic Transformation for Prosperity**’. Its stated objectives are:

- Increasing household incomes and promoting equity
- Enhancing the availability and quality of gainful employment
- Improving stock and quality of economic infrastructure
- Increasing access to quality social services
- Promoting science, technology, innovation and ICT to enhance competitiveness
- Enhancing human capital development
- Strengthening good governance, defence and security
- Promoting sustainable population and the use of environmental and natural resources

The NDP interventions aim at creating employment, raising average per capita income levels, improving the labour force distribution in line with sectoral GDP shares, raising country human development and gender equality indicators, and improving the country’s competitiveness to levels associated with middle income countries. Investment priorities will include: physical infrastructure development mainly in energy, railway, waterways and air transport; Human resources development in areas of education, skills development, health, water and sanitation; facilitating availability and access to critical production inputs especially in agriculture and industry; and promotion of science, technology and innovation.

The plan requires the sustained orientation of Government expenditures and implementation capacity towards removal of the most binding constraints to the faster socio-economic transformation. It calls for a

shake-up public sector services, tying civil servant contracts to performance and offering incentives for hard work.

The NDP recognises the health sector as an enabling sector – one whose activities should facilitate the attainment of the NDP initiatives. The NDP objectives it contributes to are:

- Objective 1: Increasing household incomes and promoting equity – through working to reduce catastrophic health expenditures by households
- Objective 3: Improving stock and quality of economic infrastructure – through construction, and rehabilitation work for health facilities
- Objective 4: Increasing access to quality social services – through improving delivery of health, and health related services
- Objective 5: Promoting science, technology, innovation and ICT to enhance competitiveness – through e-health, and other technologies for health
- Objective 6: Enhancing human capital development – through provision of health promotion, and disease prevention services that ensure people maintain their health
- Objective 7: Strengthening good governance, defence and security – through the transparency, and partnership mechanisms instituted in health
- Objective 8: Promoting sustainable population and the use of environmental and natural resources – through family planning interventions, and interventions promoting use of non-dirty fuels

#### **4.1.2 Review of the National Health Policy**

The 2<sup>nd</sup> National Health Policy, NHP II 2011 – 2020 focuses on promoting people health to enhance socio-economic development. It defines the Health Vision for the country as **‘Promoting people’s health to enhance socio – economic development’**

It aims to achieve this through focusing on provision of the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels.

This will lead to its stated goal, of attaining a good standard of health for all people in Uganda, in order to promote a healthy and productive life.

The policy objectives that the NHP will aim towards are:

1. Strengthening the organization and management of the national health systems
2. Improving access to quality hospital services at all levels in both public, and private sectors
3. Building a harmonized and coordinated national health information system with the resource centre as national custodian in order to generate data for decision making, programme development, resources allocation and management at all levels and among all stakeholders
4. Creating a culture in which health research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Uganda
5. Reviewing and developing relevant acts and regulations governing health in Uganda, and to ensure their enforcement
6. Ensuring adequate and appropriate HR for health service delivery
7. Increasing motivation, productivity, performance, integrity and ethical behaviour of HR through the development, and efficient utilization of the health workforce
8. Ensuring that essential, efficacious, safe, quality and affordable medicines are available, and used rationally at all times in Uganda

9. Providing, and maintaining functional, efficient safe, environmentally friendly and sustainable health infrastructure, including laboratories and waste management facilities
10. Mobilizing sufficient financial resources to fund the health sector programmes whilst ensuring equity, efficiency, transparency and mutual accountability
11. Effectively building and utilising the full potential of the public and private partnerships in Uganda's National Health Development, by encouraging and supporting participation in all aspects of the National Health Policy at all levels
12. Strengthening collaboration between the Health Sector, and other Government Ministries and departments, and various public and private institutions (universities, professional councils, etc) on health and health related issues
13. Implementing the National Health Policy and HSSP's within the Sector Wide Approach and IHP+ framework, through a single harmonized in country implementation effort, scaled up financial, technical and institutional support for health MDG's and ensuring mutual commitment and accountability
14. Ensuring communities, households and individuals are empowered to play their role and take responsibility for their own health and well being and to participate actively in the management of their local health services

## 4.2 Strategic framework for HSSIP

The HSSIP, therefore, is aligned towards supporting attainment of these sector, and Government wide strategic approaches, informed by the situation of the sector at the end of HSSP II. The strategic framework takes cognizance of the comprehensive set of services needed to impact on the health of the people in a manner to contribute to overall National Development, and the Health policy focus. The strategic framework recognizes the fact that the health goals are attained through actions on four critical areas

- The National Health System (NHS): All institutions, structures and actors whose primary purpose is to achieve, and sustain good health
- The actions on other health determinants: All the institutions, structures and actors not primarily meant to improve health, but have a bearing on health status. These include actions in Education (primarily female secondary education), water and sanitation, nutrition and food safety, proper housing, and environmental management
- Actions on risk factors to health: The personal, or community actions which have a bearing on the ability to achieve, or sustain health. These relate to a number of actions, such as safe sex, optimal breastfeeding, alcohol, and tobacco use, obesity and physical inactivity, and actions leading to high blood glucose high blood pressure, zinc / iron and other micronutrient deficiencies.
- Contextual factors, affecting the ability to utilize, or benefit from services provided. These factors relate to multidimensional poverty, and include income poverty, poor literacy, inadequate decision making capacity (mainly due to gender considerations), and insecurity

Improvement in the health goals is achieved through attaining adequate coverage for health services, services addressing health risk factors, and other health determinants – together with the capacity of the population to use these available services. This capacity is defined by the poverty – related contextual factors as defined above.

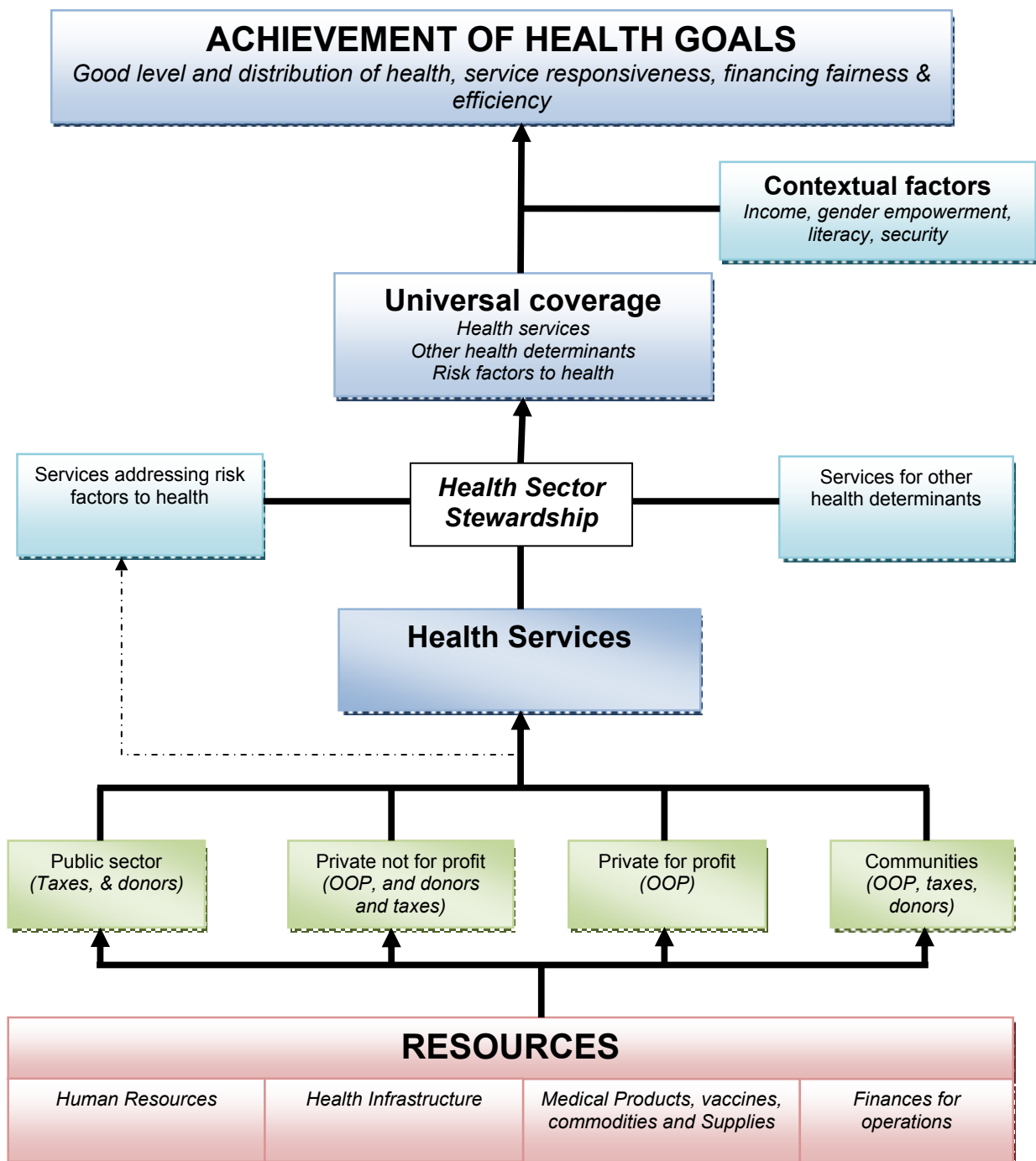
Universal coverage for the health services, other determinants and risk factors is attained through adequate stewardship by the Government of the delivery of interventions for health services (through the health system), other determinants and risk factors.

The delivery of Health Service interventions through the health system is financed through the public sector (Government taxes, and donor resources), PNFP (Government grants, and OOP), PFP (OOP), and communities (OOP, and some community initiatives). The resources are used in financing inputs needed for the delivery of services: Human Resources, Infrastructure (including ICT, transport, equipment), Medical Products (including vaccines, supplies and technologies), and operations.

The delivery of interventions addressing other health determinants and risk factors (Health Promotion activities) are primarily made outside the Health System. As these are not primarily meant to impact on health (rather to impact on other sectors), they are not considered Health Investments (decision to invest / not to invest is not primarily based on their contribution to health). However, some investments in risk factors are currently within the health system.

These different areas all interact as outlined in the framework overleaf, to give us the level of achievement of our health goals that we are getting.

**Figure 4.1: From Resources to Goals: Strategic framework for achieving Health**



### 4.3 HSSIP guiding principles

The HSSIP puts the client and community in the forefront and adopts a 'client centred' approach and it looks at both the supply and demand side of health care. The following principles, as detailed in the Uganda's Patients' Charter, the Constitution of the Republic of Uganda (1995 as amended) and international human rights standards that Uganda is party to, including the Universal Declaration on Human Rights, the International Covenant on Economic, Social and Cultural Rights, The Convention on the Elimination of All Forms of Discrimination Against Women, The Convention on the Rights of the Child, The Convention on the rights of Persons with Disabilities, the African Charter on Human and Peoples' Rights, The African Charter on the Rights and Welfare of the Child will guide the implementation of the HSSIP to progressively realize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

These principles are: equality and non-discrimination, participation and accountability and the right to health elements of availability, accessibility, acceptability and quality.

**Equality and non-discrimination:** All individuals are equal as human beings and by virtue of the inherent dignity of each human person. All human beings are entitled to their human rights without discrimination of any kind, such as race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status as explained by the human rights treaty bodies. This principle requires Government to address discrimination (intentional and non-intentional) in laws, policies and practices, including in the distribution and delivery of resources and health services.

**Participation:** Government will ensure means that people are entitled to participate in decisions that directly affect them, such as the design, implementation and monitoring of health interventions. Participation should be active, free and meaningful.

**Accountability** requires governments and other decision-makers to be transparent about processes and actions, and to justify their choices (answerability). Also, there should be mechanisms in place to address grievances when individuals and organizations fail to meet their obligations (redress). Judicial, administrative, political and policy mechanisms can be used to ensure accountability at different levels.

**Availability:** Ensure that public health and health care facilities, goods, services and programmes exist in sufficient quantity

**Accessibility:** Ensure non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility with regard to public health and health care facilities, goods, services and programmes

**Acceptability:** Ensure that public health and health care facilities, goods, services and programmes are respectful of medical ethics and culturally appropriate, sensitive to age and gender

**Quality:** Ensure that public health and health care facilities, goods, services and programmes are scientifically and medically appropriate

### 4.4 HSSIP social values

The implementation of the HSSIP shall be guided by the following principles:

**Evidence-based and forward looking:** The implementation of this National Health Sector Strategic Plan the HSSIP shall be evidence-based, forward looking and take into account emerging trends.

**Pro-poor and sustainability:** The HSSIP shall be pro-poor and shall provide a framework to support sustainable development. In order to address the burden of disease in a cost effective way. The GoU, PHNs and PFNPs shall provide services included in the UNMHCP with special attention to underserved parts of the country. GoU shall explore alternative, equitable and sustainable options for health financing and health service organisation targeting vulnerable groups.

**Partnerships:** Government considers partnership with other institutions, ministries, CSOs and the private

sector as a cornerstone of all its undertakings. With regard to service delivery, the private sector shall be seen as complimentary to the public sector in terms of increasing geographical access to health services and in terms of the scope and scale of services provided.

Efforts shall be strengthened toward joint planning, monitoring & evaluation between GoU and other institutions, ministries, CSOs and the private sector in an effort to strengthen accountability, participation and transparency.

**Primary Health Care:** PHC shall remain the major strategy for the delivery of health services in Uganda, based on the district health system, and recognising the role of hospitals as an essential part in a national health system.

Greater attention and support shall be given to health promotion, education, enforcement and prevention interventions as defined in the UNMHCP and empowerment of individuals and communities for a more active and meaningful participation in health development through VHTs and HUMCs.

**The Uganda National Minimum Health Care Package:** In order to address the burden of disease in a cost-effective way, public and private providers shall offer services that are included in the UNMHCP.

**Integrated health care delivery:** Curative, preventive, promotive and rehabilitative services shall be provided in an integrated manner.

**Gender-sensitive and responsive health care, policy formulation & programming:** A human rights and gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming human rights and gender analysis in planning and implementation of all health programs.

To facilitate and strengthen the evidence base for human rights and gender mainstreaming, efforts shall always be made to disaggregate health data by age and sex and gender analysis carried out on the results in order to enhance the effectiveness and efficiency of interventions & programmes.

Every effort to be made, when involving CSOs, to specifically include women-centred CSOs

**Mainstreaming of health into other sectoral policies:** Health shall be mainstreamed in all relevant policies and MoH, with its stewardship role on health issues, shall provide advice to other government ministries and departments and the private sector.

**Uganda in the international context:** In order to minimize health risks, the GoU shall play a pro-active role in initiating cross border initiatives in health and health-related issues.

The HSSIP shall follow the principles of the Paris Declaration and the Accra Agenda for action through the IHP+ in the interaction and collaboration with national and international development partners.

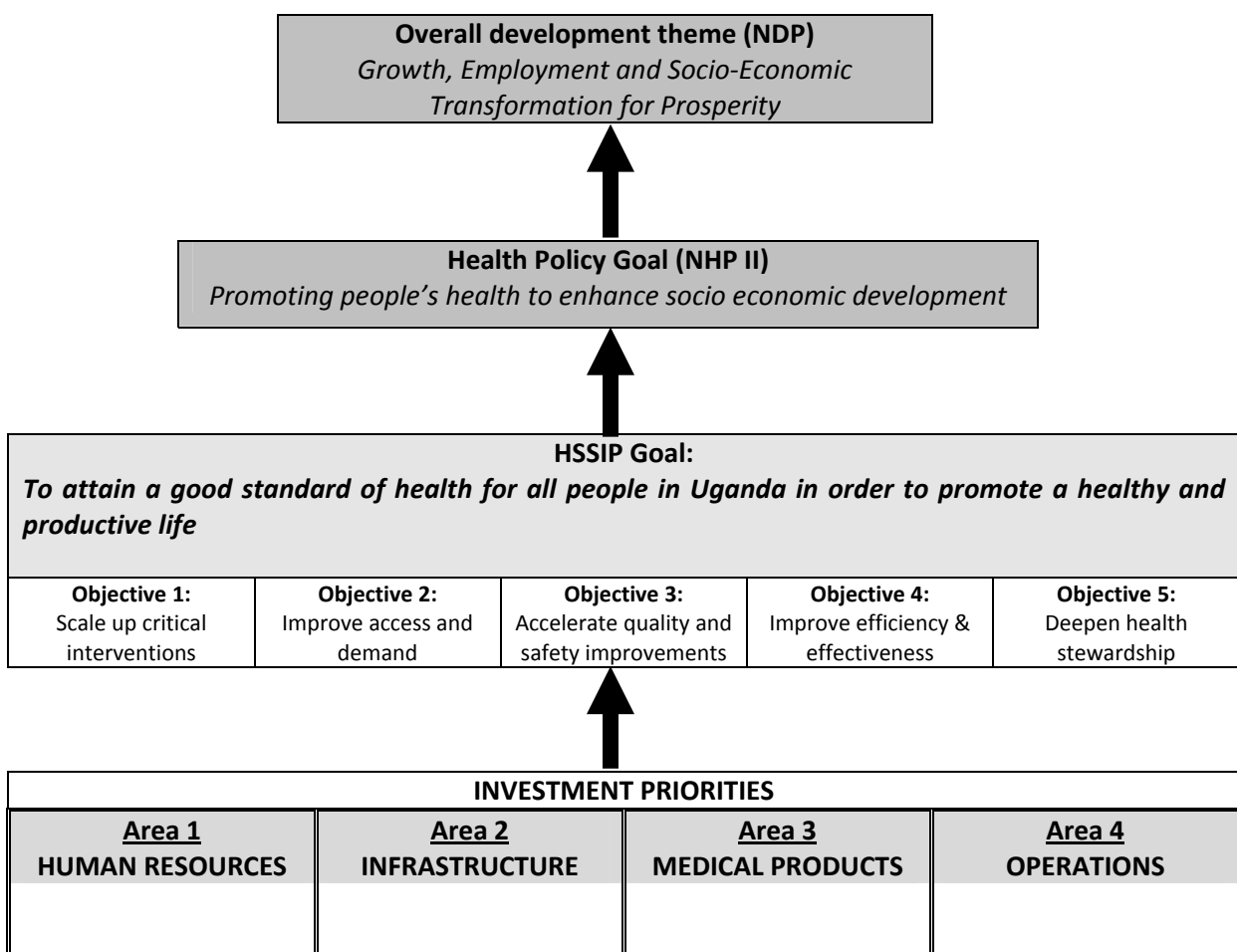
**Decentralisation:** Health services shall be delivered within the framework of decentralisation. However, the MoH will continue to advocate for re-centralization of some aspects of health services delivery, training and recruitment.



## 5. STRATEGIC FOCUS

**H**SSP III strategic focus is derived from the previous chapters. In this chapter, we define the goal, strategic objectives, and priorities that the Health Sector intends to focus on, to ensure implementation of the health agenda in 2010/11 – 2014/15. The conceptual framework for HSSIP is shown in the figure below.

Figure 5.1: HSSIP Conceptual Framework



## 5.1 HSSIP goal, and strategic objectives

The HSSIP goal – the Medium Term goal for the health sector – is defined, based on the NDP / NHP II expectations of the health sector, aligned to the current situation as outlined in the recommendations from the Health Situation Analysis earlier presented.

The overall goal for the Health Sector during HSSIP will therefore be

**To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life**

The goal, when achieved, shall lead to **acceleration** in the improvements in the level, and distribution of health in the country, as captured in the health impact indicators.

To achieve this goal, the health sector shall focus on achieving universal coverage with quality health, and health related services through addressing the following objectives.

1. Scale up **critical interventions** for health, and health related services , with emphasis on vulnerable populations
2. Improve the levels, and equity in **access and demand** to defined services needed for health
3. Accelerate **quality and safety** improvements for health and health services through implementation of identified interventions
4. Improve on the **efficiency**, and **effectiveness** of resource management for service delivery in the sector
5. Deepen **stewardship** of the health agenda, by the Ministry of Health

Universal coverage ensures the majority of persons targeted are receiving the provided interventions, with coverage at a level able to impact on overall health seen in the population in Uganda.

The relationship between the strategic objectives, the NHP and the emerging recommendations from the situation analysis is highlighted in the table below.

**Table 5.1: Rationale for defined strategic objectives**

Objectives	Situation analysis recommendation responding to	NHP policy objective responding to
1: Scale up critical interventions	REC 1: Strategies, to address the challenges to health in different parts of the country. REC 2: Comprehensive approach to addressing health services. REC 4: Scale up of health services REC 6: Achieving equity in health should be prioritised by the sector	NHP 14: Ensuring communities, households and individuals are empowered to play their role and take responsibility for their own health
2: Improve access & demand	REC 1: Put in place different strategies, to address the challenges to health in different parts of the country. REC 6: Achieving equity in health should be prioritised by the sector	NHP 2: Improving access to quality hospital services at all levels in both public, and private sectors NHP 6: Ensuring adequate and appropriate HR for health service delivery NHP 8: NHP 8: Ensuring that essential, efficacious, safe, quality and affordable medicines are available, and used rationally NHP 9: Providing, and maintaining functional, efficient safe, environmentally friendly and sustainable health infrastructure
3 Accelerate quality and safety improvements	REC 2: Comprehensive approach to addressing health services.	NHP 2: Improving access to quality hospital services at all levels in both public, and private sectors

<p>4: Improve efficiency and budget effectiveness</p>	<p>REC 3: Better understanding of investments needed to achieve the health outputs being sought. REC 7: A comprehensive Health Financing Strategy</p>	<p>NHP 7: Increasing motivation, productivity, performance, integrity and ethical behaviour of HR NHP 8: Ensuring that essential, efficacious, safe, quality and affordable medicines are available, and used rationally NHP 9: Providing, and maintaining functional, efficient safe, environmentally friendly and sustainable health infrastructure NHP 10: Mobilizing sufficient financial resources to fund the health sector programmes</p>
<p>5: Deepen health stewardship</p>	<p>REC 5: Comprehensive knowledge management approach is needed in the sector REC 8: Scale up sector coordination and partnership.</p>	<p>NHP 1: Strengthening the organization and management of the national health systems NHP 3: Building a harmonized and coordinated national health information system NHP 4: Creating a culture in which health research plays a significant role in guiding policy NHP 5: Reviewing and developing relevant acts and regulations governing health NHP 10: Mobilizing sufficient financial resources to fund the health sector programmes NHP 11: Effectively building and utilising the full potential of the public and private partnerships NHP 12: Strengthening collaboration between the Health Sector, and other Government Ministries and departments NHP 13: Implementing the National Health Policy and HSSP's within the Sector Wide Approach and IHP+ framework,</p>

## 5.2 Strategic Interventions

Within each Strategic objective, the priority deliverables strategies, interventions, targets and the implementation arrangements are defined.

### 5.2.1 Objective 1: Scale up critical interventions

The sector will work towards scaling up critical interventions that will impact on health.

Because of the limited resource envelope available for the health sector the NHP II recommends that a minimum health care package be delivered to all people in Uganda. This package should consist of the most cost-effective priority health care interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector. The package as defined in the NHP II consists of the following clusters:

- (i) Health Promotion, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response;
- (ii) Maternal and Child Health;
- (iii) Prevention, Management and Control of Communicable Diseases; and
- (iv) Prevention, Management and Control of Non-Communicable Diseases.

The composition of the package shall be revisited periodically depending on changes in disease burden, availability of new interventions to address these conditions, changes in the cost-effectiveness of interventions and the total resource envelope available for service delivery and shall be based on available evidence. Greater attention shall be paid to ensure equitable access to the minimum package including affirmative action for underserved areas, vulnerable populations and continuum of care.

The package, in HSSIP, will focus on implementing the priorities outlined in the table below.

**Table 5.2: Intervention areas for services in the HSSIP**

Service cluster	Intervention areas
Cluster 1: Health Promotion, Environmental Health, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response	Promote individual and community responsibility for better health
	Contribute to the attainment of a significant reduction of morbidity and mortality due to environmental health and unhygienic practices and other environmental health related conditions.
	Reduce morbidity and mortality due to diarrhoeal diseases
	Improve the health status of the school children, their families and teachers and to inculcate appropriate health seeking behaviour among this population.
	Ensure equitable access by people in PRDP districts [in conflict and post-conflict situations] to Health Services
	Prevent, detect, and promptly respond to health emergencies and other diseases of public health importance.
	Scale up delivery of nutrition services
Cluster 2: Prevention, Management and Control of Communicable Diseases	Prevent STI/HIV/TB transmission and mitigation of the medical and personal effects of the epidemic.
	Reduce the morbidity, mortality and transmission of tuberculosis.
	Sustain the elimination of leprosy in all the districts.
	Reduce the morbidity and mortality rate due to malaria in all age groups.
	Maintain the Guinea Worm free status of the country through maintenance of high quality post-certification surveillance.
	Eradicate onchocerciasis and its vector in all endemic districts in Uganda
	Achieve the global target for the elimination of trachoma.
	Reduce, and ultimately interrupt transmission of the disease in all endemic communities through the use of chemotherapy with Ivermectin and albendazole.
	Eliminate sleeping sickness as a public health problem in Uganda.
	Reduce morbidity caused by the worms by decreasing the worm burden among communities
Reduce morbidity and mortality due to Leishmaniasis among the endemic communities	
Reduce morbidity and mortality due to endemic, emerging and re-emerging zoonotic diseases	
Cluster 3: Prevention, Management and Control of Non-Communicable Diseases	Prevent Type 1 and Type 2 diabetes and reduce morbidity and mortality attributable to diabetes and its complications.
	Prevent cardiovascular and related diseases and reduce morbidity and mortality attributable to CVDs
	Establish a national framework for cancer control with emphasis on cancer prevention
	Prevent chronic respiratory diseases and reduce morbidity and mortality attributable to COPD and asthma
	Reduce the morbidity and mortality associated with sick cell disease.
	Decrease the morbidity and mortality due to injuries, common emergencies and disabilities from visual, hearing and age-related impairments.
	Ensure increased access to primary and referral services for mental health, prevention and management of substance abuse problems, psychosocial disorders and common neurological disorders such as epilepsy.
	Improve the oral health of the people of Uganda by promoting oral health and preventing, appropriately treating, monitoring and evaluating oral diseases.
Improve the quality of life of terminally ill patients and their families especially the home carers	
Cluster 4: Maternal and Child Health	Reduce mortality and morbidity relating to sexual and reproductive health & rights
	Improve newborn health and survival by increasing coverage of high impact evidence based interventions, in order to accelerate the attainment of MDG 4.
	Scale up and sustain high, effective coverage of a priority package of cost-effective child survival interventions in order to reduce under five mortality.
	Prevent morbidity and mortality due to gender based violence.

The implementation of the minimum package in the HSSP II was limited by inadequate resources, both human as well as financial, at all levels of health care.

To achieve this strategic objective,

- Priority shall be given to interventions proven effective against diseases targeted for control, elimination or eradication, and in conjunction with the private sectors provide in an integrated manner, promotive, preventative, curative and rehabilitative services that have been proven effective, cost effective and affordable.
- Ensuring that all people in Uganda, both users and providers of health services, understand their health rights and responsibilities through implementation of comprehensive and gender sensitive advocacy, communication and social mobilisation programs.
- Improving people's awareness about health and related issues in order to bring about desired changes in knowledge, attitudes, practices and behaviours regarding the prevention and control of major health and nutrition problems in Uganda. In order to achieve this, government will promote the use of social marketing and establish a clear marketing plan that will be pro-active in targeting groups with the greatest need and use varying media according to the target audience.
- Strengthening responsible self-care, especially at primary care level, for selected health problems and patient categories through carefully planned and evaluated- pilot phases.
- Strengthening community health services.
- Prevention, management and control of communicable diseases.

The specific issues, objectives, strategies, interventions, targets and the implementation arrangements for each of the clusters are now elaborated.

### **Cluster 1: Health promotion, environmental health and community health initiatives**

There are 4 elements of the health promotion and disease prevention cluster namely: HPE, environmental health, school health and epidemic and disaster prevention, preparedness and response. As a result, there are four priorities defined, one for each of the elements.

#### **5.2.1.1 *Promote individual and community responsibility for better health***

Prevailing cultural beliefs, attitudes and practices constitute some of the major determinants of health seeking behaviour in most African countries. Uganda is no exception with 60% of the people seeking care from TCMPs before resorting to modern health facilities. People might be ignorant about the aetiology of disease and how to prevent ill health. HPE helps to address these issues and should therefore be a component of all health programmes as it promotes behavioural change.

The major thrust in health promotion and disease prevention has been the establishment of VHTs at community level to facilitate creation of awareness, community participation and delivery of efficient and effective health interventions at community level. In addition to VHTs, during the HSSP II the MoH worked with the media available in all districts to disseminate health messages to promote behaviour change. As of November 2009 31% out of the districts had functional VHTs. Inadequate funding has led to delayed implementation of the VHT strategy. At district level there is also inadequate capacity for planning and implementation of HPE activities mainly due to shortage of health educators. While demand for information has been created at community level, the need for IEC materials is not being met because of the lack of funding.

During HSSIP these shortfalls shall be addressed through mobilisation of adequate resources for rolling out the VHT strategy to all districts in Uganda. The MoH and other stakeholders will continue working with the media. In this period the MoH will also work with universities to train health educators in order to address the shortage of these professionals in both the public and private sectors. The training of health educators is necessary because the number of districts has increased and the training institutions cannot match the

demand. Currently half of the districts have health educators while most of the new ones only have one or none. The MoH will also revitalise the health education printing unit and funds mobilised for dissemination of messages on the FM radio stations.

### **Strategies and interventions**

- *Strengthen IEC initiatives to bring about changes in health and related behaviours among people in Uganda.*
  - Provide leadership in setting standards and guidelines for the production and delivery of IEC messages among institutions that are responsible for such activities.
  - Develop and disseminate IEC messages on health issues through VHTs, print and electronic media.
  - Liaise with Department of Human Resource Development and Institutions of Higher Learning to build capacity for health education and promotion and provide incentives for HRH to take up the training.
- *Roll out the VHT strategy in all districts in Uganda.*
  - Complete the establishment and training of VHTs in all the districts in Uganda.
  - Provide adequate tools (e.g. registers, IEC materials) to make the VHTs operational.
  - Provide the necessary incentives to VHTs as detailed in the NHP II.
  - Pool resources from programs for the common functions of VHT which cut across programs.
- *Initiate and implement advocacy programmes to influence provision of effective preventive health services.*
  - Promote the development and enforcement of byelaws by district local governments in conjunction with other line ministries..
- *Strengthen intersectoral linkages for health promotion.*
  - Identify and exploit the potential, existing in other sectors such as gender, education, water and environment.

### **Indicators with targets**

- Standards and guidelines (including criteria for gender sensitivity) for the production and delivery of IEC messages developed and disseminated among institutions by 2011/2012.
- The proportion of districts with trained VHTs increased from 31% to 100% by 2014/2015.
- The proportion of health facilities with IEC materials maintained at 100%.

### **Implementation arrangements**

At the national level, the Division of Health Promotion and Education at the MoH headquarters will take the lead and stewardship role in implementing HPE programmes. The Division will:

- In conjunction with the private sector, CSOs and other relevant Government agencies develop and review a strategic plan for HPE and related activities.
- Collaborate with specific technical programmes in the review/development of policy, overall coordination and guidance on HPE activities countrywide and it will also provide technical support and supervision to DHS including the CSOs and the private sector.
- Liaise with other Government agencies and NGOs to establish and review standards and regulations pertaining to HPE and monitor and supervise activities.

At district level the District Health Office shall be responsible for planning, management, monitoring

and coordinating IEC activities and will work with all agencies including the District Information Office, community development officers, private health institutions, religious and cultural institutions and civil society organisations. Operational plans will also be developed for HPE with the leadership of the DHO. At health centre level HPE activities will be carried out by available health professionals and VHTs and this will be based on need and health problems most prevalent at household and community level. The effective implementation of this component of the health promotion and disease prevention cluster will depend on effective coordination and a multisectoral approach to programming of HPE activities.

**5.2.1.2 *Contribute to the attainment of a significant reduction of morbidity and mortality due to environmental health and unhygienic practices and other environmental health related conditions.***

Environmental factors such as availability of safe water, pit latrines and safe disposal of waste facilities are major determinants of health outcomes. The Health Promotion, Environmental Health and Community Initiatives Cluster therefore focuses on improving the above environmental health factors. Poor hygiene and other environmental health factors which are often linked to disease and poverty are the major causes of ill health in Uganda. The 2006 UDHS shows that 59% of the households have pit latrines; 77% have access to safe water sources; 75% live in houses made of temporary materials; and 14% of persons wash hands with soap. Only 25% of the districts are implementing water quality surveillance. There are a number of factors that are responsible for this situation: inadequate allocation of resources for environmental health activities; inadequate human resource; high levels of poverty; and inadequate facilitation especially transport. Climate change which is related to global warming has significant impact on human health, environment and health service delivery. The increase in temperatures has an influence on the geographical range of diseases e.g malaria and diarrhoeal related illnesses. Climate patterns such as El Nino result into flooding which exacerbates the spread of waterborne diseases like cholera, typhoid and dysentery. Uganda has experienced some of these impacts of climate change; hence the need to pay attention to climate change and related issues. During the implementation of HSSIP priority shall be given to the provision of adequate resources for environmental health programmes and the private sector in particular shall be mobilised to be involved in these activities. Special attention shall be given to addressing poor sanitation and hygiene to move households up the sanitation ladder from slums to facilities that can be cleaned and having hand washing facilities next to them, water quality surveillance, food hygiene and safety, occupational health and safety and increasing awareness about climate change and its impacts.

**Strategies and key interventions**

- *Advocate and promote improved sanitation and hygiene as detailed in the Kampala Declaration on Sanitation.*
  - Conduct home improvement campaigns and establish model villages in all districts in Uganda.
  - Sensitize political, religious and cultural leaders on the importance of sanitation and hygiene promotion.
  - Implement Participatory Hygiene and Sanitation Transformations (PHAST) and Community Led Total Sanitation (CLTS).
  - Update skills of staff in the Environmental Health Division and the private sector on emerging technologies dealing with the promotion of sanitation and hygiene.
- *Support and encourage Local Governments to formulate ordinances and bye-laws on environmental health and ensure that they are enforced.*
  - Sensitize local governments on formulation and implementation of environmental health bye laws and ordinances.
  - Orient local governments in the development and implementation of environmental health bye laws and ordinances.

- Sensitise law enforcers on new bye laws and ordinances.
- *Strengthen the capacity of public and private health care providers in health care waste and industrial waste management.*
  - Develop guidelines for health care waste and industrial waste management.
  - Sensitize health workers and private health care providers in health care waste management.
  - Sensitise industrial managers on safe industrial waste management.
  - Enforce the provision of industrial waste management services.
  - Provide facilities at all health facilities for health care waste management.
- *Support and advocate for food hygiene and safety, safe water chain and hand washing with soap and mass hand washing campaigns.*
  - Disseminate the food hygiene and safety, safe water chain and hand washing guidelines.
  - Support local governments to enforce food hygiene and safety, safe water chain and hand washing standards.
- *Mitigation of effects of climate change and health*
  - Sensitize staff at the MoH and local governments on effects of climate change on health.
  - Develop early warning systems and disseminate weather forecasts to health managers to improve preparedness and response.
  - Coordinate climate change response interventions in the health sector and collaborate with relevant line ministries and agencies.
- *Strengthen, support and improve Environmental Health Management Information System in both Public and Private sector service delivery.*
  - Build capacity for all the Environmental Health staff at all levels of government and CSOs.
  - Develop guidelines on EHMISS, operation, maintenance and utilisation.
  - Establish early warning systems on environmental health related risk factors e.g water quality, food safety and sanitation and hygiene related disease out breaks.
  - Support Environmental Health research and documentation.

### **Indicators with targets**

- The proportion of households in Uganda with pit latrines increased from 67.5% to 72% by 2015.
- Percentage of households with access to safe water.
- The proportion of districts implementing water quality surveillance and promotion of safe water chain/ consumption increased from 30% to 50% by the year 2015.
- The proportion of households with hand washing facilities with soap increased from 22% to 50% by 2015.

### **Implementation arrangements**

The implementation of the environmental health component of the Health Promotion, Environmental Health and Disease Prevention Cluster needs a multi-sectoral approach and participation of line ministries, Development Partners and CSOs involved in Water, Environment and Sanitation (WES). The Environmental Health Division in the MoH shall:

- Be responsible for coordinating environmental health programmes.



- Be responsible for policy, guidelines and standards development and periodical reviews on all environmental health aspects. This will be carried out in liaison with key stakeholders.
- Be responsible for technical support supervision, monitoring implementation of environmental health interventions.
- Build capacity of Environmental Health staff, CSOs, private sector involved in Environmental health.
- Shall carry out operational research, data collection, utilisation and documentation of best practices.

At district level, the DHO will be responsible for coordinating these activities with technical support from the MoH headquarters. At HSD level, the in-charge with support from the Health Inspectors will coordinate activities. The Health Assistant shall coordinate the environmental health activities at sub-county level while at community level VHTs shall be responsible for creating awareness about these interventions. Monitoring at community level shall be the responsibility of a technical staff from the sub-county.

### **5.2.1.3 Reduce morbidity and mortality due to diarrhoeal diseases**

Diarrhoeal diseases including acute watery diarrhoea that is not cholera, cholera, dysentery and persistent diarrhoea are the third leading causes of attendances at health facilities, after malaria and acute respiratory infection. Diarrhoeal diseases are the second leading cause of childhood death after malaria. During HSSP II epidemic diarrhoeal diseases (cholera and dysentery) outbreaks were controlled in all parts of the country. The outbreaks were due mainly to poor sanitation, low safe water coverage, poor domestic and personal hygiene practices and mass movement of populations - refugees and internally displaced persons owing to disasters such as landslides, floods, and post-election violence.

As has been mentioned in Chapter 3 overall there was a decrease in the incidence of diarrhoeal diseases and the CFR for diarrhoea and cholera during the period of the HSSP II. There is continuing need for strengthening national capacity at all levels to prevent and effectively control epidemics of diarrhoea. During HSSIP, emphasis shall be placed on integration of interventions for IMCI, environmental health, health promotion and education, capacity building of service providers especially with regard to the new diarrhoea management policies (e.g. use of zinc) and community based health activities.

## **Strategies**

- *Strengthen initiatives for control and prevention of diarrhoea at all levels.*
  - Train health workers at central, district and community levels in the management and prevention of diarrhoeal diseases.
  - Provide technical support supervision, monitoring and evaluation of CDD interventions
  - Conduct advocacy and social mobilisation for control of diarrhoeal diseases.
  - Make available medicines and supplies for control of diarrhoeal diseases.
  - Conduct diarrhoeal diseases surveillance, epidemic preparedness and response.

## **Indicators with targets**

- The incidence of annual cases of cholera reduced from 3/100,000 to 1.5/100,000 by 2014/2015.
- The incidence of annual cases of dysentery reduced from 254/100,000 to 1.5/100,000 by 2014/2015.
- The cholera specific case fatality rate from 2.1% to <1.0% by 2014/2015.
- The dysentery specific case fatality rate from 0.08% to 0.01% by 2015.
- The acute watery diarrhoea specific case fatality rate from 0.9% to 0.4% by 2015.

## **Implementation arrangements**

The control of diarrhoeal diseases is multisectoral. It is based on the involvement of various sectors including Health, Water, Education, Local Government, Information and Office of the Prime Minister (disaster preparedness and response). The MoH headquarters will develop or review relevant policies and guidelines; mobilise resources; do national level planning; and carry out technical support supervision, monitoring and evaluation of CDD interventions. However, the actual implementation of CDD interventions is the responsibility of District Local Governments. Strengthening health systems will be useful in order to detect cases early. Involvement of communities and individuals is central in prevention and management of diarrhoeal diseases; and the VHT strategy, therefore, is expected to contribute significantly to the success of reduction in incidence and prevalence of diarrhoeal disease. Diarrhoea specific case fatality rate reduction will be dependent mainly on the use of appropriate treatment guidelines and the availability of relevant medicines and health supplies at service delivery points.

### **5.2.1.4 Improve the health status of the school children, their families and teachers and to inculcate appropriate health seeking behaviour among this population.**

These programmes were introduced in HSSP I to provide comprehensive preventive and promotive health services to school going children and instil healthy habits and practices in children. The full implementation of the school health programmes in HSSP II was hampered by the lack of a school health policy and a MoU between the MoE and MoH, insufficient ownership of the programme by the MoES, understaffing at MoH and local government level, absenteeism by teachers and health workers and the poor enforcement of available guidelines in local governments.

During the implementation of the HSSIP focus for school health programmes will be on primary and secondary schools and teachers training institutions. The MoU will be instituted and the School Health Policy will be in place. It is expected that the school health programmes will improve the health of school children, reduce dropout rates and increase school performance.

## **Strategies and interventions**

- *Expand the coverage of the school health and nutrition programme to include more schools*
  - Advocate with the MoES for the appointment and retention of School Health Nurses;
  - Make available the required equipment for the establishment of the basic health and nutrition programme.
  - Where there are no school health nurses, implement the Motivation and Retention Strategy for HRH of the MoH, 2009.
- *Strengthen the policy and legal environment for provision of school health services.*
  - Finalise the development of a MoU with the MoES to govern the implementation of school health programmes.
  - Develop the missing health standards (e.g. nutrition and screening) and operationalise all standards.
- *Strengthen the capacity of districts to implement school health programmes.*
  - Integrate school health programmes into district health plans.
  - Monitor the implementation of school health programmes using a new set of indicators
  - Coordinate school health programmes at intersectoral technical committee level
  - Orient district and lower level staff including teachers and the community on school health programmes.

- *Expand the provision of clean water and improved sanitation to schools, with special emphasis on primary schools*
  - Advocate and work together with MoES to install clean and safe water sources in all schools
  - Distribute water treatment chemicals to control outbreaks of waterborne diseases.
  - Support the construction of latrines at schools.

### **Indicators with targets**

- The % of schools in Uganda that provide basic health and nutrition services increased to 25 % by 2015.
- The % of primary and secondary schools with safe water source within 0.5 km radius of the school increased from 61% and 75% resp. to 80% by 2015.
- The % of schools with pupil per latrine stance ratio of 40:1 or better increased from 57% to 70% by 2015.

### **Implementation arrangements**

The implementation of school health programmes will be a joint responsibility of the MoES and MoH but it will also involve other school health stakeholders. The coordination office for the school health programmes will be housed in the Ministry of Education and Sports. Specialised school health interventions will be implemented by relevant sectors and a MoU will be signed by implementing partners which will include the MoH and other government ministries and departments, the private sector, CSOs and NGOs. These will be responsible for the development and implementation of the school health programmes.

Clear roles and responsibilities of the implementing partners will be spelt out. The MoH will provide guidelines and technical supervision to all districts while monitoring shall be a joint exercise of the MoH and MoE and other stakeholders. The MoH, MoE and stakeholders shall ensure that all schools are properly equipped to provide health education and health promotional activities. The DHO will coordinate school health programmes at district level but will also work with District Education Office to ensure that these programmes are implemented.

#### **5.2.1.5 Prevent, detect early and promptly respond to health emergencies and other diseases of public health importance.**

Over the years Uganda has been prone and has also experienced disasters such as floods, drought, famine and epidemics such as Ebola, Marburg, meningitis and cholera among others which have far reaching social and economic implications including decreased tourism, trade and opportunities for investment both from within and outside of Uganda. The environmental degradation, global warming and climate change are further exacerbating the vulnerability of the population. During the HSSP II mechanisms for disaster preparedness and response in all the districts were established but inadequate resources and logistics, weaknesses in planning for emergencies, understaffing and lack of skills especially at lower levels and the fact that epidemic and disaster preparedness is not given priority at district and national level hampered the country's response system. Furthermore the disjointed approach using various task forces without a focal person to coordinate and overlook disaster and emergency preparedness at the MOH level have contributed for the weak coordination and delayed response. The GoU will therefore target to improve its preparedness and response to disasters and epidemics to reduce morbidity and mortality from these events.

### **Strategies and key interventions**

- *Strengthen epidemic, disaster prevention, preparedness, response and management at all levels.*
  - Strengthen the health systems and build the capacity at the community level on preparedness, detection, response, management and mitigation of epidemics and disasters.

- Strengthening intersectoral coordination mechanisms within the country and at inter-country level on management of epidemics.
- Develop emergency preparedness and response plans including stock piling and contingency planning at all levels.
- Conduct vulnerability and risk mapping exercise to guide policy and strategy development.
- Produce and make available Standard Operating Procedures (SOPs), formats and tools at all levels.
- Strengthening capacity for implementation of International Health Regulations (2005).
- Strengthen integrated disease surveillance, with particular emphasis on the early warning system and linkage with meteorological forecasts.
- Establish and sustain a reliable and functioning early warning system in collaboration with line ministries on meteorology and seismology.
- Expand coverage of the IDSR Strategy.

### ***Indicators with targets***

- The proportion of suspected disease outbreaks responded to within 48 hours of notification increased from 52% to 80%.
- The proportion of districts with functional epidemic preparedness and response committees increased from 76% to 100%.
- The proportion of districts with epidemic preparedness plans increased to 100%.
- The timeliness and completeness of weekly and monthly reports maintained at greater than 80%.

### ***Implementation arrangements***

At national level the Department of Community Health<sup>42</sup> has the responsibility for the development of the national strategy for prevention and control of epidemics, carrying out national disease surveillance and training of DHMTs and VHTs in disease control. The commissioner community health will be responsible for chairing a working group on Emergency and disaster preparedness which will be established under the Basic packages of HPAC. A new IDSR/EPR/IHR strategic plan corresponding to the HSSIP period has been developed and will be the basis for implementation and monitoring of interventions/activities to strengthen epidemic and disaster prevention, preparedness and response. International Health Regulations (2005) shall be adhered to in the course of EPR. The Department of Community Health:

- In conjunction with the Office of the Prime Minister and other stakeholders such as CSOs and the private sector shall be responsible for development of policy and guidelines on control of epidemics and management of disasters.
- Shall provide all the necessary supervision and technical support to districts in order to ensure that they do their work accordingly.

The DHO shall be responsible for coordinating these activities at district and lower levels including working with communities (and VHTs in particular) in the detection of disease outbreaks. The private sector shall fully be involved in the detection, management and prevention of epidemic.

#### ***5.2.1.6 Ensure equitable access by people in PRDP districts [in conflict and post-conflict situations] to Health Services***

The insecurity in Northern Uganda (sub-regions of West Nile, Acholi, Lango, Karamoja and Teso and

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neighbouring districts) in the past years resulted in massive displacement of the population into Internally Displaced Peoples camps. The table below shows the affected district as of 2007

**Table 5.3: Grouping of the forty<sup>43</sup> districts in Northern Uganda under PRDP as of 2007**

Location	Northwest (West Nile)	North Central	North East
Type of Conflict	Armed Rebellion	Armed Rebellion	Deterioration of Law and Order
Districts	Moyo, Adjumani, Nebbi, Arua,	Gulu, Kitgum, Pader, Lira, Apac, Amuru, Dokolo,	Kotido, Moroto, Nakapiripirit, Soroti, Kumi, Pallisa, Kapchorwa, Mbale,
	Yumbe, Koboko, Maracha	Amolatar, Oyam, Masindi and Buliisa	Sironko, Kaberamaido, Katakwi, Abim, Kaabong, Bukwo, Bukedea, Budaka,

Some of the IDP camps were congested with inadequate social infrastructure. Access to water and education was also inadequate. Most of the trained health workers were in urban areas leaving operation of services in rural areas to unqualified personnel. In addition, the insecurity disrupted the provision of health services leading to closure of some health facilities and stagnation some services.

The table below shows comparison of Health indicators to the national average

**Table 5.4: Comparison of health indicators in Conflict and post-conflict region of Uganda**

Indicator	National average	Rural areas average	North Region	West Nile Region	IDPs	Karamoja
Infant mortality rate, per 1,000 births	76	88	106	98	123	105
Under 5 mortality rate, per 1,000 births	137	153	177	185	200	174
Total fertility rate	6.7	7.1	7.5	7.2	8.6	7.2
Women using modern contraceptive methods (%)	18	15	8	11	18	0
T12 coverage in pregnancy (%)	51	50	55	51	63	53
Births with skilled birth attendant (%)	42	37	31	35	34	18
DPT3 coverage in children 12-23 months (%)	64	64	67	61	84	66
Under 5 stunted children (%)	38	40	40	38	37	54
Under 5 wasted children (%)	6	6	7	8	6	11

Source: (UDHS/UBOS 2005/6)

Following the restoration of peace in the Northern region, the government of Uganda in 2007 launched the Peace Recovery and Development Plan for the 40 districts in the region. This is a comprehensive plan whose implementation is coordinated by the Office of the Prime Minister. The plan aims at addressing the causes of conflict and instability in the region, restoring livelihoods and revitalize social sectors. The Health Sector Component of the Peace, Recovery and Development Plan focuses on addressing the disparities in health service delivery and poor health indicators.

Though the launching had been done, full implementation of PRDP could not start immediately due to several reasons one of which was lack funding. However, in financial year 2009/10 funding was availed and implementation of the plan started and will continue into HSSP-III.

## Strategies and key interventions

In order to strengthen health services, more health facilities will be constructed, rehabilitated and equipped in

<sup>43</sup> Please note that PRDP focuses on geographical area. Thus, the splitting of PRDP district, increases on the numbers of district in the PRDP plan

conflict regions of Acholi and Lango. This work is guided by service availability mapping which was conducted in Acholi and Lango sub regions.

Initially, priority was centred to areas of high return however; later the whole region will be covered.

In the post conflict areas, the focus will be to improve the quality of existing health facilities and services. This will be in phases which will allow restoration to pre-conflict status and thereafter upgrading of the health services to match those in other parts of the country with better health services.

During implementation of activities priority is given to major causes of mortality and morbidity namely: Malaria Prevention and Control, Reproductive Health, Child Health, HIV/AIDS, Human Resources for Health, Infrastructure and Equipment, Epidemic Preparedness and Response, Mental Health and Disability and Rehabilitation. During implementation both preventive and curative interventions will be promoted. In addition special interest is given to addressing the challenge of attraction and retention of health workers through accelerated recruitment, and incentives.

Similarly, Public Private Partnership will be strengthened to ensure wide coverage of the population.

### ***Indicators and targets.***

Investment will be made with the intention of improving the following key indicators:

- Increased access to functional health facilities: this should enable a larger percentage of the population to be within 5km or less of the facility

#### ***5.2.1.7 Scale up delivery of nutrition services***

The nutritional situation of the population is generally poor especially among under fives, children of school going age, women of reproductive age, the elderly, the displaced and those with communicable and non-communicable diseases. Data from the previous three UDHSs in Uganda report high levels of child and maternal under nutrition that have not changed much over the past 15 years. Although there is widespread consumption of iodized salt, goitre is still commonly seen in the population. Field evidence shows that other micronutrient deficiencies such as zinc and folate exist. Sub-optimal child care and inappropriate feeding practices impact on the health and nutrition of children. Only 60% of infants 0-6 months are exclusively breastfed and at 4-5 months only 35% of infants receive breast milk only and this has been complicated by HIV infection. Timely introduction of complementary feeds is estimated as 77%. Malnutrition starts early in foetal life resulting into foetal retardation in utero which continues throughout infancy, childhood, adolescence and adulthood constituting the vicious cycle of malnutrition if there are no interventions. Most irreversible stunting in children takes place between one and two years of age. Malnutrition makes the population vulnerable to infections and other diseases and contributes to 60% of under five deaths hence the need for its prevention and control.

Despite the implementation of a variety of interventions by the GoU and other stakeholders to address nutrition issues, malnutrition levels remain unacceptably high. During the HSSIP there is a need to create awareness among community members especially women about nutrition and promote appropriate feeding practices, make available appropriately trained health workers (nutritionists) to deal with nutrition issues at all levels, advocate for financial resources for implementation of nutrition programmes, develop and implement a comprehensive policy framework for micronutrient deficiency control, procure appropriate equipment and construct infrastructure for nutrition programmes. The delivery of nutrition services is affected by inadequate financial and human resources, the lack of equipment in nutrition units, lack of infrastructure and the general lack of a comprehensive policy framework for micronutrient management among other issues.

### ***Strategies and interventions***

**Strategy 1:** To reduce the incidence and prevalence macro- and micro-nutrient deficiencies and associated mortality among vulnerable groups.

- **Strengthen maternal nutrition interventions to ensure optimal pregnancy outcomes and healthy infancy**
  - Provide micronutrient supplements (iron, folic acid, vitamin A and other relevant) to targeted groups.
  - Encourage and support antenatal care services through health and nutrition education.
  - Promote the consumption of high nutrient density local foods.
- **Integrate infant and young child nutrition interventions into maternal, infant and young child services to ensure growth and development.**
  - Provide infant and young child feeding counselling services during ante-natal and post-natal care.
  - Strengthen growth monitoring and promotion services at facility and community levels.
  - Support infant and young child feeding in the context of HIV.
  - Provide bi-annual Vitamin A supplementation and deworming to targeted groups.
- **Scale up micronutrient initiatives.**
  - Develop a comprehensive policy framework for micronutrient deficiency control.
  - Provide support for implementation of a consolidated policy on micronutrient deficiency control.
  - Promote food fortification by working with relevant public and private stakeholders.
  - Promote food supplementation
- **Promote good quality diets through diet diversification.**
  - Conduct nutrition education and counselling at facility, family and community levels.
  - Promote consumption of locally produced fortified foods.
  - Encourage the production and preparation of a variety of locally available nutritious foods.
- **Integrate the management of malnutrition into the health delivery system.**
  - Integrate identification, screening, referral and management of acute malnourished children into routine service delivery at facility level and community levels using national IMAM protocols.
  - Support and promote national procurement of therapeutic feeds and supplies.
  - Promote local production of therapeutic feeds.
- **Integrate nutrition into the treatment and management of HIV/AIDS, TB and malaria.**
  - Incorporate nutrition support into the management and treatment of HIV/AIDS, TB and malaria interventions.
  - Establish coordination mechanisms among partners involved in food and nutrition and HIV, TB and malaria interventions.
  - Support community involvement in provision of nutrition support to HIV/AIDS and TB patients.

**Strategy 2: To improve access and quality of nutrition services at facility and community levels.**

- **Support institutional feeding.**
  - Procure equipment for nutrition management like weighing scales, MUAC tapes, height meters, demonstration meters and food preparation equipment.
  - Conduct pre- and in-service training for service providers to promote nutrition interventions.
  - Develop curricula and training manuals for nutrition training.
  - Determine the human resource needs for nutrition services.

- Train trainers and equip the VHTs, community resource persons and other community based organizations with nutrition knowledge and skills.
- Provide technical support supervision and mentoring of health workers.
- Support nutrition response in emergency

**Strategy 3: To review, formulate, enforce and coordinate nutrition related policies, regulations, standards and programmes in consultation with other relevant sector stakeholders.**

- *Develop and disseminate nutrition policy and implementation guidelines.*
  - Initiate the review and up-date of the 2002 Uganda National Food and Nutrition Policy.
  - Develop implementation guidelines for the reviewed Uganda National Food and Nutrition Policy and other related nutrition policies.
  - Orient stakeholders on the revised Uganda National Food and Nutrition Policy.
- *Strengthen nutrition related standards and regulations.*
  - Review the regulations on salt iodization.
  - Review regulations on maternity protection.
  - Support the development of the Codex on complementary foods and food supplements.
  - Develop a regulatory framework for food fortification.
- *Strengthening inter-sectoral collaboration and public-private partnership in the designing and implementation of nutrition programs.*
  - Operationalise the National Food and Nutrition Council and its secretariat.
  - Conduct national, regional and district coordination and planning meetings.

**Strategy 4: To strengthen advocacy and social mobilization for behavioural change.**

- *Strengthen advocacy, social mobilization and communication at all levels.*
  - Develop a comprehensive nutrition communication strategy.
  - Develop and disseminate nutrition IEC materials using mass media including audio, visual and print media.
  - Promote nutrition campaign initiatives.

**Strategy 5: Strengthen nutrition information management systems for monitoring and evaluating nutrition interventions programs.**

- *Strengthen the regular collection of nutrition indicators in HMIS and other systems.*
  - Operationalise the Uganda Nutrition Information System.
  - Establish nutrition sentinel sites to assess nutrition trends.
  - Conduct basic and operational nutrition research.
  - Collaborating with UBOS in collection of nutrition indicators during annual food consumption surveys.
  - Conduct periodic nutrition surveys.

**Indicators with targets**

- The proportion of underweight in under five year children reduced from 16% to 10%.
- Vitamin A deficiency among children 6-59 months reduced from 20% to 10% and women of reproductive age from 19% to 9%.



- The proportion of stunted children below 5 years reduced from 38% to 32%.
- Vitamin A supplementation coverage increased for children aged 6-59 months from 60% to 80%.
- Deworming coverage for children 1-14 years increased from 60% to 80%.
- Iodine deficiency eliminated.
- The proportion of the households consuming iodised salt increased from 95% to 100%.
- The prevalence of anaemia among children decreased from 73% to 60%, women from 49% to 30% and men from 28% to 15%.
- The proportion of underweight women of reproductive age decreased from 12% to 6%.
- Exclusive breastfeeding at 6 months increased from 60% to 80%.
- Timely complementary feeding increased from 73% to 80%
- Accessibility to appropriate and gender sensitive nutrition information and knowledge increased to 100%.
- Nutrition services to health units and the community scaled up to 100%.

### **Implementation arrangements**

In order to address the problem of malnutrition in Uganda a multi-sectoral approach is required. While the MoH and Ministry of Agriculture are the line ministries dealing with food and nutrition security it is necessary that other government ministries and departments, CSOs and the private sector should participate in the fight against malnutrition. The implementation of nutrition activities in Uganda shall be guided by the UFPN and the policy guidelines on infant and young child feeding developed in 2009<sup>44</sup>.

At national level the Nutrition Unit at the MoH headquarters shall be responsible for coordinating nutrition activities and lead the process of formulating policies and guidelines relating to nutrition. In order to do this it shall work with other departments within the MoH, other government ministries and departments, the UNFNC and other stakeholders. The Unit shall provide technical support to the DHO including supervision. At district level the DHOs shall be responsible for coordination of nutrition activities. VHTs at community level shall be capacitated to provide the necessary nutrition education and other nutrition related interventions to members of the community and build capacity of the community to become active participants in nutrition programs.

### **Cluster 2: Control of Communicable Diseases**

Communicable diseases account for about 54% of the total burden of disease in Uganda. Malaria, HIV/AIDS and TB are leading causes of ill health and mortality. HSSP II prioritized the prevention and control of communicable diseases in order to reduce the high national disease burden. The priority health care interventions in the Cluster of Prevention and Control of Communicable Diseases include: Prevention and Control of STI/HIV/AIDS, Prevention and Control of Malaria, Prevention and Control of Tuberculosis and elimination and/or eradication of some particular diseases such as Leprosy, Guinea Worm, Onchocerciasis, Trachoma, Lymphatic Filariasis, and Trypanosomiasis soil transmitted helminths and Schistosomiasis. The overall objective for the communicable diseases cluster is to reduce the prevalence and incidence of communicable diseases by at least 50% and thus contribute towards achieving the health related MDGs and the overall goal of the NDP. This section provides details for each disease in this cluster including the objectives, strategies and targets.

#### **5.2.1.8 Prevent STI/HIV/TB transmission and mitigate the medical and personal effects of the epidemic.**

Inside a quarter of a decade, HIV/AIDS remains a major health concern. Uganda has made great progress in HIV/AIDS service delivery and prevention since the advent of the epidemic in 1982. By September 2009, HIV

<sup>44</sup> Ministry of Health. (2009). Policy guidelines on infant and young child feeding. Kampala: Ministry of Health.MoH.

testing and counselling services were provided in 1215 of the 1229 eligible health facilities. Between July 2008 and June 2009, 968,157 pregnant women were tested and received their HIV status results. PMTCT services were provided in 66% of all facilities up to HC III while ART services were provided in more than 90% of health facilities up to HV IV by end of 2008/09 FY. By the end of September 2009, there were 200,213 receiving ARVs, 8.5% of them being children. The need to integrate these successful HIV services with others especially TB, RH and MCH is now a glaring issue.

However, albeit the above achievements recent evidence suggests that the epidemic has shifted from the single younger-aged individuals to older individuals aged 30–35, who are married or in long-term relationships. Multiple concurrent partnerships, extra-marital relationships, discordance and non-disclosure are among the key factors driving the spread of HIV in Uganda. There is limited programming for the Most At Risk Populations (MARPs) and yet conspicuous evidence highlights high prevalence rates among these populations<sup>45</sup>.

There are also challenges in programme management and coordination of the national response to HIV/AIDS. The multi-sectoral approach brought in very many actors and stakeholders; which simultaneously created parallel systems for service delivery. This phenomenon weakened the existing health support systems. One of the examples is the Health Management Information System (HMIS) of the MoH that has been made more or less dysfunctional by partners and programmes setting up separate systems for recording, reporting, monitoring and evaluation requirements. While this was in response to the need for regular, timely, accurate and reliable data for programme reporting, monitoring and evaluation, it affected the functionality of the HMIS and subsequently rendered it difficult for MoH to ensure equitable and cost-effective availability of HIV/AIDS data for HIV programming and service delivery in the country as a whole.

In addition, in this era of the global recession, financial resources for the HIV response seem to have peaked and flattened. This calls for review of the health sector interventions to ensure that the available resources are optimally used and the GoU needs to allocate more funds for control of the HIV/AIDS epidemic; and contemporary programming should consider health systems strengthening approach.

## **Strategies and key interventions**

- *Strengthen all aspects of HIV prevention namely reduction of sexual transmission of HIV, prevention of MTCT of HIV and prevention of HIV transmission through blood and blood products.*
  - Increase and sustain the distribution of free male and female condoms targeting among others discordant couples and people in stable relationships.
  - Scale up social marketing of condoms to general and high risk populations.
  - Review and harmonise all curricula and materials relevant for HIV and AIDS trainings and ensure that they incorporate strong elements of gender-responsiveness.
  - Provide life skills education targeting both youth in and out of school.
  - Provide HCT services in all HC II and higher level facilities and community HCT especially in high prevalence communities.
  - Promote and scale up safe male medical circumcision.
  - Extend the provision of PMTCT services to all HC IIIs and make it an integral component of antenatal services.
  - Screen all blood and blood products for HIV and other blood transmissible infections before transfusion.
  - Provide PEP to health workers and other eligible persons in line with the existing policy guidelines.
  - Train health workers in the management of STIs.
- *Improve access to quality HIV treatment and care services at all levels including treatment for opportunistic infections.*

<sup>45</sup> CRANE Study 2009

- Provide ART including paediatric ART to all those who are eligible.
- Monitor and improve ART treatment protocols and train health workers accordingly.
- Increase access to treatment of opportunistic infections, including STIs, TB and malaria
- Scale up supportive home based care to ensure that PLHIVs are treated and counselled at home.
- Review, update and disseminate therapeutic feeding guidelines and protocols for PLHIVs.
- Ensure that essential, efficacious, safe, and quality HIV related medicines are available and rationally used.
- Monitor and prevent emergence and transmission of HIV Drug Resistance.
- *Strengthen coordination, management, monitoring and evaluation of HIV programs at all levels.*
  - Facilitate the functionality of the national and decentralised coordination structures.
  - Establish and operationalise a comprehensive National HIV/AIDS monitoring and evaluation framework for proper monitoring and reporting.
  - Put in place a partnership framework to guide private sector participation in delivery of HIV/AIDS services.
  - Mainstream HIV/AIDS in planning and budgeting at national and local government level.
  - Strengthen multi-sectoral collaboration in control of HIV/AIDS i.e. ensure linkages of ACP/MOH with other departments, ministries and institutions to address issues like protection of OVCs, PLHIVs and other vulnerable, as well as establishment of income generating activities
  - Strengthen generation, and use of new evidence (including surveillance and operations research) to improve policy and programming for HIV/AIDS services
  - Develop/strengthen a national system for timely, accurate and complete recording and reporting of data to monitor and evaluate programme performance.
- *Strengthen the policy and legal environment for the national HIV/AIDS response.*
  - Finalise and disseminate the National HIV/AIDS Policy and ensure that it reflects a strong commitment to gender responsiveness.
  - Promote the development and implementation of the sectoral HIV/AIDS policies and guidelines.
  - Enact the HIV/AIDS Bill.
  - Print and disseminate the HIV/AIDS Policy and the HIV/AIDS Bill.
  - Collaborate with Ministry of Justice to train law enforcers on HIV/AIDS legislation and policy.
  - Strengthen IEC and community mobilisation initiatives with emphasis on the ABC principle.
  - Develop and print gender sensitive IEC materials on HIV prevention, treatment and management targetting most at risk populations.
  - Produce and broadcast HIV/AIDS programmes on major radio and television channels.

### **Indicators with targets**

- HIV prevalence among pregnant women (19-24 yrs) attending antenatal clinics reduced from 7% to 4%.
- The proportion of people who know their HIV status increased from 38% to 70%.
- The proportion of people who are on ARVs increased from 53% in 2009 to 75% by 2015 among adults and from 10% to 50% in children less than 15 years of age.
- The proportion of children exposed to HIV from their mothers access HIV testing within 12 months

increased from 29% to 75%.

- The proportion of pregnant women accessing HCT in ANC increased to 100%.
- HCT services available in all health facilities including HC IIs, and at community level (Proportion of health facilities with HCT services; Proportion of community structures with HCT services)
- PMTCT services available in all health facilities up to HC III's and 20% of HC IIs (Proportion of health facilities with PMTCT services; Proportion of HC IIs with PMTCT services).
- ART services available in all health facilities up to HC IV and 20% of HC III by 2015. (Proportion of health facilities with ART services; Proportion of HC IIs with ART services).
- The proportion of males circumcised increased from 25% to 50% (denominator is number of all males in Uganda).
- Reduce the HIV prevalence from 6.7% to 5.5% in the general adult population (15-49 years).

#### ***5.2.1.9 Reduce the morbidity, mortality and transmission of tuberculosis.***

The burden of Tuberculosis is still high with annual notifications at about 50,000 cases. Decentralized TB care called Community Based DOTS has been expanded to all districts. Challenges however remain: only 50% of cases nationwide are notified for various reasons; under staffing; lack of laboratory equipment; weaknesses surrounding community mobilisation; a high HIV prevalence, emerging drug resistant TB and that even though the cure rate target is at 85% globally in Uganda this has not been achieved – it is still at 73%.

There is need to consolidate the provision of CB DOTS, operationalise the public private mix (PPM) for TB control strengthen laboratory capacity and to integrate TB control in the District health system. The strategies and interventions described below are in line with the Global Plan to STOP TB strategy (2006-2015).

### ***Strategies and interventions***

- *Expand and consolidate high-quality DOTS services in all districts by 2015.*
  - Conduct case detection through quality-assured bacteriology.
  - Provide standardised treatment, with supervision.
  - Carry out contact tracing and tracing treatment interrupters.
  - Ensure uninterrupted drug supply and management system.
  - Sustain EQA coverage at all Diagnostic and Treatment Units (DTUs) in the districts.
  - Mobilise communities to participate in CB-DOTS in all districts with involvement of VHTs.
  - Provide TB preventive, diagnosis and treatment services among children in line with international standards (ISTC) and guidelines.
  - Operationalise the TB Infection Control plans at all DTUs nation wide.
- *Expand and strengthen TB/HIV collaborative activities, address MDR-TB and other challenges in special settings and populations.*
  - Consolidate implementation of TB/HIV services nationwide.
  - Operationalise programmatic management of Drug Resistant TB (DR-TB).
  - Develop a policy and legislation for drug resistance TB management.
  - Conduct drug sensitivity testing (DST) on all category II (Retreatment) TB cases reported by 2015.
  - Scale up TB control services in high risk population groups such as prisons, UPDF, Police, IDPs, and Refugees.
- *Contribute to the Strengthening of health systems.*

- Actively participate in efforts to improve sector-wide policy, service delivery, medicines and supplies management, information systems, health workforce, financing, Leadership & Governance at all levels of the NTLP.
- Adapt innovations from other fields: - integration within community, PHC outreach, social mobilization like HIV/AIDS, regulatory actions and financing schemes, PIA
- *Engage all care providers in TB care.*
  - Enhance public-public and public-private mix in TB control.
  - Maintain Village Health Teams (VHTs) participation and involvement in implementing DOTS as informal care providers in TB care.
  - Re-invigorate ACSM activities so as to increase Central and Local Government commitment, community awareness and demand for TB services.
  - Promote the application of International Standards of TB Care (ISTC).
  - Strengthen the Uganda Stop TB Partnership.
- *Empower people with TB and the communities to participate in TB care.*
  - Advocate at national and district level for increased resources allocation (dedicated budget) for TB control.
  - Mobilise communities to participate in CB-DOTS in all districts
  - Improve ACSM activities for TB using VHTs, CBOs, patient organisations, communities – allocate roles for each beyond formal health sector.
  - Develop patients' Charter for Tuberculosis care.
- *Enable and promote operational and other research.*
  - Train NTLP staff to perform and oversee OR.
  - Conduct research to develop new diagnostics, drugs and vaccines.
  - Promote evidence based interventions as well as the practice of turning evidence into action.
- *Build capacity for TB control.*
  - Carry out a training needs assessment on DOTS management for laboratory staff, clinicians and SCHWs at DTUs.
  - Train general health workers in performance improvement approach and quality in the eyes of the clients for TB control activities.
  - Train microscopists in peripheral laboratories.

### **Indicators with targets**

- TB case detection rate increased from 57.3 to 70%.
- TB cure rate increased from 32% to 80% (Treatment success to 85%).
- TB associated death rate reduced from 4.7 to 2.5%
- The proportion of TB cases on supervised DOT increased from 48% to 100%.
- DST uptake among smear positive Relapse cases (CAT II) increased to 75%.
- High False Negative (HFN) prevalence at DTUs reduced to less than 5% in all districts.
- Proportion of TB patients tested for HIV increased from 71% to 100%
- Proportion of TB/HIV patients started on cotrimoxazole increased from 88 to 100%

- Proportion of TB/HIV patients started on ART increased from 18.5% to 50%
- Proportion of MDR TB patients started on treatment increased from 0% to 100%

#### ***5.2.1.10 Sustain the elimination of leprosy in all the districts.***

During HSSP II, the elimination status of prevalence of less than 1 leprosy patients per 10,000 populations which was achieved in 1994 nationally and a system of monitoring leprosy elimination at national and district levels have been maintained. Rehabilitative services like foot wear, prosthesis and socio-economic activities for persons affected by leprosy has been maintained in all the six national centres. This success could be hampered by elimination of the position of District TB and Leprosy Supervisors (DTLS) during the Local Government restructuring exercise with the potential to lower the quality of support supervision to units and sustaining knowledge and skills for Leprosy amongst the general health workers with reduced prevalence remains a challenge.

There is need for sustained funding for leprosy control activities at national and district level as well as for establishing at least one Health Centre III per HSD for continued diagnosis and treatment of leprosy patients as an integral part of health care. This will increase case detection, reduce delay in diagnosis and further reduce disabilities amongst new cases.

### ***Strategies and key interventions***

- *Strengthen the capacity of health workers to diagnose and treat leprosy cases.*
  - Train health workers in diagnosis, treatment and referral of leprosy cases.
  - Equip program officers and managers with skills for advocacy, resource mobilisation and leadership.
  - Create awareness among community members to identify and refer cases of leprosy to health facilities.
  - Promote self care among persons affected by leprosy.
- *Conduct a sustained leprosy elimination and treatment campaign.*
  - Conduct active case finding in high burden areas.
  - Carry out systematic surveillance of contacts of new leprosy cases.
  - Build synergies with CBR teams at district and sub-county levels to address the rehabilitation needs of people with rehabilitation needs after completion of leprosy treatment.
  - Procure and distribute MDT and rehabilitative appliances.
  - Conduct surveillance for drug resistance.
  - Conduct periodic examination of school children

### ***Indicators with targets***

- The prevalence of leprosy reduced to less than 1 case per 10,000 people.
- At least one “Skin Clinic” per Health Sub District (HSD) held on a weekly basis in all HSDs across the country.
- The rate of grade II disability in newly diagnosed leprosy cases reduced to less than 5 per cent.

#### ***5.2.1.11 Reduce the morbidity and mortality rate due to malaria in all age groups.***

Malaria remains one of the major causes of morbidity and mortality in Uganda. During HSSP II progress was made in terms of seeking treatment within 24 hours after the onset of fever as well as coverage of IRS, ITNs and availability of antimalarials in health facilities at all levels. These modest gains were underpinned

by several challenges and constraints such as: poor coordination and harmonization of partners to embrace the “three ones” principle; inadequate procurement and delayed delivery of malaria commodities especially ACTs (Coartem); inadequate trained health workers in health facilities; and weak laboratory infrastructure for malaria diagnosis among other issues. In the current strategic plan, the sector will focus on a rapid scale up for impact, providing an enabling environment for implementation of key Malaria interventions. There will also be deliberate efforts to implement a comprehensive policy on malaria diagnostics and treatment, strengthen the procurement and delivery of malaria commodities, and strengthen RBM coordination mechanisms as well as M&E and general health systems. The goal for this component is to halt by 2015 and begin to reverse the incidence of malaria and thereby minimise the social effects and economic losses attributable to malaria in Uganda.

### **Strategies and interventions**

- *Strengthen measures to control malaria transmission.*
  - Procure and distribute LLINs and contribute to achieving universal coverage.
  - Expand coverage of indoor residual spraying to both epidemic prone and endemic districts, as well as to institutions.
  - Improve environmental control methods for malaria’(propose specific mechanisms)
  - Ensure malaria epidemic preparedness and response.
- *Strengthen the implementation of a comprehensive policy on malaria diagnostics and treatment.*
  - Promote effective case management of malaria in all population groups including pregnant women and under-five year children.
  - Expand parasitological diagnosis up to HC IIIs, and use of RDTs up to HC IIs and community level.
  - Ensure that all pregnant women access IPTp and ITNs at service points.
  - Strengthen home based management of fevers through VHTs for prevention and management of cases at community level.
- *Strengthen coordination and management of malaria activities in the country.*
  - Strengthen the RBM partnership at national level
  - Facilitate the functionality of decentralized coordination structures like NGO fora.
  - Strengthen multi-sectoral collaboration in control of malaria i.e. to ensure linkages of Malaria programme/MOH with other departments, ministries and other institutions.
- *Strengthen IEC/BCC for malaria prevention and control*
  - Design and print gender sensitive IEC/BCC materials for malaria control and prevention.
  - Distribute IEC/BCC materials for malaria prevention.
  - Promote the use of electronic and other media in prevention and management of malaria.
  - Promote involvement of NGOs and the private sector in malaria control.
- *Build the capacity of health workers for malaria control, prevention and treatment.*
  - Train and supervise health workers in the management of malaria.

### **Indicators with targets**

- Reduce the prevalence of malaria among under fives from 44.7% to 20%.
- The proportion of under-fives with fever who receive malaria treatment within 24 hours from a VHT increased from 70% to 85% by 2015.

- The proportion of pregnant women who have completed IPT2 uptake increased from 42% to 80% by 2015.
- The percentage of under-fives and pregnant women having slept under an ITN the previous night increased from 32.8% to 80% and from 43.7% to 80%
- Proportion of households sprayed with insecticide in the last 12 months increased from 5.5% to 30% by 2015.
- The case fatality rate among malaria in-patients under five reduced from 2% to 1% by 2015.
- Proportion of households with at least one ITN increased from 46.7% to 85% in 2015.
- The percentage of public and PNFP health facilities without any stock outs of first line anti-malarial medicines increased to 80% throughout the strategic plan period.
- The percentage of government and PNFP health centres IIs and IIIs without stock out of rapid diagnostic tests.
- 100% of planned RBM partnership review meetings held.

### ***Implementation arrangements for communicable conditions***

The MoH, through the Department of National Disease Control, will be responsible for coordination of activities aimed at the control of STIs/HIV/AIDS, tuberculosis and malaria. The Department will work with the entire health sector and other government departments including NGOs in development of policies and guidelines for the prevention and control of communicable diseases. The Department of National Disease Control will work specifically with disease programmes in these efforts namely:

- The National Malaria Control Programme for the prevention and control of malaria.
- The National TB and Leprosy Control Programme for tuberculosis and leprosy.
- UAC for STIs and HIV and AIDS.

These disease programmes will take the lead in the coordination and implementation of their respective diseases. At district level the responsibility for coordinating and implementing communicable disease control programmes will be with the DHO who will in turn support and provide guidance to HSDs to develop their annual operational plans and budgets. At community level the VHTs will play an important role in the mobilisation of their respective communities for the prevention and control of communicable diseases.

### **Diseases targeted for elimination**

There are a number of diseases that have been targeted for elimination or eradication by the international community. Uganda as a signatory to the treaties and conventions for the elimination of certain diseases is committed to these processes. The diseases targeted for elimination and/or eradication are as follows: poliomyelitis, guinea worm, onchocerciasis, measles, leprosy, trachomalympathic filariasis, trypanosomiasis and schistosomiasis.

During the HSSIP emphasis will also be to strengthen crossborder disease control initiatives if Uganda will be on track to eliminate these diseases. The overall objective for this cluster of diseases is to achieve national and global targets for elimination or eradication of targetted diseases. There are gender dimensions affecting incidence, access to management and rehabilitation for several of these diseases. This section gives details on objectives, strategies, targets and implementation arrangements for the control and prevention of diseases targetted for elimination. Efforts will be made to incorporate gender responsiveness to programming as much as is possible.



#### **5.2.1.12 *Maintain the Guinea Worm free status of the country through maintenance of high quality post-certification surveillance.***

During HSSP II period guinea worm status of no indigenous transmission was maintained and 100% containment of imported guinea worm patients was achieved, and Uganda was certified as free of Guinea Worm Transmission. With reduced conflict in northern Uganda it is hoped that this good situation will be maintained within the period 2011 to 2016 provided that there is continued financial support to the programme by the Government and Partners to maintain high quality surveillance in the post-certification period and repair and maintenance of non functional boreholes in the villages of formerly endemic districts, is undertaken and more sources of safe drinking water are provided especially in areas with former internally displaced peoples' camps that have returned to their homes.

### **Strategies and key interventions**

- *Strengthen the existing surveillance systems for elimination of guinea worm*
  - Conduct and maintain high quality community-based surveillance through VHTs and sub-county supervisors.
  - Carry out prompt and in-depth investigation of all rumors of suspected cases and containment of any imported cases.
  - Implement an enhanced and nation-wide reward scheme for the improvement of sensitivity of surveillance.
  - Work with neighbouring countries to ensure eradication of guinea worm.
- *Expand the treatment and control of guinea worm in Uganda*
  - Manage and contain all cases of guinea worm.
  - Work with other stakeholders such as the Ministry responsible for water and CSOs to increase access to safe water supply in endemic districts and repair of broken down boreholes.
  - Control vectors through application of Abate to ponds and other water bodies.
- *Build the capacity of health workers for control and prevention of guinea worm.*
  - Provide refresher training for health workers involved in the treatment, control and prevention of guinea worm.
  - Conduct regular training of VHTs and community members.

### **Indicators with targets**

- Timely reporting of guinea worm from villages at risk of importation maintained at 100%.
- All (100%) rumours of suspected guinea worm cases investigated.
- Case containment of imported guinea worm cases maintained at 100%.
- A MoU signed with neighbouring countries on elimination of guinea worm.

#### **5.2.1.13 *Eradicate onchocerciasis and its vector in all endemic districts in Uganda***

Onchocerciasis is endemic in 29 districts of Uganda mainly those bordering the Democratic Republic of Congo, where more than 2.5 million people are at risk of acquiring the disease. During HSSP II 100% of all affected communities were treated with more than 75% of all eligible individual receiving the drug. In addition, 90% of endemic districts integrated CDTI activities within their district health plans.

In spite of these successes, challenges remain for the control of onchocerciasis: districts have only continued to contribute minimally to CDTI activities due to inadequate funds at this level; as the burden of onchocerciasis is progressively reduced, policy makers and health service managers reduce the financial and other logistical inputs for CDTI support; inadequate motivation and the presence of many community development and health interventions constrain community medicine distributors (CMDs). As a result, the CMDs fail to do adequate community mobilization. There is therefore a need for sustained advocacy for CDTI implementation at all levels and to integrate implementation and supervision of all community interventions.

### **Strategies and interventions**

- *Strengthen IEC activities for the control and elimination of onchocerciasis at all levels.*
  - Conduct advocacy campaigns for CDTI support at all levels.
  - Develop and print IEC materials on onchocerciasis prevention and treatment and distribute them in all endemic districts.
- *Conduct capacity building at district and community levels and in schools for prevention and management of Onchocerciasis.*
  - Train health workers and teachers at district and lower levels on onchocerciasis prevention and treatment.
  - Scale up the role VHTs in onchocerciasis control and prevention in all endemic districts.
- *Expand treatment and vector elimination in all endemic districts.*
  - Implement integrated control with other neglected tropical diseases and other health interventions such as LLIN and IRS.
  - Conduct biannual treatment and vector elimination in all endemic districts.
  - Promote CDTI for the control of onchocerciasis.

### **Indicators with targets**

- Simulium niviae eliminated in all endemic districts in Uganda.
- At least 75% therapeutic coverage in all affected communities and 100% geographic coverage achieved in endemic districts.
- CDTI activities integrated within their district health plans in all endemic districts to sustain integration.

#### **5.2.1.14 Achieve the global target for the elimination of trachoma.**

Uganda is a signatory to the WHO alliance for the Global Elimination of Trachoma (GET) by 2020. Trachoma is known to be endemic in 24 districts where about 700,000 children below the age of 10 years have active disease and about 7 million people are at risk of being infected. Predominantly trachoma affects people with poor access to water, sanitation and health services. It is also estimated that overall, 47,000 people in Uganda are blind from various forms of trachoma.

During HSSP II a survey was done to quantify the burden of trachoma in 19 districts. The prevalence of active and non-active Trachoma in all the surveyed districts was more than 20% and more than 4%, respectively, which are above the threshold set by WHO for massive antibiotic distribution, with three being hyperendemic (TF>65%)<sup>46</sup>. The control of trachoma is hindered by shortage of HRH, low funding levels and low priorities accorded to the disability sector in general at all levels. As a signatory to GET Uganda is committed to eliminate trachoma through the SAFE strategy<sup>47</sup> as developed and recommended by WHO.

<sup>46</sup> Ministry of Health. (2007). *Trachoma Control Strategic Plan 2007-2010*. Kampala: Ministry of Health

<sup>47</sup>SAFE is an acronym for a comprehensive strategy which combines treatment with public health education and environmental health

## Strategies and interventions

- *Build the capacity of health workers to provide services to patients suffering from trachoma.*
  - Train lid rotation surgeons to increase access to trachoma treatment.
  - Provide requisite equipment for performing surgery.
  - Improve accessibility of the blind and visually impaired to existing rehabilitation programmes.
- *Build the capacity of schools and communities for prevention and control of trachoma.*
  - Train teachers and VHTs on the prevention, control and treatment of trachoma.
  - Teach children in schools on facial hygiene practices to prevent spread of infection.
  - Promote family sanitation and improved water supply through the school health programs to sustain prevention of trachoma.
- *Improve access to treatment for trachoma.*
  - Implement mass community distribution of tetracycline and azithromycin in all endemic districts to reduce prevalence.

## Indicators with targets

- Prevention and control measures for trachoma *fully* integrated within the district work plans in all endemic areas during all years of the strategic plan.
- All endemic districts reached with mass distribution of Tetracycline and Azithromycin during the years of the strategic plan.
- The provision of surgical services to patients with trichiasis increased from 10% to 30% by 2015.
- Number of lid rotation surgeons trained.

### 5.2.1.15 *Reduce and ultimately interrupt transmission of the disease in all endemic communities through the use of chemotherapy with Ivermectin and albendazole.*

During HSSP II mass medicine administration was scaled up from 2 pilot districts to 24 districts with a population of 7.2 million people being reached. Disability management initiated, in the form of *hydrocelectomies and lymphoedema management*, was undertaken in two districts. A training of trainers' manual, field guide for Community Medicine Distributors, Registers and IEC materials were developed, printed and distributed. The major challenges included lack of funds for mass medicine distribution (MMD) at district level and insecurity in some districts. There is still need of mapping for lymphatic filariasis in those districts where it has not yet been done; Scaling- up of MMD to cover all the eligible districts and to develop a comprehensive disability management programme to be implemented alongside MMD.

## Strategies and key interventions

- *Improve access to chemotherapy, disability management programmes and control measures in all endemic districts.*
  - Procure and distribute ivermectin and albendazole in all endemic districts through integrated NTD control.
  - Conduct mapping of areas for lymphatic filariasis in districts where it has not been done.
  - Develop and implement a comprehensive disability management programme.
  - Integrate control activities for lymphatic filariasis into district workplans and with other control strategies such as LLINs.

improvements: S: Surgery; A: Antibiotics; F: Face washing; and E: Environmental change.

- *Strengthen IEC activities for the control and prevention of lymphatic filariasis.*
  - Develop, print and disseminate ender sensitive IEC materials on prevention and control of lymphatic filariasis.
  - Engage VHTs and other community members in creating awareness about lymphatic filariasis at community level.

### **Indicators with targets**

- Therapeutic coverage for the affected people with single annual dose of Ivermectin and Albendazole increased from 93% to 100% by 2015.
- Mapping of areas with lymphatic filariasis completed in all endemic districts conducted by 2011/12.
- Morbidity and disability associated with lymphatic filariasis reduced by 25% by 2015.

#### **5.2.1.16 Eliminate sleeping sickness as a public health problem in Uganda.**

During HSSP II, the MoH in consultation with Ministries of Agriculture developed a draft national policy and plan of action on control of tsetse & trypanosomiasis. Seven (7) new sleeping sickness diagnostic and treatment centres were established and operationalised. Over 100,000 people were screened for sleeping sickness in the newly affected districts (Soroti, Kumi and Kaberamaido) and drugs for sleeping sickness were availed 100% of the time. However, there is lack of transport for the surveillance staff in the field; inadequate Social mobilization; gradual threatening of geographical overlap of the chronic disease with the acute disease and resistance to Melarsoprol (Mel.B) is escalating year by year.

There is therefore need to strengthen disease surveillance and community participation and mobilize financial resources for programme implementation. During HSSP II, the focus was on scaling up efforts to interrupt transmissions through integrated vector management and active case detection and management.

### **Strategies and key interventions**

- *Strengthen the capacity of health institutions to control and prevent sleeping sickness.*
  - Train health workers in control and prevention of sleeping sickness.
  - Set up surveillance systems for sleeping sickness.
- *Improve access to drugs for the control and treatment of sleeping sickness.*
  - Conduct mass chemoprophylaxis of human populations.
  - Conduct active screening of communities at risk to identify patients at an early stage.
  - Procure adequate quantities of NECT for effective management of sleeping sickness.
- *Strengthen advocacy and social mobilisation at all levels.*
  - Develop and disseminate IEC materials using different media channels.
  - Advocate for an increase in resources allocated for the control and prevention of sleeping sickness.
  - Strengthen sleeping sickness control and management at community level using VHTs.

### **Indicators with targets**

- Access to diagnostic procedures and treatment of sleeping sickness for communities to increase from 40% to 80% by 2015.

### 5.2.1.17 *Reduce morbidity caused by the worms by decreasing the worm burden among communities*

The implementation of HSSP II focused on scaling up core interventions to reach the new population at risk in addition to re-treatment of previously treated populations in both the communities and schools. During HSSP II control was scaled up from 20 districts to cover 42 districts and it was integrated with Child Days plus (CDP). Capacity building for school teachers and community medicine distributors (CMDs) for mass chemotherapy has continued. A number of health units in geographical areas which don't qualify for mass chemotherapy, were stocked with praziquantel and albendazole for selective chemotherapy. IEC materials were designed, produced and distributed to schools and communities in affected districts for social mobilization.

Control is however still faced with some challenges such as: Inadequate funding, particularly at the district level to facilitate the implementation of activities that lead to mass chemotherapy; and inadequate manpower at the health unit level to monitor, evaluate and supervise implementation of the programme. There is need for a comprehensive programme on sanitation and domestic water sources that should be initiated and implemented alongside mass chemotherapy; improving staffing levels at health units should be stepped up and funding increased for the programme particularly at the district level.

### **Strategies and interventions**

- *Strengthen advocacy and social mobilisation at all levels for the control and prevention of schistosomiasis.*
  - Develop and disseminate IEC materials on schistosomiasis.
  - Integrate schistosomiasis control with child plus days.
- *Improve access to treatment and control of schistosomiasis.*
  - Implement periodic mass chemotherapy at community level.
  - Conducting systematic regular treatment in school-age children at risk of morbidity.
  - Conduct selective vector (snail) control.
- *Capacity building in communities and schools to address the prevention and control of Schistosomiasis.*
  - Orient VHTs and teachers in the prevention and control of schistosomiasis.
  - Provide IEC materials to VHTs and schools on prevention and control of schistosomiasis.

### **Indicators with targets**

- Coverage with mass chemotherapy in all the endemic districts increased from 74% to 100% by 2015<sup>48</sup>.
- All endemic districts integrate prevention and control measures within the district work plans during all the years of the strategic plan.

### 5.2.1.18 *Reduce morbidity and mortality due to Leishmaniasis among the endemic communities*

The control of this disease in the area where it is endemic in the country was undertaken by Medicins Sans Frontiers (MSF) of Switzerland between 2000 and 2006 when they (MSF/Switzerland) relocated to Kacheliba, Kenya, leaving a vacuum until August 2007 when the Drugs for Neglected Diseases Initiative (DNDi) took over the programme at the request of the MoH. DNDi is currently supporting control activities in order to attract patients for a drug combination study at Amudat Hospital. Leishmaniasis is the collective name for a number of diseases which have diverse clinical manifestations. The form that is most deadly, visceral leishmaniasis (VL) is the one that is endemic in Uganda. This disease (VL) if left untreated, invariably leads to death, thus making early diagnosis and treatment a matter of paramount importance. The circumstances of the transmission of this disease are continually changing in relation to environmental, demographic and human behavioural factors. Changes in the habitat of the natural host and vector, HIV Infection, and the Consequences of conflict,

<sup>48</sup>This is based on 9 districts in 2008/09.

all contribute to the changing leishmaniasis landscape. Tools available for the control of the disease are not properly validated. The sector will work towards reducing morbidity and mortality due to Leishmaniasis among the endemic communities, through empowering the endemic communities to participate in the prevention and control of the disease.

### **Strategies and interventions**

- **Strengthen the control and prevention strategies for leishmaniasis**
  - Deploy Intergrated vetor Management (IVM), using, e.g. ITNs.
  - Conduct mapping for the disease to establish its magnitude and extent in the country.
  - Conduct social mobilization and advocacy campaigns.
  - Develop National and District Capacity for the prevention and control of the disease

### **Targets**

- The magnitude and full extent of the disease in the country is established by 2010/2011
- Increase early case detection to 60% by 2015.

### **Implementation arrangements for diseases targeted for elimination**

The Department of Community Health in the MoH shall coordinate this prevention and elimination and shall work with other departments within the MoH and the entire health sector to develop policies and guidelines for the diseases targetted for elimination or eradication. CSOs and other government sectors shall be involved. It will have responsibility as well to provide technical support and supervise the DHOs which will in turn supervise and support lower level efforts. The VHTs at community level will be capacitated to educate members of the community about the control and prevention of diseases targeted for elimination.

Endemic, emerging and re-emerging Zoonotic Diseases

#### **5.2.1.19 Reduce the morbidity and mortality due to endemic, emerging and re-emerging zoonotic diseases**

Globally, in the last 15 years almost all newly emerging and re-emerging human infections have been of animal origin or zoonotic in nature. There are over 150 known zoonotic diseases with potential for transmission and spread from animals to humans. The most notable are; Highly Pathogenic Avian influenza (H5N1), pandemic influenza H1N1, Severe Acute Respiratory Syndrome (SARS), Bovine Spongiform Encephalopathy / variant-Creutzfeld-Jakob Disease (Mad Cow Disease). In Uganda, outbreaks of Ebola Heamorrhagic fever (HF) and Marburg HF have occurred with increasing frequency in the last five years.

There has also been a re-emergency of anthrax, mange and plague which occur sporadically in wildlife and domestic animals and they occasionally spill over and spread into the human populations. At the same time long established zoonotic diseases such as rabies, bovine TB, brucellosis, cysticercosis and hydatidosis have remained endemic among the population in most developing countries including Uganda. There is need to build enough capacity in the country for early detection, prevention and control of these newly emerging and endemic zoonotic diseases as well as to reduced animal-related ill health among the Ugandan population.

Strategies and interventions

- Strengthen the policy environment for prevention and control of zoonotic diseases.
  - Develop and disseminate zoonotic diseases prevention and control technical guidelines and operational manuals.
- Strengthen IEC activities on the major zoonotic diseases of public health importance.

- o Train health workers, VHT together with Veterinary Extension Workers and wildlife staff in creating awareness about these diseases.
- o Develop and disseminate IEC materials on zoonotic diseases to raise awareness about their transmission, animal and human risk factors and appropriate means of prevention and control.
- o Give prominence to rabies prevention and control through commemoration of World Rabies Day on 28th September annually.
- Develop capacity for collaboration, investigation and management of zoonotic diseases.
  - o Conduct in-service training for health workers, veterinarians and wildlife staff and other stakeholders.
  - o Conduct operational research, situational analysis and field assessment to identify risk factors and disease burden for selected zoonotic diseases in the country.
  - o In collaboration with laboratory services, develop diagnostic capacity for selected zoonotic diseases at HC IVs, general hospitals and RRHs.
  - o Promote closer collaboration with animal and wildlife health sectors, research institutions and laboratories to embrace the concept of “One Health” as a viable strategy to address existing and emerging zoonotic disease threats.

#### Specific targets

- Zoonotic diseases technical guidelines, developed and disseminated by 2011/2013.
- The proportion of General Hospitals and RRH conducting proper laboratory diagnosis of brucellosis increased by 20% and 50% by 2015 respectively

#### Implementation arrangements for zoonotic diseases and diseases targeted for elimination

The Department of Community Health in the MoH shall coordinate this prevention and elimination and shall work with other departments within the MoH and the entire health sector to develop policies and guidelines for the diseases targeted for elimination or eradication. The department will liaise closely with ESD, UVRI and CPHL in prevention and control of zoonotic disease. CSOs and other government sectors shall be involved. It will have responsibility as well to provide technical support and supervise the DHOs which will in turn supervise and support lower level efforts. The VHTs at community level will be capacitated to educate members of the community about the control and prevention of zoonotic diseases and diseases targeted for elimination.

### **Cluster 3: Non-communicable diseases/conditions cluster**

Uganda is experiencing dual epidemics of communicable and non-communicable diseases. The Cluster on Prevention and Control of Non-Communicable Diseases/Conditions. These include Cardiovascular Diseases, cancers, Diabetes, Chronic Obstructive Pulmonary Diseases and sickle cell disease. This section examines each of these elements.

Non-communicable diseases, particularly diabetes, cardiovascular diseases, cancers, chronic respiratory diseases caused over 60% of all deaths globally in 2005 (estimated at 35 million deaths). Total deaths from NCDs are projected to increase by a further 17% over the next 10 years. Low-income countries like Uganda are the worst affected by these diseases, which are largely preventable by modifying their common risk factors through Primary Health Care interventions. Uganda lacks precise data on the prevalence of NCDs and their risk factors. During HSSP II, the MoH initiated the process of conducting a baseline study on risk factors and magnitude of non-communicable diseases in the country. The survey is yet to be completed due to financial constraints. Among the *challenges to* NCD control in Uganda are; lack of baseline data on the prevalence of NCDs and their risk factors; lack of community awareness; high prevalence of unhealthy

lifestyles; inadequate capacity of the existing health system to provide quality NCD services, and the high cost of medicines/supplies for treatment.

The lack of baseline data has delayed the formulation of evidence based national NCD policies and strategies as well as the development of a comprehensive and integrated action plan against NCDs in our population. *The priority actions shall include; obtaining baseline data through a national NCD survey, raising public awareness and promoting healthy lifestyles; screening for early disease detection and provision of quality treatment; surveillance of NCDs and their risk factors in the communities. The overall objective of the non-communicable diseases cluster is to reduce the morbidity and mortality attributable to NCDs through appropriate interventions targeting the entire population of Uganda.*

#### **5.2.1.20 Prevent Type 1 and Type 2 diabetes and reduce morbidity and mortality attributable to diabetes and its complications.**

Almost 80% of diabetes deaths occur in low- and middle-income countries such as Uganda. WHO projects that deaths related to diabetes will double between 2005 and 2030. In Uganda precise data on the prevalence of diabetes is lacking. Data available is incomplete and facility based. Type 2 Diabetes accounts for over 80% of the total cases of diabetes in Uganda and this is related to unhealthy lifestyles. Type 1 Diabetes is largely under diagnosed and is associated with a high mortality. The existing interventions are curative oriented and are poorly coordinated and supported. The major challenges facing the control and prevention of diabetes in Uganda include insufficient adequately trained human resource, lack of standards and guidelines for diabetes interventions and inadequate supply of screening, diagnostic and monitoring equipment. Community awareness on diabetes and its risk factors is unacceptably low hence it affects the choice of therapy. Medicines for the treatment of diabetes are expensive and are not readily available particularly at lower health level facilities. The World Diabetes Foundation (WDF) has extended support to the MOH to establish a National Diabetes Prevention and Control Program. This program is supporting improvement in the quality of diabetes care through the training of health workers, supplying diagnostic and monitoring equipment and developing a tool for improved data collection and documentation. The program is also supporting the on-going national survey on Diabetes. During HSSIP there will be a need to strengthen the existing program particularly in the areas of improving data collection, increasing public awareness, diabetes control and prevention, early diagnosis and quality treatment and care for diabetes and its complications.

### **Strategies and interventions**

- *Strengthen public awareness programmes for the control, prevention and management of diabetes in Uganda.*
  - Develop a gender responsive community oriented communication strategy to increase public awareness about diabetes and its associated risk factors utilizing appropriate media channels.
  - Commemorate World Diabetes Day annually.
- *Promote healthy lifestyles in schools, work places and communities.*
  - Develop and implement gender responsive national guidelines on physical activity, appropriate diet, tobacco and alcohol use.
  - Design and implement community-based interventions for diabetes prevention and control.
  - Conduct targeted screening for populations at risk in selected workplaces.
- *Improve early diagnosis, treatment and care of diabetes and related complications including its prevention.*
  - Establish integrated clinics for NCD prevention and control from HC IV and above.
  - Supply clinics with appropriate equipment, medical supplies and medicines for NCD screening, diagnosis, treatment and care.



- Establish specialised services for attending to children with Type 1 diabetes from HC IV and above.
- Screen pregnant women to facilitate earlier identification, treatment and diagnosis of gestational diabetes.
- Develop and implement gender responsive guidelines for NCD screening in patients on Anti retroviral therapy (ART).
- Conduct needs assessment for prevention and control of diabetes in health facilities at all levels
- Develop and implement a gender responsive package for prevention, screening, diagnosis, treatment and care of diabetes and its complications at different levels of health care in schools
- Conduct appropriate training courses for health workers in diabetes prevention, care and counseling at all levels of health care
- *Strengthen partnerships for the control, prevention and treatment of diabetes.*
  - Establish partnerships and strengthen collaboration with key stakeholders e.g. Ministries, Health Development Partners, CSOs, NGOs, the private sector, professional organisations, to create an enabling environment for diabetes interventions and to scale up diabetes prevention and control activities.
  - Organise annually the National NCD Symposium for key NCD stakeholders.
- *Establish and strengthen routine data collection systems for diabetes.*
  - Integrate diabetes surveillance within the existing disease surveillance system.
  - Review existing HMIS tools to accurately capture the burden of diabetes in the country.
- *Conduct a national survey to obtain baseline data on the prevalence of diabetes and its risk factors as well as their social determinants.*
- *Develop standard diabetes files for use in all health facilities.*

### **Indicators with targets (Baseline surveys to be conducted)**

- Public awareness on diabetes and risk factors increased by 5% by 2015.
- *Percentage of HCIVs and hospitals equipped with equipment to diagnose diabetes increased by 5% by 2015.*
  - Standard diabetes files utilized in 30% of health facilities HCIVs and hospitals by 2015.

#### **5.2.1.21. Prevent cardiovascular and related diseases and reduce morbidity and mortality attributable to CVDs**

In Uganda CVDs are on the rapid increase. Records at the Uganda Heart Institute have shown an increase in outpatient attendance due to heart related conditions of 500% over 7 years (2002 – 2009). In Mulago Hospital there has been an increase in cases of ischaemic heart disease from 1.8% out patient in 2002 to 7% in 2009. Hypertension is the leading cardiovascular disease accounting for over 50% of all cases seen annually. People in low- and middle-income countries are more exposed to risk factors leading to CVDs and other non-communicable diseases and are less exposed to prevention measures than people in high-income countries. Modifiable CVD risk factors include physical inactivity, inappropriate diets which are high in calories, salt and sugar but low in fruit and vegetable content, alcohol abuse, tobacco consumption, high blood pressure, high blood sugar, and obesity. Non modifiable risk factors include genetic predisposition, age and black race. In 2009 The Uganda Heart Institute became an autonomous body under the MoH. It is mandated to provide super-specialized tertiary cardiovascular and chest surgical care. At the RRH and general hospitals CVD health care services are being provided by specialist physicians and medical officers respectively. During the HSSIP priority will be given to creating awareness about CVDs, improving access to prevention and treatment and

ensuring that data is available for informing programming.

### **Strategies and interventions**

- *Create awareness about CVDs and associated risk factors amongst policy makers and the community.*
  - Conduct community sensitization about CVD and associated risk factors.
  - Develop national standards and guidelines for CVD prevention and management.
- *Improve access to early diagnosis, quality treatment and care of CVDs and their complications including prevention.*
  - Develop/review and implement management guidelines for CVDs and related diseases.
  - Conduct Continuing Professional Development sessions on CVDs.
  - Avail equipment, essential medicines and supplies for management of CVDs.
  - Develop and implement national guidelines for interventions against CVD risk factors.
  - Conduct targeted screening for populations at CVD risk in selected workplaces.
- *Strengthen data collection systems for CVDs.*
  - Develop and avail appropriate tool for data collection at all health facilities.
  - Conduct a National Burden of CVD survey and operational research on risk factors for CVDs

### **Indicators with targets by 2015**

- Standards and guidelines for CVD prevention and management developed by 2014/15.
- Public awareness on CVDs and their risk factors increased by 10% by 2014/15.
- The percentage of health facilities from HC IV and above equipped to diagnose CVDs increased by 5% by 2014/15.

#### **5.2.1.22 Establish a national framework for cancer control with emphasis on cancer prevention**

The World Health Organization (WHO) estimates that the global cancer burden will increase by 6 million between 2000 to 2020, most of this increase will be in the developing countries especially Sub Saharan Africa. Thirty percent of cancers in developing countries are related to infection, most cancer patients are young and in their prime as opposed to elderly population in the developed world. HIV has emerged as a single major factor in the recent accelerated burden of cancer in this region. Uganda is one of the countries with very high morbidity and mortality due to cancer. Kaposi sarcoma accounts for about 80% of all male cancer. In females cervical cancer is the commonest cancer since early periods but the incidence has increased tremendously, accounting for 30% of bed occupancy in the gynaecological wards at Mulago Hospital. Trend of cancer incidence for the last four decades has been upward. The most dramatic increase in cancers has been noted in cancers associated with HIV such as Kaposi's sarcoma, Non Hodgkin's lymphoma, Carcinoma of the cervix, Squamous cell carcinoma of the conjunctiva. The second factors responsible for the increase in cancer are lifestyle changes such as lung cancer (strongly related with tobacco) Hepatocellular carcinoma (related to consumption of alcohol, aflatoxin due to poor storage of grains and infection with hepatitis viruses). The third category of factors are nonspecific possibly linked to environmental change which has led to increase in cancers such as Hodgkin's lymphoma, Burkitt's lymphoma, Leukemia's, Hepatocellular carcinoma, and Stomach cancer.

Special mention should be made of cancers in childhood which have dramatically increased in the region without specific causes. The high morbidity and mortality due to cancer in the country is attributed to late disease presentation, reflecting lack of access to early diagnosis and treatment as a result of the poor status of cancer care system in the country. Further the cost of cancer treatment cancer in the country is out of

reach of many patients. Uganda, like many developing countries, has not been well prepared for the sudden burden of cancer it is now experiencing. The majority of these cancer cases however could be prevented or cured if detected early. The major challenges to cancer control in the country stems from lack of specific policy on cancer, the magnitude of the disease is unknown, lack of cancer awareness hence late disease presentation. During the HSSIP period the priority will be to create enabling policy environment for cancer control, raise level of awareness, promote cancer prevention and control, improve referral system, expand cancer registration and provide training for lower level health workers on cancer.

### **Strategies and interventions**

- *Creation of an enabling policy environment for cancer prevention and control in Uganda*
  - Formulate national cancer control policy and National cancer control program.
- *Raise the level of cancer awareness in the country*
  - Develop a communication strategy for effective Information, Education and Communication on cancer for policy makers and the general public.
- *Strengthen initiatives that promote primary and secondary cancer prevention*
  - Tobacco control
  - Vaccination against hepatitis B
  - Screening for cervical cancer
  - Breast self examination
- *Establish a national infrastructure for patient referral and follow-up*
- *Expansion of cancer registration and establishing a National cancer registry data base*
  - Establish population based and facility based cancer registries
- *Training and capacity building for lower level health workers on cancer*
  - Develop guidelines and SOP focusing on prevention, early detection, early diagnosis and the cancer referral system.

### **Indicators with targets**

- Cancer policy and National Cancer Control Program in place by 2013
- Increase in cancer awareness activities by 50 % by 2013
- Availability of cervical cancer screening in all Health centre IV country wide by 2015
- Establishment of two population based cancer registry and a national cancer data base by 2015
- Cancer guidelines and SOP for lower level training in place by 2013

#### **5.2.1.23 Prevent chronic respiratory diseases and reduce morbidity and mortality attributable to COPD and asthma**

Adult respiratory diseases, particularly chronic respiratory disease, constitute a major burden in terms of morbidity and mortality in the developing world. They contribute to work-limiting health problems, lost work days, and premature death resulting from delayed diagnosis and treatment. A strong case can also be made for moving resources in developing countries from expensive curative interventions to more cost-effective preventive interventions.

The burden of chronic adult respiratory diseases has been rising throughout the world, now including not only tuberculosis but also, chronic obstructive pulmonary disease (COPD) and asthma, and occupational lung

diseases. COPD, are often caused by environmental exposure to tobacco smoke or unvented biomass fumes. Since the bulk of mining and manufacturing activities have transferred to the developing world where controls on risky exposure are conspicuously lacking, occupational lung diseases, including silicosis and asbestosis present a particular problem.

Although various interventions are indicated for each of these disease categories, they can be costly and of limited efficacy in lowering premature mortality. In the developing world, preventive and therapeutic strategies may have greater societal effect than managing the diseases after they arise. Cost-effective interventions include smoking prevention and reduction programs to tackle both asthma and COPD. When disease strikes, educating local healers on the importance of initiating treatment early could translate into savings with respect to worker productivity and medical costs and also reduce fatalities.

Epidemiological data describing the burden of COPD and Asthma as well as associated risk factors in the Ugandan population is lacking. There is a large evidence-care gap in the current management practice in Uganda which in addition is predominantly facility based. Community based interventions to prevent and mitigate the impact of COPD and Asthma are non-existent.

There is need to collect epidemiological data, initiate health promotional activities geared towards the prevention of COPD and asthma to improve the quality of care at all levels.

### **Strategies and interventions**

- *Public awareness and advocacy for diabetes prevention and control*
- *Develop national policy and guidelines on COPD and asthma prevention and management*
- *Strengthen Implementation of Tobacco Control policies*
- *To create awareness about Chronic respiratory diseases and associated risk factors.*
- *To improve early diagnosis treatment and care.*
  - Conduct targeted COPD and asthma Continuing Professional Development sessions
  - Equip all health facilities with appropriate, cost effective diagnostic tools and ensure proper maintenance.
  - Avail essential medicines and supplies for management of COPD and asthma
- *To improve the quality of data collection and documentation.*
  - Develop and avail appropriate tool for data collection at all health facilities.
- *To promote operational research in Chronic respiratory diseases*
  - Conduct a National Burden of Chronic Respiratory Disease survey and operational research on common causes of COPD and asthma in the communities.
- *Inter-sectoral collaboration*
  - Encourage and Support operationalization of professional societies such as the Uganda Thoracic Society (UTS).

### **Indicators with targets**

- Increased awareness on COPD and asthma disease and risk factors
- Improved diagnostic capacity and treatment at all levels of care
- Improved quality of data on COPD and asthma
- Increased quality operational research targeted to improve the prevention and management of COPD and asthma

#### 5.2.1.24 *Reduce the morbidity and mortality associated with sickle cell disease.*

In West African countries such as Ghana and Nigeria, the frequency of the sickle cell trait is 15% to 30% whereas in Uganda it shows marked tribal variations, reaching 45% among the Baamba tribe in the west of the country. At the Mulago Hospital Sickle Cell Clinic 460 new cases of sickle cell were diagnosed in 2005, 556 patients in 2006, 459 patients in 2007 and 459 patients in 2008. There is no accurate data on the prevalence of sickle cell in Uganda as only the few patients that report to Mulago hospital are registered. Public awareness about sickle cell is low. Sickle cell anaemia is a condition of importance to the health sector in Uganda particularly due to the high prevalence of the abnormal gene, the endemicity of malaria and the morbidity and mortality attributed to it. The sickle-cell gene has become common in Africa because the sickle-cell trait confers some resistance to falciparum malaria during a critical period of early childhood, favoring survival of the host and subsequent transmission of the abnormal haemoglobin gene. Although a single abnormal gene may protect against malaria, inheritance of two abnormal genes leads to sickle-cell anemia and confers no such protection. Malaria is a major cause of ill-health and death in children with sickle-cell anaemia. Sickle cell services are currently centered at the national teaching hospital. Regional facilities are yet to be established within the country. Training of appropriate manpower and procuring the required equipment is still a big challenge. Under the Sickle cell Initiative, patients, parents and well wishers have formed the Sickle cell Association which delivers community health education and counseling to persons living far from the national teaching hospital. Over the next 5 years priority will be given to raising awareness about the disease, formulating policies on management of sickle cell, capacity building and expanding access to services.

### **Strategies and interventions**

- *Strengthen public awareness programmes for the control, prevention and management of diabetes in Uganda.*
  - Promote community education, including health counseling, and associated ethical and social issues.
  - Advocate for formulation of policies and guidelines for sickle cell prevention and management..
  - Increase access to sickle cell screening and diagnostic services
  - Establish Sickle cell clinics at every Regional Referral Hospital.
  - Equip Sickle cell clinics with basic facilities and equipment to conduct screening and diagnostic tests (CBC tests, Urinalysis and HB electrophoresis).
- *Improve the policy environment for management of sickle cell disease*
  - Formulate policies and guidelines on sickle cell disease.
    - *Build capacity to improve quality of sickle cell care*
  - Train health workers on sickle cell issues and management of sickle cell disease.
  - Strengthen in-service training on sickle cell disease.
- *Create and sustain partnerships for the control and management of sickle cell*
  - Encourage the formation of Sickle cell associations in every Regional Referral Hospital.
  - Establish partnerships and strengthen collaboration with key stakeholders e.g. ministries, health development partners, CSOs, NGOs, the private sector, professional organizations to create an enabling environment for sickle cell prevention and control activities.

### **Indicators with targets**

- Policy and guidelines on Sickle cell disease developed by 2014/15.
- Sickle cell clinics established in 30% of Regional Referral Hospitals by 2015.

### ***5.2.1.25 Decrease the morbidity and mortality due to injuries, common emergencies and disabilities from visual, hearing and age-related impairments.***

Injuries, disabilities and rehabilitative health encompass conditions that result in an individual's deprivation or loss of the needed competency. This can be due to damage or harm done to or suffered by a person before or after birth. Such deprivation or loss of competency includes conditions like: deafness, blindness, physical disability and learning disability. Some challenges exist that deter the effective prevention and control of injuries, disabilities and rehabilitative health: understaffing, inadequate support to orthopaedic workshops, low priority accorded to disability at all levels and challenges of coordination of many different stakeholders with varying interests. There is need to address these issues.

### **Strategies and key interventions**

- *Put in place preventive, promotive and rehabilitative interventions to reduce mortality and morbidity or disability caused by injuries.*
  - Create awareness at national, district and community levels about the prevention and management of injuries and disabilities through use of media and VHTs.
  - Promote the rehabilitation and construction of public and private facilities to make them accessible to people with disabilities.
  - Advocate for enforcement of protective legislation e.g. use of seat belts, policing drunken driving, restricted smoking among others.
  - Scale up the production of various types of assistive devices for people with disabilities.
  - Develop and disseminate guidelines on handling of trauma, disabilities and rehabilitation.
  - Strengthen intersectoral collaboration in the prevention and management of injuries and disabilities.
  - Conduct periodic studies to determine the burden of disability in Uganda which will inform the development of policies and interventions.
- *Improve access to health services by people with disabilities.*
  - Develop and disseminate a protocol for provision of services including reproductive health services to people with disabilities.
  - Rehabilitate health facilities to make them accessible to people with various forms of disabilities.
  - Orient health workers on control, prevention and treatment of injuries and disabilities.

### **Indicators with targets**

- Hearing impairment reduced from 8% to 6% by 2014/2015.
- Visual impairment reduced from an estimated 0.8% to 0.7% by 2014/2015.
- Assistive devices provided to 80% of PWDs who need them by 2015.
- The proportion of the population reached with messages on disability prevention and rehabilitation increased to 80% by 2015.

### ***5.2.1.26 Ensure increased access to primary and referral services for mental health, prevention and management of substance abuse problems, psychosocial disorders and common neurological disorders such as epilepsy.***

Mental health problems and substance abuse disorders contribute 12.5% of the global burden of disease. The

burden is likely to be higher in Uganda due to effects of civil strife, the consequences of HIV/AIDS and increase in alcohol and drug abuse due to an inefficient and poorly enforced substance use control law. During HSSP II, there was an increase of mental health services at RRHs from 50% to 100% under SHSPP II; community access to mental health services increased from 20% to more than 50% and the proportion of HC IVs with at least one antipsychotic, one antidepressant and one anti epileptic medicine increased from 10% to 30%. There is a need to keep this momentum through increasing psychiatric staff numbers and by allocating more resources for purchase of essential mental health medicines. The mental health program also coordinates management of neurological disorders such as epilepsy which affects about 3% of the general population and contributes 70% of attendances at Mental Health Units. The implementation of mental health programmes is impeded by underfunding, stockouts of mental health and epilepsy medicines, delayed repeal of mental health law and negative attitudes of some managers which hinders integration of mental health into general services.

### **Strategies and interventions**

- *Strengthen the legal and policy environment for provision of mental health services in Uganda.*
  - Repeal the Mental Treatment Act which is outdated.
  - Develop mental health policy and strategic plan.
  - Promote the rights of the mental ill.
  - Develop a community strategy for control and prevention of mental health problems.
  - Develop and implement an alcohol control policy and drug control master plan.
- *Improve access to mental health services.*
  - Develop and disseminate standards and guidelines for the integration of mental health into primary health care.
  - Integrate mental health services into primary health care.
  - Provide care for neurological disorders at primary care level.
  - Provide food for all unaccompanied mental health patients.
  - Provide essential mental health and anti-epilepsy drugs.
  - Ensure the availability of functional mental health units in all RRHs.
  - Provide a psychiatrist and other specialist mental health professionals for each RRH.
  - Provide alcohol and drug abuse treatment and rehabilitation services at all levels of care.
- *Build the capacity of health workers in provision of health services to the mentally ill.*
  - Orient health workers in mental health in order to address the negative attitudes of some managers.
  - Increase the number of Psychiatric Nurses and Psychiatrists being trained in health training institutions.
  - Provide basic training in mental health to general practitioners and health officers.
  - Provide refresher training for mental health and general health workers
- *Strengthen IEC messages create awareness about mental health including de-stigmatisation of the mentally ill.*
  - Develop and disseminate appropriate messages for improving community mental health.
  - Provide public education for demand reduction for alcohol and drug abuse.

### **Indicators with targets**

- Mental Health Law enacted by 2011/12.
- Mental Health Policy finalised and operationalised by 2010/11.
- Operationalise Mental Health Units in all RRHs by 2010/11.
- Community access to mental health services increased from 60% to 80%.
- A community strategy for prevention of mental health problems developed by 2010/11.
- Services for alcohol and drug abuse management are available at HC IV by 2013/14.

#### **5.2.1.26 Improve the oral health of the people of Uganda by promoting oral health and preventing, appropriately treating, monitoring and evaluating oral diseases.**

Oral Health encompasses the positive aspects of good oral health, all oral conditions including dental caries, periodontal disease and derangement of the oro-facial tissues and other oral pathology including oral cancer. Some modest progress has been made during HSSP II in implementation of oral health: for example equipping HC IVs with dental units and putting in place a operationising the national oral health policy. Progress has been slow because of among other reasons lack of dental equipment in most government hospitals and HC IVs; lack of dental infrastructure in many districts, especially the newly created ones; non- or under-utilization of many of the oral health care workers in the district PHC activities and lack of specialists in the dental field and lack of transport for support supervision. Thus there is need to budget for phased rehabilitation and construction of new infrastructure for oral health, especially in the newly created districts; equip the government health units with dental equipment should be done in phases, e.g. 5 health units per annum.

### **Strategies and interventions**

- *Strengthen the policy environment for implementation of oral health interventions.*
  - Operationalise the oral health policy.
  - Develop, disseminate and implement oral health policy implementation guidelines.
- *Strengthen IEC activities on oral health.*
  - Operationalise the oral health policy.
  - Train VHTs to be involved in creating awareness about oral health.
  - Develop and disseminate IEC materials on oral health to raise awareness about oral health risk factors and appropriate means of oral health care.
- *Develop capacity for the delivery and management of oral/dental health conditions services.*
  - Conduct in-service training for dentists and other technicians, oral and non-oral health professionals.
  - Organise preventive oral health promotion programmes in primary schools and among people with disabilities.
  - Ensure fully operational oral health infrastructure at HC IVs, general hospitals and RRHs.
  - Develop, in collaboration with other sectors, a national water fluoridisation programme.
  - Generate data through oral health research to inform development of oral health interventions.
  - Integrate oral health into other health programmes.
  - Identify and develop collaborative approaches to initiatives that address oral disease common risk factors such as tobacco, sugar, alcohol, unsafe sex, chronic medication, and violence and vehicle accidents.



### **Specific targets**

- Oral health policy implementation guidelines developed and disseminated by 2010/2012.
- The proportion of HCIVs with well equipped and functional dental units increased from 85% to 80% by .
- The proportion of the population with access to primary oral health care from increased from 20% to 80%.

#### **5.2.1.27 Improve the quality of life of terminally ill patients and their families especially the home carers**

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with diseases not responsive to cure, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other symptoms, physical, psychological and spiritual. Currently, very limited services are available. It is well-known that the burden of care for family members falls overwhelmingly on women and girls in the household, a role that is often unsupported and that has been documented to lead in some circumstances to the deterioration of the health of the carer, and in other circumstances in some girls having to drop out of school to play this role.

### **Strategies**

- *Build the capacity for palliative care in collaboration with other stakeholders.*
  - Develop guidelines and standards for palliative care including for appropriate support to the carers.
  - Train health workers and male and female volunteers in palliative care.
  - Establish partnerships with community based palliative care providers including for their support.
  - Establish outreach palliative care services.
  - Integrate palliative care into the curricular of health training institutions.
  - Intensify public education on palliative care.
- *Improve access to palliative care.*
  - Provide palliative care in all hospitals and HC IVs.

### **Indicators with targets**

- Guidelines and standards for palliative care developed.
- All hospitals and HC IVs providing palliative care.
- Adequate stocks of appropriate medication and supplies at palliative care centers are available.

### **Implementation strategy**

In 2006 the MoH created the Programme for Non-Communicable Diseases which has the responsibility to coordinate the control and prevention of epidemics. The National Non-Communicable Diseases Programme will work with other Departments within the MoH, the private sector and CSOs to develop policies, strategies and guidelines for the control and prevention of NCDs. The responsibility to coordinate this programme at district level shall lie with the DHO.

## **Cluster 4: Sexual, Reproductive Health and Rights and Child Survival**

#### **5.2.1.28 Reduce mortality and morbidity relating to sexual and reproductive health, and rights**

Maternal and child mortality rates in Uganda are quite high: MMR stands at 435/100,000 and IMR at 76/1,000. The proportion of deliveries by skilled personnel is still low at 34% and the provision of Emergency and Basic Obstetric and Newborn Care (EmONC) is limited. The CPR is low at 24% and the unmet need of FP is 41%.

Total fertility rate has remained high at 6.5. While a significant proportion of Uganda's population consists of adolescents, adolescent sexual and reproductive health services are limited and they do not address the needs of adolescents. Adolescent pregnancy stands at 23% (UDHS 2006). Maternal malnutrition, due to both macro and micro deficiencies, still contribute prominently to still births, maternal and child morbidity and mortality. Sexual and Gender-Based Violence is a major concern that impacts on maternal morbidity and mortality. The right to Sexual and Reproductive Health and Rights is important as it aims at reducing the MMR, U5MR and TFR, all key elements of the health MDGs. There is international consensus on the interventions to bring these statistics down. The challenge remains with the implementation of these interventions in a coordinated and sustained fashion. As has been highlighted in Chapter 3 implementation of interventions to address maternal health problems in Uganda is hampered by inadequate funding of the interventions, lack of HR, medicines and supplies and appropriate buildings and equipment including transport and communication equipment for referral. The lack of decision making at household level by women affects their health seeking behaviour including during pregnancy.

### ***Strategies and interventions***

- *Strengthen IEC activities on sexual and reproductive health*
  - Develop, print and disseminate evidence based, gender sensitive IEC materials.
  - Through VHTs, create awareness about sexual and reproductive health including pregnancy surveillance, family planning among community members with a special focus on men.
  - Sensitize and empower communities about sexual and reproductive health and rights and their responsibilities.
  - Promote deliveries by skilled attendants.
- *Build institutional and technical capacity at national, district and community levels for RH*
  - Ensure quarterly technical MCH cluster meetings with key stakeholders including health training institutions.
  - Train health workers in the provision of SRH services including management of obstetric emergencies.
  - Strengthen referral systems for SRH services with a focus on transport and communication..
  - Provide quarterly technical support supervision to districts and lower level
- *Expand the provision of quality SRH services.*
  - Provide integrated Family Planning services in all health facilities according to levels of care.
  - Procure and distribute contraceptives to men and women of reproductive age group including adolescents.
  - Strengthen and expand coverage of goal oriented antenatal care including PMTCT.
  - Conduct outreach SRH services from health facilities.
  - Institutionalize deliveries in HC IIs with priority being given to hard to reach areas.
  - Ensure availability of midwives in all HC IIIs.
  - Provide basic and comprehensive emergency obstetric care and newborn care according to levels of care.
  - Improving inter and intra-sectoral co-ordination and collaboration between actors in reproductive health.
  - Conduct operational research aimed at improving the uptake of SRH services.
  - Design programmes to engage men family planning services and use.

- Prevent and control Obstetrical Fistulae.
- *Strengthen adolescent sexual and reproductive health services.*
  - Ensure availability of updated IEC materials on adolescent health and development.
  - Integrate and implement adolescent sexual and reproductive health in school health programmes.
  - Increase the number of facilities providing adolescent friendly sexual and reproductive health services.
- *Strengthen the legal and policy environment to promote delivery of SRH services.*
  - Review SRH and related policies and address institutional barriers to quality SRH services including access to FP commodities through all the possible agreed channels including PNFP subsector.
  - Review SRH policies, standards, guidelines and strategies as need arises.

### **Indicators with targets**

- The proportion of pregnant women attending ANC 4 times increased from 47% to 60% by 2015.
- The proportion of women who deliver in health facilities increased from 34% to 90% by 2015.
- The proportion of health facilities with no stock-outs of essential RH medicines and health supplies increased from 35% to 70% by 2015.
- The proportion of health facilities that are adolescent-friendly increased from 10% to 75% by 2015.
- The % of health facilities with Basic and those with Comprehensive emergency obstetric care increased from 10% to 50% by 2015.
- The proportion of pregnant women accessing comprehensive PMTCT package increased from 25% to 80%.
- Contraceptive Prevalence Rate increased from 24% to 35% by 2015.
- The unmet need for family planning reduced from 41% to 20% by 2015.
- To increase the proportion of deliveries attended by skilled health workers from 40% to 60% by 2015.
- To reduce adolescent pregnancy rate from 24% to 15% by 2015.
- The proportion of mothers who have completed IPT II increased from 18% to 80%.

### **Implementation arrangements**

The overall responsibility of implementing this component of the HSSIP will lie with the Division of Reproductive Health at the MoH headquarters. It will be responsible for the development of policies as well as providing overall coordination and guidance of Sexual reproductive Health (SRH) activities and provision of technical support to the District Health services (DHS). It will work through the MCH cluster to engage various stakeholders in the planning, monitoring and evaluation as well as approving SRH policies, strategies and standards. The responsibility of implementing SRH policies and interventions will lie with the District Health Officers (DHO) together with CSOs and health care providers at delivery points within the district.

#### **5.2.1.29 Improve newborn health and survival by increasing coverage of high impact evidence based interventions, in order to accelerate the attainment of MDG 4.**

In Uganda, 29 neonatal deaths out of 1000 live births occur each year, translating into at least 45,000 neonatal (UDHS 2006). According to the newborn situation analysis (SITAN) of 2008 40% and 25% of deaths among infants and children under-five, respectively, are under 28 days of life. The first week of life poses the highest risk of deaths for newborns, with 75% of deaths occurring during this time and 50% occurring within just

the first 24 hours of life. Newborn deaths have maintained the high-sustained levels of the IMR, making it impossible for Uganda to achieve the MDG 4 target by 2015.

### **Strategies and interventions**

- *Mobilize and develop capacities for households and families to keep newborns healthy, make healthy decisions and respond appropriately to illness.*
  - Through the VHT promote essential New Born care practices (warm, clean chain, breast feeding, recognition of danger signs, care seeking and avoidance of local harmful behaviours)
  - Strengthen social networks and male involvement in newborn and maternal health
- *Improve capacities and quality of health services at community and facility level and of their interactions with caregivers.*
  - Review, disseminate post natal care policy and build capacity for conducting post natal home visit checks at day 1, 3 and 7 in the community and 6hrs, 6 days and 6 weeks at the health facility.
  - Widely disseminate and support implementation of minimum service standards for newborn care. (supplies, equipment, medicine, information, records, and guidelines for managing newborn )
  - Build capacities in districts and training schools for routine and extra newborn care skills including resuscitation, KMC, examination and management of sepsis and other conditions.
- *Building awareness of the right to health and survival of the Newborn.*
  - Develop advocacy plans and materials to raise awareness of the rights to health, survival and development and demand for appropriate newborn service
  - Do cost effectiveness analysis of selected strategies and services for preventing newborn deaths to inform policy and planning for newborn health
  - Partnerships and alliances with professional bodies in obstetrics and neonatology, private sector, other sectors to develop a common plan for improving newborn survival
- *Strengthen linkages between service levels and ensure continuum of care.*
  - Advocate for reproductive health community financing and transport schemes when referral is needed including communication systems.
  - Develop and disseminate the maternal, newborn and child handbook for information kept by the mother and families, to promote continuity between maternal, neonatal and child-care and health records.
  - Build and coordinate capacity building and monitoring implementation of newborn activities.

### **Indicators with targets**

- The proportion of neonates seen in health facilities with septicaemia/pneumonia disease reduced by 30%
- The proportion of newborns receiving at least three post natal care visit during the 1st week Increased to 60%
- Health facilities implementing more than two thirds of the minimum service standards increased from 20 to 40%
- Proportion of mothers of newborns 1-2 weeks practicing clean cord and skin care, keeping babies warm, exclusively breast feeding and recognize danger signs, increased by at least 30% from baseline figures

## **Implementation arrangements**

Interventions for strengthening delivery of newborn care services will be implemented within the framework of the existing system with the MoH divisions of reproductive and child health taking leadership and supported by the national newborn steering committee. The centre will be responsible for providing policy and guidelines, monitoring and building capacity for districts. The district is the most appropriate level for linking up local priorities with national health policy guidelines and resource allocations, and for coordination between health delivery services and communities, between government and private sector, and between health and other sectors. The key gaps identified in the situation analysis include limited capacity to plan for newborn health at different levels of care and patchy coverage of interventions falling short of getting the desired outcome, and this will constitute most of the early implementation activities. Partners will support MoH to finance and integrate newborn health in their programs. Other sectors e.g. MoE&S are expected to prioritize newborn health as part of the existing curricula on child health, safe motherhood/reproductive health in the pre service training of health workers at all levels.

### **5.2.1.30 Scale-up and sustain high, effective coverage of a priority package of cost-effective child survival interventions in order to reduce under five mortality.**

The survival of children under-five years of age is a major public health concern in Uganda and over the past two decades there have been modest gains in child survival mainly due to public health interventions and improving economic and social performance. More than 200,000 children under-five years still die every year mainly due to preventable conditions including malaria, pneumonia, diarrhoea, vaccine-preventable diseases (e.g. measles), HIV/AIDS, and neonatal conditions. The first week of life poses the highest risk of deaths for newborn, with 75% of deaths occurring during this time and 50% occurring within just the first 24 hours of life. According to the Uganda newborn situation analysis (SITAN) of 2008, 40% and 25% of deaths among infants and children under-five, respectively, are under 28 days of life, and 29 neonatal (UDHS 2006). Newborn deaths have maintained the high-sustained levels of the IMR, making it impossible for Uganda to achieve the MDG 4 target of reducing by two-thirds the mortality rate among children under-five is to be achieved by 2015. The GoU has developed a Child Survival Strategy to address the main bottlenecks of child health, and aim to reduce the under five-mortality rate from 137 per 1,000 live births to 56 per 1,000 live births by 2015.

Immunisation is a cost effective intervention for improvement of child health and ensuring the prevention of vaccine preventable diseases. Currently the targeted diseases are measles, poliomyelitis, whooping cough, tetanus, tuberculosis, diphtheria, Hepatitis B, Haemophilus influenzae type b and Human Papilloma Virus (in 2 districts). Plans are also underway for possible introduction of Pneumococcal and Rotavirus vaccines; and scale up of HPV vaccination to cover the entire country. While immunisation coverage has been high and some diseases such as measles are about to be eliminated there are some problems relating to the immunisation programme in Uganda: funding is low, the available data is not used adequately for planning purposes, irregularity in gas and vaccine supply to districts, aging fleet of vehicles and inadequate cold and dry storage space at the central vaccine store. There is still threat of polio importation in Uganda, given the circulating wild poliovirus in Southern Sudan and DRC and the declining trend of immunisation coverage. The aim of the programme is to reduce morbidity and mortality resulting from targeted vaccine preventable diseases maintains polio-free status and eliminates maternal and neonatal tetanus.

## **Strategies and interventions**

### **• Family oriented community based newborn and child health services**

- Improve family & neonatal care through behaviour change communication on newborn home care practises to ensure early initiation and exclusive breastfeeding, clean cord and skin care, maintenance of warmth and appropriate care seeking; post natal home visits/checks on the mother/baby pair during the 1st of life; and effective & timely referral of newborn to the health facility.
- Provision of family preventive/WASH services for child health and development through increased

community access to child health commodities (mama kits, insecticide treated mosquito nets, water quality testing kits, PCR test for HIV tests) to VHTs; food manufacturers fortifying of infant foods; linking communities to outreaches; and provision of incentives for use of services.

- Improve infant and young child feeding through promotion of early and exclusive breastfeeding practices; conduct health facility and community growth monitoring and promotion and referral of high risk children; and community therapeutic feeding for HIV+ children and those in special situations including emergencies.
- Introduce community illness management of diarrhoea, pneumonia and malaria through VHT training on priority areas; provision of first line anti-malarial, rapid diagnostic tests for malaria, oral rehydration salt and zinc for diarrhoea, antibiotics for pneumonia to VHTs; provision of job aids and IEC materials to trained VHT; household registration and recording patients treated and referred; and health facility VHT catchment planning for community child health activities.
- Improve supervision/monitoring of child health and nutrition at community through integrated supervision checklist, streamlining village HMIS to include common illnesses and nutrition, build capacity of health workers in HC II to and mentor and accredit VHTs to treat children; and facilitate VHT to attend quarterly meetings for reporting and refresher sessions.

● **Provision of and increase population oriented schedulable services for child health & survival.**

- *Improve preventive care for adolescents*, antenatal care through the roadmap.
- *Improve paediatric HIV/AIDs prevention care* through prevention of mother to child transmission (PMTCT) including testing and counselling on infant feeding options, early infant diagnosis using PCR during outreaches and linking tested babies to care; incentives for caregiver use of testing services and re-attendance for follow up; PCP Prophylaxis for children of HIV+ mothers and treatment of opportunists infections; and integration of promotion of family planning counselling.
- *Expand and integrate routine health facility outreaches services* to cover all interventions (immunisation, Vitamin A supplementation, deworming, malnutrition screening, Family planning, HIV testing, treatment of common childhood illness, information and education of mothers and families); conduct joint/integrated micro planning for outreach services with involvement of communities; strengthening information collection, reporting and feedback; districts and sub districts capacity to manage &strengthen commodity supply chain.

● **Improve preventive infant & child care through immunisation.**

- *Ensure vaccine supply and quality*; through expansion of cold storage space at the national, regional, district and health sub district levels; review and strengthen cold chain system at all levels; strengthen and maintain the gas and vaccine supply chain and build district and sub district capacity for cold chain management.
- *Improve access to immunization services*; through raising awareness and demand for immunization among community members and families; immunization through static and outreach services using innovations that will ensure that “missed-outs” and “drop-outs” from routine services are identified, particularly in urban, remote and underserved areas; advocate for and scale-up of HPV vaccination and introduction of pneumococcal and rotavirus vaccines into the routine immunization programme; strengthen monitoring and evaluation of the immunisation services including coverage.
- *Strengthen measles control, maternal and neonatal tetanus and polio eradication measures through*; conducting proven interventions to achieve global targets of polio eradication, elimination of maternal and neonatal tetanus, and accelerated measles control such as mass immunization campaigns; support disease-specific surveillance efforts and research to inform future policy in these areas.

● **Provision of individually oriented clinical services for newborn & child health basis.**

- *Improve neonatal care at primary health facility level* through increase capacity of facility based workers to manage newborn conditions (birth asphyxia, very low birth weight, sepsis, jaundice and HIV) including revision of curricula to include newborn health care; in and pre-service training; improve

quality of care through development, regular external and internal assessments/audits; certification of facilities as newborn friendly; and build capacity for peri-natal death audit and reviews.

- *Improve the management of common childhood illness at the primary level* through improving health facility supports for IMCI; improve and expand health worker capacity to manage common illness including nursing assistants; establish quality improvement approaches and strengthen referral compliance to higher level.
- *Strengthen clinical referral level secondary and tertiary care* through defining child and newborn minimum standards, improved infrastructure and equipment, drug availability of hospitals for specialist care; introduction and build capacity for emergency triage and treatment (ETAT) and helping babies breathe (HBB); innovative ways provision of oxygen, medication colour coding, sepsis prevention and control; strengthen capacity for specialist outreach services; and continuous quality improvement including health information management systems.
- **Creation of an enabling environment at national level**
  - *Regular review of policy and regulatory frameworks* for child health including task shifting, regulation for code for marketing breast milk substitutes, enforcement guidelines for hygiene and sanitation, advocacy and sensitisation of food industries to fortify food, political and decision makers on new childhood vaccines and developments in child health.
  - *Expand district and national programme management capacity* through recruitment of staff, specialist e.g. nutritionist, orient managers on management of child health programs; partnerships with private sectors and other sectors e.g. agriculture and education to ensure appropriate pre-service training and long distance training for relevant child health skills;
  - *Coordination of interventions/thematic policy across child health* concerned department through advocating to fully mainstream child health into PMNCH principles, harmonization of PMTCT, HIV, malaria policies in child health, develop integrated communication and advocacy strategies encompassing child, newborn and maternal health, nutrition, PMTCT, HIV and hygiene; strengthen functionality and review terms of references for child health expert committees.
  - *Build knowledge base on critical areas of child survival* through operational research on child survival delivery channels (family, population and individual services), post natal community newborn care, performance based financing, private sector engagement, IMCI, EID, PMTCT, and NBH; strengthen documentation of polio free status and surveillance efforts (Hib, pneumococcus, yellow fever, Rotavirus); child newborn verbal autopsy assessments; program evaluations to inform future policy.

### **Indicators with targets**

- Probable and confirmed malaria inpatient under five deaths reduced from 0.6 to 0.3%
- Stunting rates among children under-fives reduced from 38% to 28%
- Neonatal septicaemia rates in health facilities reduced by 30%
- Neonatal tetanus rates reduced and maintained at zero
- Non Polio Acute flaccid poliomyelitis rates maintained at greater than 2 per 100,000, and cases of paralysis due to wild polio virus maintained at zero
- Under-fives who slept under an ITN the previous night increased from 10 to 60%
- DPT-3/Pentavalent coverage for under 1's increased from 74%-85%
- Measles vaccination coverage by 12 months increased from 75% to 95%
- U5s with malaria treated correctly within 24 hrs increased from 26% to 60%
- U5 pneumonia managed with correct antibiotic increased from 17% to 50%
- Children 6-59 months receiving doses of Vitamin A increased from 36%-80%

- HIV-exposed infants started on cotrimoxazole prophylaxis within 2 months of birth increased to 80%
- Mother/newborn pair checked twice in 1<sup>st</sup> week of life (1st visit within 24 hrs) increased to 50%
- Exclusive breast-feeding rate by the age of 6 months increased to 60%
- Diarrhoea cases receiving ORT during illness increased from 37% to 60%
- Index of U5s managed in an integrated manner at the facility using IMNCI increased from 30%-60%
- Index of facility availability of tracer drugs and vaccines (anti-malarial, cotrimoxazole, measles vaccine, sulphadoxine/pyramethamine, depoprovera and ORS,) increased from 23% to 50%
- Number of facilities assessed and accredited as baby friendly (BFHI) increased from 15 to 70
- Health workers who are competent in material resuscitation upon completing of training

### **Implementation arrangements**

Interventions for strengthening delivery of newborn, child health and immunization services will be implemented within the framework for child survival, maternal newborn child adolescent health continuum. The child health division and EPI program at the national level will be responsible for providing policy and guidelines, monitoring and building capacity for districts. It will work with other government ministries, Local Governments, the private sector and CSOs in order to effectively deliver of services. The EPI program and child health division shall provide technical supervision and coordination of the immunization services in Uganda. Partners will support MoH to finance and integrate child and newborn health in their programs. Other sectors e.g. MoE&S are expected to prioritize health as part of the existing curricula on child health, safe motherhood/reproductive health in the pre service training of health workers at all levels. The district is the most appropriate level for linking up local priorities with national health policy guidelines and resource allocations, and for coordination between health delivery services and communities, between government and private sector, and between health and other sectors. At the district level the DHO shall coordinate and supervise the provision of immunization services by both the public and private sector. At community level the VHTs will play an important role in creating demand for services. The technical programs will build capacity at all levels in the delivery of services. While all communities shall be targeted, emphasis shall be on urban, remote and underserved areas. A multi-year plan will be developed to guide the implementation of the immunization and other child health services and to support mobilization for additional resources from government and partners.

#### **5.2.1.31 Prevent morbidity and mortality due to gender based violence.**

Gender based violence is very common in Uganda. As reported in the 2006 UDHS , 39% of women (15-49 years) versus 11% of men of the same age group have ever experienced sexual violence, the incidence being higher in rural areas for both sexes, but higher among men in the highest wealth quintile, as opposed to being higher among women in the lowest wealth quintile. Intimate partner violence is the most common form of violence for women age 15-49 years. UDHS 2006 document that more than two-thirds (68%) of ever-married women had ever experienced any kind of violence (physical, sexual or emotional) by a husband or intimate partner. While programmes are being implemented to address GBV challenges exist: lack of resources and equipment including transport and requisite skills among health workers to deal with such issues. In addition there is poor coordination and collaboration amongst different stakeholders in Uganda and this tends to weaken the national response to sexual and gender based violence. There are also existence of obsolete legal stipulations (such as for completion of certain forms required by law enforcement units, examination of survivors, testifying in courts of law all of which have posed a barrier to willing survivors to press for the enforcement of their human rights to dignity and bodily integrity, and also which have reinforced the notion of impunity of the perpetrators. These policy/legal stipulations need to be carefully examined and amended. There is need to enhance awareness creation to all health workers and all other stakeholders; roll-out training of health workers on management of SGBV both in-service and pre-service; develop, translate and disseminate IEC materials on SGBV, empower and support male change agents for SGBV and to Educate



school pupils, students and communities on health consequences and response of SGBV.

### **Strategies and key interventions**

- *Build the capacity of health workers, their respective institutions and communities to manage cases of SGBV.*
  - Create awareness about SGBV among all health workers, teachers, VHTs and all other stakeholders.
  - Provide both inservice and preservice training to health workers on management of SGBV.
  - Educate school pupils, students and communities on health consequences of SGBV.
  - Develop user friendly manuals to facilitate the implementation of gender mainstreaming in the health sector.
  - Provide PEP to victims of rape.
- *Strengthen IEC activities on the effects of SGBV.*
  - Develop, translate and disseminate IEC materials on the negative health and development effects of SGBV.
  - Empower and support male change agents for SGBV.
  - Develop a strategy to address SGBV in the health sector.
  - Create awareness about the effects of SGBV among communities using VHTs and CSOs.
  - Conduct a mapping exercise to determine the organisations dealing with SGBV in Uganda and work with them to create awareness about the effects of SGBV.
- *Strengthen the capacity of the health sector to conduct SGBV related M and E activities.*
  - Compile and analyse information available to establish the prevalence of GBV in Uganda and formulate strategic interventions for the health sector.
  - Work with UBOS to incorporate SGBV issues in national surveys such as the UDHS.
  - Strengthen inter-sectoral collaboration for GBV prevention and management:
- Train appropriate cadres of staff to review and streamline the management of GBV and referral
- Review the policies and stipulations relating to the completion of Police form 3 with the intention to removing current barriers to appropriate examinations, reporting ( and enforcement of the rights of survivors to due process) and abolition of impunity of perpetrators, resulting in none pursuance of cases.

### **Indicators with targets**

- An integrated strategy to address SGBV in the health sector developed and disseminated.
- Health service provision for survivors of rape scaled up in all district hospitals and 50% of HC IIIs.
- PEP Kits available in all district hospitals and 50% of HC IIIs.
- Health workers trained in clinical management of survivors of rape increased to 25% by 2015.

#### **5.2.2 Objective 2: Improve levels, and equity in access and demand**

Access to services is affected by a number of factors. Where access is poor, the clients are not able to utilize services. As such, the sector will focus on putting in place the necessary inputs that are needed, to ensure there is improved access to health services. These inputs relate to the human resources, infrastructure (including equipment, ICT and transport), and medical products.

Priority interventions will be as follows:

- To improve access to equitable and quality clinical services at all levels in both the public and private sectors and institutions.
- To attain and maintain an adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce matched to the changing population needs and demands, health care technology and financing
- To increase access to essential, efficacious, safe, good quality and affordable medicines at all times
- To provide and maintain functional, efficient, safe, environmentally friendly and sustainable health infrastructure including laboratories and waste management facilities for the effective delivery of the UNMHCP, with priority being given to consolidation of existing facilities.

#### ***5.2.2.1 Improve access to equitable and quality clinical services at all levels in both the public and private sectors and institutions.***

Hospitals are at three levels: the NRH, the RRHs and the general hospitals. According to the National Hospital Policy, there is limited management capacity in most hospitals; inadequate transport and communication systems; inadequate basic emergency infrastructure, health supplies, equipment and finance; and the shortage of human resources affect the efficiency and effectiveness of the hospital operations. Referral systems from lower to higher levels do not function well and effective support supervision of hospitals at all levels is inadequate. These factors generally affect the delivery of the UNMHCP including integrated essential clinical care (IECC) by the hospitals. Infection control is an important component of health care delivery, unfortunately, dismal importance is attached to it.

The HSSIP will therefore ensure that these issues are addressed. The goal is to improve the management structure, management capacity, patient transport and communication, basic emergency infrastructure, supplies and equipments, finance and human resources and referral systems. In order to improve services offered by hospitals and HC IVs there is need for mobilisation of resources and training and recruitment of appropriately trained health workers. These issues will be addressed in the health financing and HRH sections, respectively.

### ***Strategies and interventions***

- *Strengthen the capacity of hospitals to provide integrated care.*
  - Provide adequate and relevant equipment including ICT, transport and other logistics.
  - Establish functional accident and emergency units in all RRHs and in all hospitals along the highway.
  - Develop and sustain standards of best practice in all hospitals.
  - Ensure availability of essential medicines and health supplies.
  - Establish functional ICU/CCU in RRH.
  - Provide quality and affordable services consistent with the minimum package.
  - Introduce palliative care in all HCIVs and above.
  - Provide imaging services in selected HCIVs in districts with no general hospital.
  - Develop protocol for the referral system and ambulance services.
  - Develop, disseminate and implement infection control standards in all hospitals and HC IVs.
- *Increase the range of health services provided by hospitals.*
  - Provide basic care for common illnesses including non-communicable diseases and injuries.

- Provide specialised hospital care including for reproductive health with focus on FP and EmONC.
- Introduce palliative care in all HCIVs and above.
- Train health workers in infection prevention and control.
- Scale up infection prevention and control in health facilities.
- Procure appropriate equipment for infection prevention and control for all hospitals.
- Provide public education on prevention and control of common illnesses and injuries
- Ensure availability of essential medicines and supplies.
- **Improve quality of hospitals in line with BFHI and CFHI.**
  - Conduct baseline assessment to establish quality standards for newborn healthcare.
  - Develop, print and disseminate standard guidelines on minimum standards for newborn care.
  - Conduct peri-natal death audits.
  - Conduct internal and external assessments in order to certify health facility as Baby Friendly.

### **Indicators with targets**

- The functionality of the HC IVs increased from 5% to 50% by 2014/15.
- Standards for best practice in hospitals established by 2012.
- Infection control guidelines finalised and being used in all health facilities by 2012/2013.
- Functional Accident and Emergency Units established in all RRHs by 2014/15.
- Blood Transfusion Centres set up in all RRHs (2 each year)
- ICU/CCU established in 40% of the RRHs (1 ICU in RRH each year) by 2014/15

### **Implementation arrangements**

The National Hospital Policy was launched in May 2008 and it will guide the implementation of this component of the HSSIP. The National Hospital Policy calls for the establishment of an independent accreditation body which will be responsible for accrediting hospitals to ensure there is compliance with standards of best practice. The Department responsible for Quality Assurance shall take a leading role in this process. General hospitals shall have Management Committees while NRHs and RRHs shall have Hospital Management Boards which shall be responsible for managing hospitals at these levels.

In order to increase the efficiency and effectiveness of the hospital sector:

- Management of hospitals shall work with the relevant Departments in the MoH to train hospital managers including Boards and Committees.
- MoH shall work with the respective service commissions to recruit, promote and retain staff to fill existing vacancies in the hospital sub-sector.
- The MoH shall work with the training institutions in order to increase the number of health workers they train so that an adequate number of health workers are available on the market.
- The MoH shall be responsible for ensuring that all lower health facilities have or have access to adequate logistics for referral including vehicles and ICT.
- The Department of Clinical Services will ensure regular technical support supervision and ensure that the minimum set standards are adhered to.
- The Department of Clinical Services shall ensure that infection control practices are established and

observed in all health facilities and that up to 50% of health facilities have palliative care services.

***5.2.2.2 Attain and maintain an adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce in partnership with the private sector, matched to the changing population needs and demands, health care technology and financing.***

As is the case with other developing countries Uganda experiences a shortage of HRH and a skills imbalance with the existing workforce. Nearly half of the established positions are vacant and the situation is worse in rural than urban areas. Health workers are also unevenly distributed between the public and private sectors. The health sector recognises the critical role of human resource in health in terms of numbers and skills mix in order to deliver a quality basic package. Over the course of the HSSIP focus will be on strengthening human resources through attraction, improved motivation and remuneration of human resources relevant to the needs of Uganda and promotion of professionalism among health workers.

***Strategies and key interventions***

- *Attain and retain the right HRH numbers and skills mix in the health sector.*
  - Advocate for annual increases in recruitment to increase the proportion of filled positions in order to improve quality health services delivery
  - Review staffing norms in the sector with a view to increasing the numbers and scope of cadres as necessary.
  - Develop and implement a safe working environment to minimize health risk for the human resources and patients.
  - Use evidence to advocate for appropriate remuneration of health workers.
  - Provide decent and safe accommodation for health workers at health facilities especially in hard to reach areas.
  - Develop and implement incentive schemes for attraction and retention of health workers, especially in hard-to-reach areas while addressing the gender and human rights aspects
- *Develop a comprehensive, well coordinated and integrated HRH information System.*
  - Plan, design and install HRHIS ICT infrastructure and software for HRH management and development.
  - Ensure that complete, reliable, timely, efficient and effective HRH development and management information for health care is provided and shared among all stakeholders in the sector.
  - Train, recruit and deploy required human resource for effective HRH data management and dissemination at all levels.
- *Strengthen capacities for HRH policy, planning, Leadership and Management.*
  - Develop and implement a practical course in HRH policy and planning in partnership with Institutions of Higher Learning.
  - Develop and disseminate guidelines for districts HRH planning processes.
  - Train a critical mass of health managers with capacity in HRH Policy, Planning, Leadership and Management.
- *Improve HRH training and development to ensure adequate, relevant, well mixed and competent community focused health workforce.*
  - Review curricula and training strategies incorporating gender and human rights perspectives to enable health workers cope with emerging health challenges.

- Advocate for the increase in the training of health workers especially cadres in short supply such as emergency medicine, health promotion, among others
- Support the training of HRH originally from hard to reach areas such as Karamoja to address the long term HRH problem in such areas.
- Improve skills and professional development for HRH through appropriate and integrated in-service training approaches including strengthening CPD Centres, promoting Distance and e-Learning
- Develop an integrated in-service training plan for the sector guided by the MoPS Training Policy Implementation Guidelines in order to harmonize training and capacity building for effective quality health services delivery.
- Redefine the institutional framework of health workers training institutions including the mandate, leadership and coordination mechanism among all stakeholders.
- *Strengthen HRH Systems and Practices.*
  - Improve efficiency of recruitment, deployment and placement of health workers.
  - Develop and implement a system of career development in the health sector.
  - Review and establish appropriate management structures at different levels.
  - Review job descriptions for health workers at RRH, NRH and central level Institutions.
- *Improve the utilization and accountability for HRH resources in respect of HRH management.*
  - Strengthening management and leadership skills at all levels in public and private health sectors to ensure clear roles and responsibility for HRH resources.
  - Improve productivity of HRH through supportive supervision and performance management for health workers.
  - Revitalize Health Unit Management Committees for all levels of the health service delivery system

### **Indicators with targets**

- *Attain the right HRH numbers and skills mix in the health sector.*

Increase proportion of approved filled positions at Local Government from 49% to 75% by 2014/15

Increase proportion of approved positions filled by trained health professionals from 51% to 75% by 2014/15

Improve the staffing for midwives in HC IIIs in Hard-to-reach areas from 46% to 100% by 2014/15

- *Develop a comprehensive, well coordinated and integrated HRH information System.*

Increase the number of districts with functional HRIS from 19 in FY 2010/11 to 80 districts by 2014/15

Core HRHIS subsystems (Local Government, MoH (HRD), MoH (HRM), MoPS, and Professional Councils) integrated, linked and functional by end of FY 2012/13

Develop a database for HRH that captures PNFP and PHP within two years

- *Strengthen capacities for HRH policy, planning, Leadership and management.*

Train 70 health managers in HRH Policy, Planning and Management annually over the next five years

Train 70 HRH managers in Leadership and Management annually over the next five years

- *Improve HRH training and development to ensure adequate, relevant, well mixed and competent community focused health workforce.*

Establish a system for review of curricula by 2012

Proportion of bonded pre-service trainees absorbed increased to 100% in 2015, baseline to be determine by 2011

Integrated in-service training plan for the sector developed by 2011

Mid Term Review of the in-service training plan conducted by 2013

- *Strengthen HRH Systems and Practices.*

Strategy to ensure career development of health workers developed by 2012/13

Appropriate management structures at different levels reviewed by the end of FY 2011/12

Reduce the time taken to access payroll from 6 months to one month by 2014/15

- *Improve the utilization and accountability for HRH resources in respect of HRH management.*

Establish the baseline for Absenteeism Rate by 2011/12

Reduce the Absenteeism rate by 20% per year over the next five years

Results Oriented Management rolled out to General Hospitals by 2012/13

Proportion of functional Health Unit Management Committees (GoU and PNFs General Hospitals and HC IVs = 308,) increased to 100% by 2014/15 (establish baseline in 2010/11).

Proportion of health managers (RRH, GH, HC IVs) with signed Performance Agreements

### **Implementation arrangements.**

The MoH has led the health sector HRH development and management programs in the country during HSSP II through the development and implementation of the HRH Policy (2006) and the HRH Strategic Plan 2005-2010 (2007). In 2008, the sector also developed an HRH Strategic Plan Supplement providing a “Health for the People scenario” in line with World Health Organisation health care delivery standards and the Global Health Workforce Alliance (GHWA) HRH Action Framework (HAF) declarations. These two processes have provided accepted HRH policies, strategies, systems, processes and action frameworks to address the HRH crisis in Uganda. The new HSSIP will build on these previous processes and achievements.

The MoH, in collaboration with Ministries of Public Service and Local Government has established staffing norms for each level of health care. It will be important at the beginning of the HSSIP for the sector in conjunction with the Health Development Partners, other sectors such as the Public Service institutions, MoFPED, MoLG and the private sector identify the gaps further in the existing health workforce including their training and competences. Once these gaps have been identified, the MoH will work collaboratively with the MoES and other key HRH education and training stakeholders to effectively plan for and develop the needed numbers and competences. In addition, the Human Resource Development and Management agencies in the MoH will work with the HSC, the DSCs and other relevant stakeholders to fill the existing vacancies in the health sector. The MoH shall adopt strategies to ensure equitable distribution and retention of staff including the recentralization of the recruitment and deployment of critical cadres of health staff at district level.

#### **5.2.2.3 Increase access to essential, efficacious, safe, good quality and affordable medicines at all times**

Over the period of the HSSIP priority will be given to increasing access to *medicines* and other health supplies required for the effective delivery of the UNMHCP. The implementation of this component of the HSSIP will be guided by the National Pharmaceutical Sector Strategic Plan (NPSSP II). In order to achieve this, government shall continue to consolidate, strengthen and ensure an effective and harmonized procurement and supplies management system is in place. Currently there are no guidelines on donated medicines which are important for purposes of coordination and rationalisation. There is inadequate staffing for management of the pharmaceutical sector at national and district and lower levels for management of pharmaceuticals and health supplies. The National Medical Stores shall be further strengthened and required resources (human and financial) allocated and deployed. The health sector will also work with the MoE in order to increase the

outputs for pharmacists and pharmacy technicians from training institutions such as Makerere, Mbarara and paramedical training schools.

The sector will therefore focus on increasing the access to essential, efficacious, safe, good quality and affordable medicines at all times, compliance of patients with prescribed medicines, and knowledge among patients about correct handling and use of medicines

### **Strategies and key interventions**

- *Strengthen the policy and legal environment governing the production, procurement and distribution of pharmaceuticals in Uganda.*
  - Develop pharmaceutical and related policies based on research and evidence.
  - Develop and enforce laws and regulations in the pharmaceutical sector.
  - Orient health workers and law enforcers on new pharmaceutical laws and policies.
  - Work with the MoES and PNFPs to increase the number of pharmacists graduating from training institutions.
  - Review and enforce regulations on traditional and complimentary medicines.
  - Review existing laws with regard to private practice and facilitate enforcement.
- *Strengthen coordination among different stakeholders in the pharmaceutical sector.*
  - Promote regional and international collaboration on medicine regulation and bulk purchasing.
  - Work with local companies and encourage them to produce medicines locally in compliance with Standards of Current Good Manufacturing Practices.
  - Facilitate the National Drug Authority to ensure safety and efficacy of medicines and health care products
  - Promote and support good and relevant aspects of traditional and complementary medicines.
  - Establish a mechanism for coordinating information management in the pharmaceutical sector.
  - Recognise and facilitate the JMS.
  - Develop guidelines for donated medicines.
- *Financing an adequate volume of pharmaceuticals and medical supplies in both the public and private sectors.*
  - Procure adequate pharmaceutical, medical and laboratory supplies for the UNMHCP at all levels of health care.
  - Advocate for adequate financing of essential medicines and health supplies in the national budget and gradually move towards reliance on sustainable sources of funds
  - Promote, support and sustain interventions that ensure rational prescribing, dispensing, use and patient safety.
  - Put in place mechanisms where boarding schools with sick bays procure ACTs from NMS and DHOs.
- *Strengthen the organisational structure of the pharmaceutical sector management.*
  - Expand the MoH Pharmacy Division.
  - Establish appropriate structures at district and lower levels for medicines management.
- *Strengthen the delivery and storage of pharmaceutical and medical supplies at all levels.*
  - Provide safe and adequate storage and distribution costs at all levels.

## **Implementation arrangements**

At the national level the MoH in conjunction with the National Drug Authority and the National Medical Stores will be responsible for overall coordination and guidance of procurement of medicines and other health supplies including rational use. These institutions will provide technical supervision of quality control, regulation and support to districts and lower levels. Professional councils will enforce maintenance of highest levels of ethics and professional standards in the practice. The capacity of the MoH will be enhanced to enable it provide overall coordination of the harmonised management of the pharmaceutical sector. Specifically the NDA will be responsible for monitoring the quality of medicines and other health supplies used in Uganda while the NMS will be responsible for the procurement and distribution of medicines.

## **Indicators with targets**

- The percentage of health units without monthly stockouts of any indicator medicines decreased from 72% to 20%.
- The funds in the MOH budget for procurement of EMHS increased from meeting 30% to 80% of need
- The service level of NMS for all EMHS increased to 80%.
- The % of NDA budget directly financed by GoU (consolidated funds) increased to 25%.
- Guidelines for donated medicines developed by 2012.

### ***5.2.2.4 Provide and maintain functional, efficient, safe, environmentally friendly and sustainable health infrastructure including laboratories and waste management facilities for the effective delivery of the UNMHCP, with priority being given to consolidation of existing facilities.***

Over the years the proportion of households living within walking distance to health facilities has improved: it was 49% at the beginning of HSSP I and currently it is estimated at 72%. This is because the number of health facilities for both the public and private sectors has increased. The target for both HSSP I and II was that by the end of these plans 85% of the population of Uganda should live within 5 km of the health centre. This however has not been achieved. While new facilities will be constructed during the implementation of the HSSIP priority will be given to consolidation of existing facilities: most facilities are in a state of disrepair, do not have the required facilities for them to function effectively (e.g. staff housing, water and energy, theatres, equipment, stores etc) and required ICT and related infrastructure. These tend to compromise the efficiency, quality and access of these services. The consolidation of facilities will also include the upgrading of facilities to higher level facilities and installation of water, electricity and making available ambulances.

As was the case in HSSP I the link between health infrastructure and HR availability will be a key determinant of the pace of new construction. As a matter of urgency the GoU will address issues on land acquisition and land titling for all health facilities in Uganda. For mobile populations during the HSSIP it will be necessary to design mobile services to reach such populations.

## **Strategies and key interventions**

- *Increase physical access to health services through development of health facilities.*
  - Conduct an inventory of health facilities in Uganda including those belonging to the private sector and determine their status.
  - Renovate and maintain existing health infrastructure to support the delivery of the minimum package.
  - Equip priority health facilities (HCIIIs and HCIVs) with basic efficient utility systems such as water, electricity and ICT.
  - Construct new facilities (where necessary) in order to increase the proportion of the population living within 5 km of a health facility.



- Provide guidance and supervision to the private sector in health infrastructure development and adherence to minimum national standards.
- Provide an adequate infrastructure maintenance budget at all levels of health care.
- Complete unfinished health facilities and equip them.
- Establish mobile facilities target mobile populations.
- Conduct inventory of infrastructural gaps within existing health facilities.
- Provide incinerators and other relevant infrastructure for medical and other waste management.
- *Finance the purchase and maintenance of essential medical equipment for both the private and public sectors.*
  - Provide an adequate budget for the maintenance of essential medical equipment including vehicles.
  - Procure and distribute essential medical equipment according to level of facility.
  - Provide all health facilities with 2 way communication systems and where possible telephones.
  - Procure appropriate equipment (incinerators, for the management of solid medical waste).
- *Build capacity for operation and maintenance of health infrastructure.*
  - In conjunction with institutions of higher learning, train biomedical engineers for maintenance of medical equipment.

### **Indicators with targets**

- The proportion of the population of Uganda living within 5 km of a health facility increased from 72% to 90% by 2015.
- The number of health facilities increased by 30% by 2015.
- The proportion of HC IIIs and HC IVs with complete basic equipment and supplies for addressing EmoNC increased to 100%.
- The proportion of HCIVs and hospitals with functional ambulances for referral increased to 100%.
- Sixty percent of medical equipment are in good condition and maintained.
- 50% of the mobile population physically access health facilities.

### **Implementation strategy**

The Health Infrastructure Unit of the MoH has the responsibility of ensuring that there is optimum health infrastructure, required equipment and other logistics in the health sector. The Division will take the lead in the development of an Infrastructure Management Plan for the health sector. In 2002 the Unit developed a 15 year Infrastructure Development and Maintenance Plan which does not really address the current and future infrastructure development and management needs of modern Uganda. The Health Infrastructure Unit will therefore lead the process of developing a 5 year HIDM strategic plan for Uganda. In order to develop an HIDM strategic plan the Health Infrastructure Unit shall consult all the departments in the MoH, all autonomous central level institutions and regional and district management about their infrastructure and equipment needs over the next 5 years. The District Health Team will have the responsibility of developing annual operational plans for infrastructure development and management including maintenance. All stakeholders in matters concerning infrastructure shall be involved.

#### **5.2.3 Objective 3: Accelerate quality and safety improvements**

The Health Sector aims to provide services of an acceptable level of quality, to ensure the clients are able to

maximise the health benefits from available care. Specific strategies to address quality improvements will be prioritized. To attain these objectives, the sector will focus on the following deliverables;

- Ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being.
- Improve quality of health care and patient safety at all levels including the private sector while ensuring efficient utilization of available resources
- Establish dynamic interactions between health care providers and consumers of health care with the view to improving the quality and responsiveness (including gender responsiveness) of health services provided.

#### ***5.2.3.1 Ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being.***

Supervision and mentoring (S&M) aims at informing policy makers and implementers about progress towards achieving targets as set out in the annual health sector plans and the HSSP and to help managers in making appropriate decisions. It also aims at continuous quality improvement of health services as well as ensuring the safety of health providers and the clients. Supervision and mentoring also assures that the environment or conditions under which services are provided are conducive, appropriate and safe; and that the people who provide the service have the right skills, information and knowledge.

S&M in the health sector in Uganda is based on supervisory visits, coaching, periodic reviews and the health management information system. However, there are uncoordinated multiple initiatives, gaps in reporting and feedback, lack of clarity on roles and responsibilities of the different stakeholders as well as inadequate implementation of supervision and mentoring activities. These problems affect the consistency and effectiveness of supervisory and mentoring efforts and the MoH will address these issues as a matter of urgency. Supervision will respond to the Monitoring and Evaluation reports as well as routine quarterly and annual reports to track performance in the sector and guide continuous quality improvement initiatives. There will also be a need to create an inspectorate body that will be responsible for ensuring that health facilities at all levels adhere to standards and regulations for provision of quality care. A mechanism for inspection to ensure value for money for all activities in the health sector was not well articulated during HSSP I and II and will be a key area to address during this strategic planning.

#### ***Strategies and interventions***

- *Establish organizational structures for supervision and mentoring*
  - Develop a comprehensive supervision and mentoring framework
  - Build capacity for coordination of supervision and mentoring at MoH.
- *Strengthen capacity for supervision and mentoring at all levels for improvement of system performance for both private and public sector.*
  - Develop a training programme on supervision and mentoring targeting senior and middle level managers at central and district levels.
  - Train senior and middle level managers in supervision and mentoring.
  - Provide adequate logistics (transport, fuel, allowances, and supervision checklists) to facilitate supervision and mentoring.
- *Strengthen and maintain supervision and monitoring at all levels.*
  - Review, update and disseminate supervision guidelines and tools for all levels.
  - Institutionalize and implement regular supervision and mentoring using agreed checklists.

- Establish mechanism for recognition of good performance (reward).
- Documents best practices.

### **Indicators with targets**

- National supervisory framework operational by July 2011.
- Reviewed supervision guidelines and tools disseminated by 2012.
- Proportion of districts where capacity for internal supervision has been built (100% by 2015).
- Proportion of supervisory reports shared by supervisees increased to 100% by 2015.
- Proportion of planned visits that are carried out increased to 100% by 2015.
- Proportion of facilities attaining at least 75% of set standards by 2015.
- An Inspectorate Division at MoH headquarters created by 2013.

### **Implementation arrangements**

The MoH and other central level departments/agencies have the mandate to supervise and inspect the entire health sector. In line with the decentralization policy districts have the responsibility of supervising the district health system. The MoH through the Directorate of Planning and Development and Department of Quality Assurance will be responsible for the overall coordination and guidance of supervision, mentoring and inspection during the implementation of HSSPIII.

At all levels of service delivery, managers shall be responsible for ensuring regular internal supervision and mentoring.

#### **5.2.3.2 Ensure effective and efficient utilization of available resources**

Good quality of care enhances clients' satisfaction and their use of services. It increases job satisfaction and motivation among service providers, leading to effective and efficient utilization of resources. Quality of care was an important component of HSSP I and HSSP II. However, during their implementation emphasis was focused on access to health services, both geographical and financial, and less on the quality of services. This was because of the poor access to services at the start of the HSSP I. The current quality management system is not well developed and needs to be reviewed and improved. The current standards are inadequate for different levels of health care and services. The present mechanisms and standards are unable to provide effective and appropriate quality assurance. The HSSIP will build on accomplishments of both the HSSP I and HSSP II with emphasis on scaling up and improvements in quality of services. Addressing quality of care issues is important as it is one of the key elements of the right to health.

### **Strategies and interventions**

- *Institutionalize quality improvement initiatives in health*
  - Develop a national quality improvement framework and performance measurement plan.
  - Review the Yellow Star Programme.
  - Develop and disseminate national quality improvement standards, guidelines and tools.
  - Develop a mechanism for accreditation of health facilities.
- *Build capacity for quality improvement at all levels of the health service that include planning and self assessment with participation of both internal and external clients.*
  - Develop a training program on quality improvement targeting all health providers.

- Train quality improvement teams in Hospitals and HC IVs.
- Develop and integrate pre-service quality of care in training curricula for all health workers.
- *Implement quality improvement initiatives*
  - Integrate quality improvement capacity at all levels of health services.
  - Monitor and evaluate performance improvement initiatives
  - Provide an incentive scheme for health facilities that conform to standards of quality of care.
- *Further improve quality of care by establishing an inspectorate body.*
  - Establish an inspectorate body.
  - Develop guidelines including sanctions for the operation of the established inspectorate body and disseminate them widely.

### **Indicators with targets**

- National quality improvement framework and performance measurement plan operational by July 2011
- Yellow Star Programme reviewed by 2012.
- Appropriate standards, guidelines and tools developed and disseminated by December 2011.
- Proportion / number of districts implementing the QI strategy (100% by 2015)
- Number of performance monitoring activities carried out (Annual QI stakeholders meetings).

#### **5.2.3.3 *Establish dynamic interactions between health care providers and consumers of health care with the view to improving the quality and responsiveness (including gender responsiveness) of health services provided.***

The responsibility for health primarily lies with individuals, households and communities. The GoU, as part of its commitments to the right to health and gender equality, has put in place elaborate structure of the National Health System is in place to facilitate the individuals, households and communities (as rights holders) to attain and sustain good health. The individuals, households and communities therefore need to be empowered to take their due role as health producers and consumers. This section concentrates on the role of individuals and communities as consumers of health services. The utilization of health services is a combination of the supply side and the demand side. The improving utilization of health services during the HSSP I (as shown by improvements in OPD utilization, immunization) is a sign that supply and demand has been moving in the same direction. The supply side issues include: geographical accessibility, affordability, availability of supplies and human resources. These are dealt with in the other areas of this document. The demand side issues are: perceptions of quality, and individual/household characteristics which may be associated with cultural and religious affiliation and the socio-economic status of the individual or household. However, utilization of in-patient services and especially maternity services is well below desired levels to produce improvements in health status especially to make much needed decrease in maternal and child morbidity and mortality. This low utilisation shows that the maternal health services supply and quality have not yet reached the level to elicit appropriate demand. This points to a gap the health systems' capacity to respond to consumers' demands. The HSSIP will therefore attempt to address these issues.

### **Strategies and interventions**

- *Strengthen coordination initiatives among different institutions to improve quality and responsiveness of health services.*
  - Reactivate and build capacity of Health Unit Management Committees in government and PNFP health units throughout the country.

- Coordination with political and administrative leaders at all levels of government in health services delivery.
- Coordination with CSOs, (including women centered organizations) especially those working in the area of health consumer rights such as Uganda National Health Consumers' Organization to build awareness among individuals and communities about their rights and responsibilities.
- Increase awareness among individuals, consumers, health consumers' organizations and health providers about clients' rights and responsibilities.
- *Strengthen initiatives to improve client satisfaction with health services.*
  - Carry out and/or participate in surveys (National Service Delivery Surveys, Participatory Poverty Appraisals, etc.) and other studies that can provide more information about client satisfaction and gender responsiveness.
  - Step-up/Institutionalize other ways and means of receiving feed-back from communities.
  - Step up mechanisms for client / rights holders to seek redress for poor quality services and violation of their right to health in line with accountability principles (e.g. Appeal to Human Rights Commission, Professional Councils, etc).
  - Review and disseminate the Clients' charter in all districts and health facilities.
  - Review and disseminate the Patients' charter in all districts and health facilities.

### **Indicators with targets**

- Proportion of districts where Health Unit Management Committees in HC II-IV, general hospitals are functional (meeting at least once a quarter) (75%).
- Number of surveys conducted to assess client satisfaction and gender responsiveness.
- Mechanism for client / right holders redress established and operational.
- Proportion of districts with CSO participation (CSOs structures developed at all levels in 65% of districts by 2015: National, district and sub-county).
- Clients' Charter reviewed by 2012.
- Patients' charter reviewed, translated and disseminated to 100% of district by 2015.

#### **5.2.4 Objective 4: Improve efficiency and effectiveness of Services**

Uganda has a high disease burden, and current available resources are insufficient to fund delivery of the minimum health care package. Government budgetary allocation to the health sector has been on average about 9.6% over the last 10 years. While the donor community contributes significantly to the health sector, challenges remain with programming of development assistance for health in terms of alignment, predictability, planning and reporting. A significant amount of development assistance for health is off government budget. Coupled with insufficient funding, the health sector is facing pressure pushing health spending upwards<sup>49</sup> driven primarily by:

- growing population;
- adoption of more expensive service standards and new technologies (e.g vaccines) and unplanned expansion of health infrastructure;
- and rising unit cost of existing services due to inflation, rising operational costs and growing resistance to current treatment regimens (e.g ACTs, MDR TB);

Evidence points to growing out of pocket expenditure on health with the poor bearing the major brunt of

<sup>49</sup>World Bank, MoH, MoFDEP, Fiscal Space for Health, 2010.

catastrophic expenditures. Out of pocket is high currently estimated at US\$14 per utilisation<sup>50</sup> and over 31.5% household incurred levels of health expenditures deemed catastrophic in 2006.

Attainment of efficiency and equity in health spending has been hampered by absence of prioritised plans to guide implementation. There are no comprehensive and detailed procurement plans and allocation of resources is not linked to outputs. Allocative efficiency (Ensure a good input mix especially between wage and non wage in allocation of resources) and technical efficiency (Cost effectiveness of implementation) have not been adequately addressed.

#### Health Insurance

As part of Government's efforts to improve and re organise health financing and related outcomes a Health insurance plan is being designed and developed for Uganda. This plan comprises Social Health Insurance which will operate concurrently with Community Health Insurance and Private Commercial Health Insurance. Social Health insurance will be introduced in a phased approach starting with the people employed in the formal sector. This process will be over the medium term to long term. Currently the MOH has submitted a draft Bill to govern the health insurance plan to the 1<sup>st</sup> parliamentary council for drafting the law. The plan is envisioned to be fully operational by mid term of HSSPIII to the end period in 2014/15. In the fiscal year 2011/12, Social Health Insurance activities are will concentrate on building capacity of and setting up institutions and management systems. When well established with formal sector employees country wide subscribing to SHI at a rate of 8% of salaries per month, the plan is expected to raise up to 72Billion Uganda Shillings annually. The plan is designed to work in harmony with other social security benefits under development in other government sectors.

Without increased funding Uganda will not meet targets for MDGs 4 and 5 and to sustain the gains made under MDG 6. Top priority and new emphasis during HSSP111 will be advocating for increased funding to the health care service delivery, improving efficiency in resource use and reducing financial barriers to accessing health care.

#### Financial management systems

Given the importance of the health sector in the life of the country and the funds involved, it is imperative that health service organisation and agencies have financial processes that are efficient, modern, transparent, geared towards service provision and based on value for money principles.

The objective of the financial management system is to secure, allocate and distribute and utilise financial resources with regards to the HSSP 111 strategic plans and priorities.

#### Risk mitigation and Management.

The accounting officer and heads of institutions will be responsible for advising on risk management and ensuring use of effective systems of internal control. The risk management role will be carried out in collaboration with internal Audit and external audit. The risk mitigation arrangements will ensure compliance with all applicable legislation, regulation and other relevant statements of best practice agreed upon with health development partners and ensure that public funds are properly safeguarded and used economically, efficiently and effectively in accordance with statutory and other guidelines that govern resources use. Internal audit units and external audit functionality and independency shall be the corner stone for transparency, accountability and value for money.

Penalties and sanctions shall be put on public officers who cause any deficiency and or loss in management of the public resources and assets as prescribed in the financial regulations. All health institutions public and private not for profit (benefiting from PHC Funds) are required to submit on annual basis their financial statements and annual final accounts to enable them access additional funding from government in the proceeding financial years.

Strategies to improve compliance include

- Reforms in the budgeting and reporting cycle's e.g OBT.

<sup>50</sup>World Bank, MoH, MoFDEP, Fiscal space for Health, 2010.

- Timely submission of work plans, procurement plans especially for medicines
- Working closely with MOFPED and making follow ups of issues raised in review meetings.
- Building capacity of staff involved in budgeting, planning, budget execution, Procurement, Budget control and accountability.

#### **Plans to reduce house hold out of pocket expenditure**

Most Ugandans pay for their health care as direct OOP which is estimated at around 50% of Total health expenditure. The MOH plans to;

- Develop forms of pre- payment mechanisms especially in the form of health insurance; social health insurance and community based health financing schemes. Options to subsidise up to 80% of the health insurance premium for the poor will be explored. Furthermore, will work with the Social protection framework under Ministry of Gender, Labour and Social Development and the Uganda Health Insurance Commission to regulate the Private health insurance. Efforts will be made to expand Health insurance coverage in a sustainable manner.
- Regulate the private sector to ensure favourable pricing policies and good quality care
- Study the voucher system (addressing demand side issues) which is being with a view to explore its potential in improving access
- Improve management of private wings in public hospitals to streamline pricing of services, improve quality and efficiency of patient services.
- this is not a strategy to reduce OOP
- Limit self medication and over the counter sales of prescription drugs through enforcement of legislation on sale of drugs.

The HSSIP will therefore work towards mobilising, and allocating resources to implement planned services in an efficient, effective and equitable manner. Strategies to address these are:

- Mobilizing additional resources to fund the HSSIP
- Improving management of development assistance for health
- Ensuring effectiveness, efficiency and equity in resource allocation and utilisation
- Ensuring transparency and accountability in resource allocation and management
- Enhancing transparency, and use of agreed management processes

Specific strategies for implementation in each of the focus interventions are outlined below.

#### **5.2.4.1 Mobilize additional resources to fund the HSSIP**

Methods of health financing have a significant impact on the efficiency and sustainability of the health care system. While Uganda needs to continue exploring ways of getting more funds to finance the health sector, there is also need to make better use of the resources it already has. The planned strategies include;

- Develop a comprehensive and sustainable health financing strategy.
- Advocate for Increased government per capita expenditure on health from US\$7.2 in 2008/09 to US\$12 by 2015.
- Develop and disseminate advocacy briefs for policy and decision makers to build a comprehensive sector investment case.
- Support the establishment of a basket fund for essential medicines and health supplies to guarantee the delivery of the UNMHCP by the PNFP sub sector.
- Mechanisms to mobilise additional resources through Social Health Insurance has been planned in the medium term. This will eventually reduce on out of pocket expenditure on health by households. The funding mechanism will include premium payment by gainfully employed members to the scheme.

Ways will be devised to collect premiums from the informal sector. The details of the premium payment will be worked out as part of finalising the insurance bill and will be contained in the health financing strategy as well.

- Plans to reduce wastage and improve efficiency will be through frequent technical support supervision, undertaking value for money auditing, capacity building in identifies areas e.g procurement and enforcement of risk management and internal controls.
- Preparation of strategic investment plans and building an investment case for funding
- Improve the management of private wings in public hospitals
- Within the PPPH framework, explore ways of harnessing NGO resources to support health sector objectives
- Building capacity of health planners and senior official in MoH in negotiation and resource mobilisation.

Other detailed strategies to raise additional resources will be detailed in the health financing strategy.

#### **Improvement of the reporting system.**

- MOH shall require all PNFP facilities receiving subsidies under PHC grants from Government to submit annual financial statements/accounts and reports to the MOH for review of their performances. The reports shall form the basis of continued financial support from Government.
- Strengthening the LGs capacity in areas of financial reporting, leadership and financial management by building capacity of non financial managers in financial management.
- Analysis and review of the quarterly budget performance reports (BPR) and following up on recommendations.

### **Indicators/Targets**

- Development of a health financing strategy by June 2011.
- Increase level of Government allocation to Health from 9.6% to a minimum of 15% of the total GOU budget by 2014/15.
- Government per capita expenditure on health increased to 12\$ by 2014/2015.

#### **5.2.4.2 Improve management of development assistance for health,**

Strategies for implementation are

- Align development assistance to key sector priorities.
- Strengthen fiduciary capacity in the Ministry of Health to manage development assistance for health (plan and monitor implementation, ensure timely reporting, program assessment, and reconciliation of donor data base in MOH and MOFPED).
- Develop a strategy on management of off –budget funds e.g for procurement of ARVs, ACTs etc.
- Assess and screen development assistance by balancing recurrent and capital investment to ensure sustainability of programs supported by development partners.
- As part of the criteria for approval of externally supported programs and projects, assess and screen programs/projects right from inception to ensure that the programs that are adopted can be implemented and sustained and are of reasonable duration.
- HDPs shall report quarterly on disbursements and commitments in a manner consistent with IFMS classification for projects.



## Targets/indicators

- Percentage of expected quarterly HDP donor project reports on disbursements and commitments that are received timely. Target 60% by 2014/15.
- External funding for health as a percentage of total health expenditure.
- Proportion of donor project funds budgeted that is on MTEF within the Health sector votes. Target 100% by 2015.

### 5.2.4.3 Ensure effectiveness, efficiency and equity in resource allocation and utilisation :

#### Strategies for implementation are:

- Develop and implement a transparent and technically sound process to allocate resources to districts, hospitals and other spending institutions including formulation and or review of resource allocation formulars. In addition, design of new programs will give special preference to Districts with highest poverty incidence, poorest mortality indicators , hard to reach and hard to stay areas in allocation of resources. Special consideration of Neglected Tropical Disease (NTD) affected Districts will be offered preference in allocation of resources..
- Reduce waste in the health sector through minimising inputs for any given output by; improving management and performance of health workers by paying them reasonably well , providing for their welfare through incentives ,and improving logistics and procurement management systems. Given the high value of third party commodities, the sector will explore ways of improving efficiency in health spending through; management of donations of medicines, reduce waste in pharmaceuticals, reduce the costs of clearing and handling charges of medicines and vaccines and drugs procurement and deliveries.
- Study and mitigate the impact of out of pocket expenditure on households.
- Implement social health protection through insurance and other mechanisms like cash transfers and voucher systems.
- Promote contracting in health service delivery to improve efficiency through a SWAp mechanism
- Establish criteria to assess financial implications of new projects and programs
- Strengthen future audits and analysis to include value for money audit.
- Mainstream management of paying wings in hospitals

## Targets/Indicators:

- Percentage of actual releases to Districts, Hospitals, autonomous institutions and other sector spending agencies deviating less than 5% from the approved budgets.
- Per capita out of pocket expenditure on health; reduced from US\$14 per utilisation to US\$10 per utilisation in 2014/2015.

### 5.2.4.4 Ensure transparency and accountability in resource allocation and management:

#### Strategies include:

- Institutionalise the National Health Accounts.
- Improve mutual accountability and timely reporting in line with partnership principles.
- Regularly publicise in the media, funds remitted to all health sector spending agencies. E.g (NMS, RRH, Districts, Hospitals, PNFPs, Projects)

- Carry out repeated procurement audits including value for money to ascertain the degree of financial loss.
- Ensure that priorities identified in the HSSP111 have the first call on available resources.
- Ensure compliancy to GOU financial and accounting regulations and guidelines in resource use.

### ***Targets/Indicators:***

- **Institutionalise the National Health Accounts by 2012.**
- **Percentage of quarterly internal audit reports (district, hospitals, central level) prepared and submitted timely. Target 100% by 2014/15.**
- **Percentage of (district, hospitals, central level) quarterly Budget performance reports prepared and submitted timely by GOU health sector spending agencies. From 70% in 2008/09 to 100% in 2014/15**

### ***Implementation arrangements:***

The HSSIP will be funded within the NDP comprehensive expenditure framework harnessing revenues from all possible sources. The GoU shall continue providing the basic package at no fee but will continue exercising user fees in paying wings of public hospitals. The government will continue to provide subsidies to the PNFP sector within the framework of the PPPH policy.

In all financial transactions, government procedures shall be adhered to and accountability and transparency shall be the cornerstone for value for money in Health service delivery. The institutional process of monitoring health expenditure and making informed decisions indicate the need to strengthen the capacity of Ministry of Health and District Health offices in financial management and good governance.

A critical factor that limits effective delivery of health services in Uganda is low level of salaries for health workers and the price of health care. Government is committed to a sound health financing policy that will aim at improving incentives to health workers in the medium term and controlling the costs of health care both in the private and public sector.

In implementing the HSSIP, the MOH will follow out put oriented budgeting tool. (The performance contract form B which effect financial releases shall address shortfalls in aggregate reporting. It is hoped that as a result of this process, all health sector institutions will be in a position to provide better focus on the impact of public expenditure on health services delivered. Significant improvement has been achieved in financial reporting but there is scope for further improvement.

#### **Financial management**

Financial management systems and financial reporting will be based on appropriate international accounting standards and the Ugandan constitution 1995. The constitutional mandate is further amplified in; the Public finance and accountability Act 2003, The Budget Act 2001, PPDA 2003, The Local Government Financial and accounting regulations 2007, treasury accounting instructions 1998, relevant Government financial mechanisms and the accountability institutions set by government. Efforts would be made to provide appropriate financial reports in a timely manner for evidence based decision making. The accounting system purposely will demonstrate compliance and adherence to the Government laws and partner guidelines. To improve public financial management, the Ministry of Health shall build capacity of health workers and management committees in areas of financial management.

Financial accounting will follow the Public and Local Government, Finance and Accounting Regulations. These shall be supplemented by statutory instruments and guidelines issued from time to time.

**Strategies to improve on financial management systems.**

Ministry of Health shall;

- Enforce and adhere to the Legal and policy guidelines.
- Ensure effective drug price control, safe and rational use of drugs.
- Strengthen the reporting system on health expenditures to accurately inform health financing decisions through institutionalisation of the National Health Accounts.
- Seek support of Technical assistants and consultants in financial management of health service delivery programs.
- To address challenges of compliance to financial management guidelines and or donor regulations, sections of the Public Finance and Accountability regulations 2003 ,Part XXIII and Part X of the Local Government Financial and accounting regulations 2007, shall be used to persecute the accounting officers. Resources shall be withheld to institutions which do not comply and or sanctions and penalties shall be instituted on the accounting officers and or their responsible managers.

**Interventions to improve financial management controls.**

- Enhance confidence and credibility of the budget through greater comprehensiveness and transparency
- Improve budget planning execution through quarterly budget monitoring reviews and budget performance reporting (BPR).
- Strengthen efficiency of financial controls by making comprehensive, reliable and timely financial information available to all government agencies.
- Log program heads and vote controllers to the IFMS system to monitor departmental and program transactions. One customised computerised vote book shall be set up so as to get cash balances instantly.
- Ensure Timely financial reports for better financial management by government and also for timely accountability. All accountabilities shall be sanctioned by head of departments before submission to accounting officers.
- Ensure Timely production of accounts for subsidies provided to PNFP'S facilities
- release of PHC Grants to Local Governments will be based on timely submission of quarterly/ annual financial reports.
- Framework contracts shall be instituted to improve procurements
- Routine expenditure voucher checking function (post Audit) will be undertaken by by internal audit.
- Build capacity of internal Audit, budget division and accounts section for better job effectiveness.
- Harmonise and integrate the Management Information Systems (MIS)/M&E systems to the IFMS systems to ensure financial related information is captured in the reports.

To improve accountability, recording and reporting practices. Health institutions shall be required to formulate, approve and execute annual budgets and plans in accordance with GOU regulations. The Budgets should reflect all sources of revenue for, recurrent expenditure (non wage and wages expenditures), development expenditure, components for purposes of decision making. Upon approval of budgets the various Health institutions shall put into operation the provisions in their budget estimates, and all payments of public monies shall be in accordance with the authority and procedures prescribed in the regulations. The institutions shall maintain accounting records, assets registers and books of accounts in a manner prescribed in the financial regulations.

**Strategies to harmonise and integrate off- Budget financing.**

- All partners as per the Paris Declaration principles of March 2005 should re commit themselves to continue to increase efforts in harmonisation, alignment, mutual accountability and managing off aid for results with a set monitorable actions and indicators.
- Submission of Audited annual accounts by PNFP's Hospitals and health units, NGOs and CSOs offering health services shall be a requirement for continued support/subsidy by government. This shall enable the MOH capture all the off budget financing to NGOs.
- Health Development partners/donors to be transparent and prepare off- budget health financing report to the Ministry of Health on annual basis, but will be encouraged to channel most resources through budget support.
- The MOH shall cooperate with Civil Society Organisations (CSOs) to monitor the development and implementation of funding agreements between CSOs and Donors and ensure timely disclosure of aid allocations.
- MOH, through development of the IHP+ country compact/MoU, with monitorable indicators, will get GOU, donors, civil society and the private sector to commit to the IHP+ principles at Country level.
- MOH, Donors and Ministry of Finance will coordinate and participate jointly the alignment of all donor support through budget support, on or off budget donor projects to the Health Sector.
- Carry out an annual inventory of financing data by donors to capture off- budget financing
- Undertake an assessment of the off budget financing in health annually and recommend solutions to remedy shortcomings.

#### **Internal controls.**

It is the responsibility of management to ensure regulations are adhered to in so far as management of resources is concerned. The following internal controls shall be instituted to improve on financial management systems and accountability.

- Quarterly reporting system to Improve financial transparency.
- Use IFMS has a single data system to make it possible to monitor financial position and produce accurate reports and, monitor overall budgeting performance.
- Enforce use of Uniform chart of Accounts.
- Review end of year financial performance and reports of Public and PNFP receiving Government funds.
- On Quarterly basis, adjust activities to match available funds to activities so as to avoid supplementary budget request and accumulation of domestic arrears.
- Management and controls of services is entrusted to the accounting officers. Decisions made which commit resources are authorised by the accounting officer and the accounting offices are accountable for the expenditures and the out puts to be delivered.
- Systems of governance, financial control risk management and performance management have been developed under the IFMS and will be used . This provides relevant, timely and reliable information for linking resources to outputs/ outcomes.
- Quarterly meetings between Audit Committee and the Accounting Officers will be instituted.
- Certification by Ministry of Works or any appointed consultants prior to payment for construction works will be snured. The certifying body is independent at the same time there is segregation of duties.
- Accountabilities for any advances will be made within three months as stipulated in the Accounting Instructions.
- Verification of advances will be undertaken by Internal Audit as a way of ensuring segregation of duties.

- The sector will utilize services of experts in procurement of specialized equipment / machines e.g. IT personnel when procuring related items.
- Cash payments to be discouraged and any revenue to be banked as soon as possible.
- Strong system of internal controls and risk management techniques will be established such as the use of quarterly ceiling for vote functions and quarterly review of departmental expenditures.
- Internal control systems will be improved, especially through timely and accurate accountability

### **Auditing Arrangements.**

The process of reviews and audit will be used to assess the operations of HSSPIII, especially in relation to;

- The use of suitable systems of internal controls on day to day basis
- Consistent compliance with established rules and regulations related to all operational areas
- Reliability which may reasonably be placed on reports used by external parties for assessment of overall performance
- Compliance with policies and established procedures especially in areas of operation regarded as critical to the achievement of the HSSPIII objectives

### **External Audit.**

The role of the auditor general shall be to express an independent opinion on the financial statements of health institutions based on the audit. The audit is to obtain reasonable assurance that the financial statements are free from material misstatements.

The external Audit shall include;

- An assessment of the adequacy of accounting and internal controls to monitor expenditures and other financial transactions and ensure safe custody of financial assets
- A determination as to whether adequate documentation have been maintained on all relevant financial transactions
- Verification that expenditures documented are eligible for financing
- A separate opinion on the annual financial reports.

In addition to the audit reports, the auditors shall prepare a separate management letter giving observations and comments, and providing recommendations for improvements of accounting records, systems, controls and compliance with financial covenants in agreements. Although most requirements for external reviews and audit will be based on the National audit Act 2008 and agreements with partners, provisions will be made to monitor aspects of daily operations internally through the internal audit unit. In addition to external audit, other development partners may carry out their own audit.

The auditor general independently carries the audit of financial statements and expresses his opinion on all public accounts which is communicated to parliament through the Auditor general's annual reports and or other reports.

- The External audit system will annually identify and evaluate significant exposures to risk and contribute to the improvement of risk management and control systems and provide reasonable assurance that financial statements of programs is free from material misstatements.

### **Strategies to improve the health sector annual audit reports.**

- Emphasis shall be put on follow up of Audit findings and actions taken.
- Making financial management systems and their Performance a central part of any financing dialogue with partners.

- Build capacity of auditees to improve on auditing processes and reporting.

The MOH shall have a deliberate effort to avoid actions which may lead to limitations in scope of audit by setting strong internal controls.

#### **Procurement audit.**

Annual ex –post procurement audit and regular ADHOC reviews shall be undertaken by both internal auditors and external auditors to verify the following;

- Procurement and contracting procedures and processes
- Verify Technical compliance, physical completion and price competitiveness of contracts
- Review and comment on contract administration and management issues
- Review capacity of institutions handling procurements and contracts regularly

#### **Audit committee:**

This committee will inter alia, perform the following functions: Act as a liaison between the auditors and management. Recommend approval of audited financial statements to the HPAC and Monitor the implementation of recommended improvements to systems of internal controls to mitigate challenges in annual audit reports and ensure about 90% of the audit reports are unqualified during the HSSPIII Period.

There are issues over the life of HSSIP with far reaching financial implications that have to be given due attention. These include;

- The increasing population,
- Increasing standard of health service delivery as a result of new technologies and rising costs of service delivery
- creation of new Districts with administrative and capital investment requirements,
- Plans to ensure physical accessibility within 5 km radius to a health facility
- Increasing number of VHTs and increasing access to the population within a radius of 5 km to a health facility has far reaching cost implications and has strained health service delivery.
- Enhancement of salaries of health workers and general improvement of the staff welfare package.

#### **Accountability:**

To enhance accountability<sup>51</sup> and monitoring in the health sector the SBWG shall;

- track progress of implementation of programs and projects,
- Develop Health sector internal financial management systems, guidelines, standards and coordinate their implementation in the health sector to ensure efficient and effective utilization of public resources.

#### **Internal Audit.**

The internal audit unit will conduct routine technical, impact and other evaluations , investigations and monitor performance in keeping with agreed annual work plans , liaise and coordinate auditing work with that of all external auditors.

<sup>51</sup>Accountability is simply how transparent, efficiently and effectively the resource allocation, expenditure and service delivery have been undertaken.

The Internal audit departments in health institutions in liaison with the National Audit Authority shall provide independent, objective assurance services designed to add value and improve sectoral operations on risk management, control and government processes.

The internal audit system shall conduct value for money audits on key programmes to ensure that efficiency and effectiveness is enhanced. The Internal audit system shall ensure performance is routinely assessed against objectives and value for money. The Internal Audit department as an independent entity will report to the audit committee of the health sector and in still confidence among stakeholders. On regular basis the scope of the internal audit department in relation to implementation of the strategic plan shall be guided by the National Audit Act 2008, Local Government Amendment Act 2008 and the internal Audit manuals 2007;

Procurement:

The Ministry of Health shall develop a sector procurement and Disposal plan to streamline a cost effective system of procurements in the health sector. This will be in line with international and partner guidelines, the Government of Uganda Public Procurement and disposal of assets Act, 2003, the Local Governments Public Procurements and Disposal of Public Assets guidelines, 2008 .The procurement system shall ensure transparent and accountable procurements in the health sector with the ultimate aim of achieving value for money. The main actors in the procurement framework shall be the PPDA (The Authority) and the procuring and disposal entities of the Ministry of Health.

#### **5.2.5 Objective 5: Deepen sector stewardship**

In the HSSIP, the Ministry recognizes its dual role of

- Provision of critical health services for the population, together with other health service providers (PNFP's, and PFP's), and
- Providing appropriate stewardship for all other actors in health, to ensure the critical interventions needed to attain the overall goal of the HSSIP are being implemented. These other stakeholders include Health Development Partners (provision of additional financing and technical support), related health Ministries (provision of services addressing health determinants). and civil society.

The stewardship function of the Health Ministry focuses around provision of appropriate guidance to other sector actors, to what are the priorities for implementation. To appropriately carry out this function, the Ministry of Health will prioritise implementation of the following focus areas:

- Strengthen the organization and management of the national health system
- Enable evidence-based decision making, sector learning and improvement
- Create a culture in which health research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Uganda.
- Review and develop relevant Policies, Acts and regulations governing health which are gender responsive and human rights compliant and to ensure their enforcement.
- Effectively build and utilize the full potential of the public and private partnerships in the health sector
- Strengthen collaboration between the health sector and other government ministries and departments, and various public and private institutions (universities, professional councils, etc.) on health and related issues
- Implement the national health policy and the Health Sector Strategic and Investment Plan within the Sector wide Approach and IHP+ framework, through a single harmonized in country implementation effort, scaled up financial, technical and institutional support for health MDGs and ensuring mutual commitment and accountability

### ***5.2.5.1 Strengthen the organization and management of the national health system***

In accordance with the 1995 Constitution of the GoU and the 1997 Local Government Act, the MoH has been implementing a decentralised system of health service delivery over the last 10 years. Evidence exists that the decentralisation of health service provision has improved health care. A number of challenges, however, have been identified in the way health services are organised and managed in Uganda namely: the prevailing weak management systems at all levels; inadequate funding; lack of *adequate* coordination among different sectors involved in the delivery of health services; limited knowledge about decentralisation especially at district level; the limited planning and supervisory skills especially at district and lower levels; the lack of ICT infrastructure and software; and the unsatisfactory performance of the HMIS as it does not provide timely and reliable data for decision making.

The development of the HSSIP acknowledged that these issues have affected the delivery and utilisation of health services in Uganda. The proposed strategies and interventions in this plan are aimed at improving health care delivery services and systems through institution of efficient and effective health management systems. The plan will also ensure equitable delivery of health services with deliberate attempts to develop, pilot and implement service delivery models for vulnerable groups for example pastoral communities and other population groups living in hard to reach areas.

While the MoH headquarters shall continue to formulate policies and monitor the overall sectoral performance among other responsibilities, certain functions shall also continue to be delegated to autonomous national and regional institutions such as NRHs, RRHs, UHI, UCI, UAC, UBTS and other tertiary care institutions. Regulation shall be enforced through professional councils and the National Drug Authority whose role shall be expanded to include food items and its name changed to National Food and Drug Authority; and other authorised bodies. The Food Safety and Hygiene Act and the Public Health Act shall be enforced by local governments. Research shall be coordinated by the UNHRO and implemented by various institutions, both public and private.

## ***Strategies and key interventions***

- *Improve the capacity of the national health system to respond and effectively deliver the minimum package*
  - Recruit and sustain an optimum number of health workers to effectively deliver the minimum health care package as defined in the NHP II.
  - Advocate and mobilise adequate resources for the National Health Service.
  - Design, pilot and implement appropriate service delivery models for hard to reach areas and disadvantaged population groups such as the rolling out of mobile clinics in such places for mobile populations.
  - Strengthen the referral system.
  - Establish, train and sustain VHTs throughout the country.
  - Provide services in an integrated manner to harness efficiency and only maintain vertical programmes where they remain most efficient.
  - Strengthen the planning, leadership and management of health service at all levels including financial management, gender and the right to health analysis and mainstreaming.
- *Intensify supervision, inspection, monitoring and evaluation of health services and ensure use of evidence for decision making*
  - Establish a structure at regional level that will gradually assume more responsibilities, focussing on supervision, providing support in planning, monitoring and evaluation of health programmes at first before assuming other responsibilities that will be identified through an in-depth feasibility study.



- Provide and share complete, reliable and timely health management information for health care among all stakeholders in the health sector in particular the private sector.
- Ensure that the MoH central level and other appropriate national and regional level autonomous institutions carry out their core functions effectively and efficiently.
- Invest in research in areas such as health service decentralisation and quality of care in order to continuously inform improvements in service delivery.
- Endeavour to disaggregate health information, by critical variables affecting equity in distribution of coverage. These include literacy, poverty, gender, residence(urban/rural) and security.
- *Strengthen existing and widen the scope of partnerships in order to achieve the goals of the health sector.*
  - Establish, operationalise and sustain the PPPH at national, district and community levels.
  - Improve intersectoral and regional collaborations in areas of mutual benefit and complementarity.

### **Indicators with targets**

- The percentage of government budget allocated to the health sector increased from 9.6% to 15%.
- Health policies, standards and guidelines for the East African Community harmonised by 2014/15.
- Joint planning, monitoring and evaluation with various relevant sectors instituted by 2011/2012.
- Number. Of functional service delivery models designed, piloted and established for disadvantaged population groups.
- The proportion of districts that submit timely HMIS monthly and quarterly reports increased from 68% to 100% by 2014/2015.
- The percentage of districts with operational VHTs increased from 31% to 100%.

### **Implementation arrangements**

The Department of Planning in the MoH has the overall responsibility of policy formulation, development of overall sector strategic plans and guiding current and future investments in the health sector among other responsibilities. In order to ensure that the above strategies and interventions are implemented, the Department of Planning will liaise with different departments within the MoH and outside. The Department of Planning will work with:

- Department of Human Resource Management and Development in order to build capacity in management, accounting, planning and other requisite skills at different levels of health care. Local governments will have the responsibility to build such capacities at district and HSD and lower levels.
- Resource Centre and the HIDM to make the HMIS *functional* and the installation of ICT infrastructure including the necessary software for management and delivery of care, respectively.
- Local Governments to identify hard to reach areas and other disadvantaged population groups, design specific strategies for reaching such groups and ensure that these are included in their district implementation plans.
- Ministry of Finance to ensure that adequate financial resources are allocated and transferred for district health services and that allocation shall be based on need.

Lastly, communities shall participate in the delivery of health services through VHTs and HUMCs and adequate resources shall be made available in order to ensure that all VHTs have been trained during the implementation of the HSSIP.

### **5.2.5.2 Enable evidence-based decision making, sector learning and improvement**

Monitoring and evaluation (M&E) in the health sector in Uganda is based on supervisory visits, periodic reviews and the health management information system. M&E aims at informing policy makers about progress towards achieving targets as set in the annual health sector plans and the HSSP and to help provide managers with a basis in making decisions. The current challenges in the health sector regarding M&E include lack of a comprehensive M&E plan to which all partners subscribe, routine information systems wanting in quality and lack of wide consensus on tools and mechanisms to measure quality of both facility and community based services. There is also lack of sex disaggregation of health data as appropriate and of analytical capacity at the national and sub national levels to generate strategic information to support new initiatives. This lack of age and sex disaggregation and subsequent gender analysis as appropriate often leads to ineffectiveness and inefficiencies relating to coverage, utilization, acceptance, accessibility and quality of care, all basic elements of the right to health. Alongside these, there is poor dissemination and use of information is weak at both national and sub national levels. This means that a lot will have to be done to improve recording and reporting, and use of data at all levels and all stakeholders, public, private and community to effectively monitor and later evaluate our HSSIP implementation, including the M&E plan itself.

### **Strategies and interventions**

- *Institutionalize the notion of at least, age & sex disaggregation of health data, as appropriate, in order to expose sex/gender differences & factors that contribute to health inequities.*
  - Examine the feasibility of disaggregating, at least a set of strategic health data, even if on a trial basis, with a view to institutionalizing the process.
- *Build capacity for effective data management dissemination at all levels.*
  - Develop and implement a comprehensive M&E plan for the health sector.
  - Provide the necessary tools (computers and software, data collection forms etc) for data collection, analysis and reporting.
  - Train health workers at all levels in data collection, analysis and report writing.
  - Conduct inservice training for health workers on monitoring and evaluation.
  - Fill the vacancies in the resource centre at MoH headquarters and at district level.
  - Increase the training, recruitment and deployment of required human resource for effective data management and dissemination at all levels.
- *Strengthen the monitoring and evaluation system.*
  - Extend the HMIS to the private sector.
  - Adapt a set of indicators, tools and the Monitoring and Evaluation system to monitor the quality of service delivery, both at the health facility and community levels.
  - Facilitate the establishment and operation of a community based health information system linked to HMIS.
  - Ensure utilization at all levels and dissemination of information to other stakeholders for purposes of improving management, sharing experiences, upholding transparency and accountability.
  - Generate through periodic surveys, and commissioned research appropriate data for effective planning, management and delivery of health services.
  - Ensure continuity of care, design appropriate medical records and improve their utilisation at community and facility level.

## **Indicator and Targets**

- The proportion of implementing partners (NGOs, CSOs, Private sector) contributing to periodic reports increased to 90% by 2015.
- Community based HIS established and linked to HMIS by 2015.
- The proportion of planned periodic review that are carried out increased to 100% by 2015.
- Timeliness increased to 100% by 2015
- Completeness increased to 100% by 2015
- Proportion of planned validation studies that are carried out
- The proportion of sub national entities (districts, health facilities) that have reported on the key indicators as planned increased to 100% by 2015.
- selected data disaggregated by age & sex with concomitant gender analysis

## **Implementation arrangements**

The MoH through the Directorate of Planning will be responsible for providing overall coordination and guidance with regard to monitoring and evaluation of the progress made in the implementation of the HSSIP. All stakeholders will participate in the monitoring and evaluation processes (JAF). At the same time there will be quarterly District Health Teams (DHTs) Monitoring and Evaluation reports and HSD monthly monitoring and evaluation reports. The responsibilities of each level are clearly spelt out. There will also be quarterly District Health Teams (DHTs) supervision reports, technical and support program specific reports and HSD monthly supervision reports. The responsibilities of each level are clearly spelt out. Area Teams consisting of officials from various departments in the MoH and other central and regional institutions have responsibility to provide integrated technical support and supervision to a group of districts. DHTs and HSDs supervise service delivery at government and PNFP facilities at different levels, except the national and RRHs.

### ***5.2.5.3 Create a culture in which health research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Uganda.***

Research is a tool that supports evidence-based policy and intervention formulation and is therefore an important component of the HSSIP. During HSSIP emphasis will be given to how research can be used to guide the development and implementation of policy, health promotion, disease prevention and early diagnosis and treatment. The UNHRO shall be responsible for coordinating all the health related research in Uganda. A lot of health research is conducted without the integration of issues relating to the different experiences of women versus men with regards to the subject/object of the research. This has led in the past, for example, to symptoms of common illness being assumed to be the same in men & women (e.g. angina) thereby leading to inequities in access to prompt recognition of illness and delays in appropriate management.

## **Strategies and key intervention**

- *Strengthen the policy and legal environment that supports the conduct of research.*
  - Develop a policy and legal framework to ensure effective coordination, alignment and harmonisation of research activities.
- *Strengthen health research capacity in institutions at all levels and develop quality human resource and infrastructure.*
  - Develop and implement, under the coordination of UNHRO, a prioritised national health research agenda in a consultative manner and undertake effective dissemination of research findings.
  - Conduct a mapping and capacity assessment of institutions that conduct health sciences research in Uganda.
  - Develop an inventory of institutions involved in health related research

- In collaboration with institutions of higher learning, train health workers at central and district level in the development of research proposals and the principles of conducting research.
- Facilitate collaboration and coordination of health research through UNHRO.
- Develop an ethical code of conduct for health research in Uganda, promoting the safety and rights of research participants, as well as the researchers as per the UNHRO Act.
- Ensure that guidelines (including ethical guidelines) for research in Uganda reflect attention to the various gendered dimensions of research.

### **Indicators with targets**

- A policy and legal framework for effective coordination, alignment and harmonisation of research activities developed by 2012.
- A prioritised national research agenda developed by 2012.
- Institutions involved in conducting research identified by 2011.

### **Implementation arrangements**

The Bill for the establishment of UNHRO was passed by parliament in 2009 and it will take a leading and coordinating role in the conduct of health research in Uganda. The Secretariat will be responsible for mobilizing resources, setting health sciences research agenda, commissioning and organizing health research in collaboration with other research and academic institutions, NGOs. The DHO will promote and coordinate research at district and lower levels.

#### ***5.2.5.4 Review and develop relevant Policies, Acts and regulations governing health which are gender responsive and human rights compliant and to ensure their enforcement.***

Appropriate legislation and its enforcement provide an enabling environment for operationalization of the policy and the HSSIP and are essential for an effective health service delivery system. The review and enactment of the legislation is slow and that enforcement is a major problem. Currently there are several obsolete laws and regulations in the sector that require revision in order to better ensure the enjoyment of the rights they are supposed to support. Examples include the public health act, the food safety act, and the mental health act. Other policies, such as those relating to reporting and testifying with regards to SGBV have been earlier mentioned. While it will be discussed comprehensively under infrastructure, it is important that government addresses land acquisition and titling. During HSSIP priority will be given to fast tracking the review and enactment of relevant health legislation that will provide an enabling environment for the provision of quality UNMHCP and the provision of adequate resources for policy and legislation up-dates and reviews. In addition to this, there will be a need to develop laws and regulations that domesticate the international legal instruments on the right to health and further develop mechanisms to operationalise them. There will also be a need to capacitate the Policy Analysis Unit in the MoH and strengthen professional councils to perform their responsibilities.

### **Strategies and key interventions**

- *Strengthen the legal and policy environment conducive for the delivery of the minimum health care package.*
  - Initiate the review of health related policies and legislation as need arises.
  - Identify emerging health issues, conditions and therapeutic interventions that require new legislation and policies.
  - Facilitate coordination of policy development in MoH and other related sectors to ensure harmonisation and mainstreaming of health issues.

- Enforce existing legislation and policies, including inspections by regulatory bodies, and ensure that high quality services are provided by public and private sector.
- Develop an effective regulatory environment and mechanisms for clients who seek redress for poor service provision
- Develop laws and regulations that domesticate the international legal instruments on the right to health
- *Build capacity of institutions to develop and enforce health and related legislations.*
  - Recruit additional staff in the Policy Analysis Unit of the MoH and upgrade the unit into a department.
  - Consider/recruit a legal officer in the policy analysis unit of the MoH
  - Ensure the functionality of the gender focal point in the policy analysis unit of the MoH
  - Train staff from MoH, NDA and professional bodies in the review and development of health and related policies.
  - Train law enforcers on new legislation and policies to ensure implementation of legislation and policies.
  - Train local governments in the development and implementation of byelaws that can directly impact on social determinants of health.
- *Promote enforcement, observance and adherence to professional standards, codes of conduct and ethics.*
  - Enforce professional standards.
  - Establish and operationalize a Joint Professional Council with decentralized supervisory authorities.
  - Review guidelines for establishing and operating private clinics and health training institutions.
  - Review and streamline staffing levels of the Professional Councils.
  - Increase logistical and financial support to the Professional Councils.

### **Indicators with targets**

- Number of policies reviewed and developed.
- Number of relevant international legal instruments on health that have been domesticated
- Number of laws reviewed and developed to make them gender –responsive and human rights compliant.
- Number of law enforcers trained in new legislation and policies to ensure implementation of legislation and policies.
- An effective regulatory environment and mechanism developed.
- An adequate and functional staffing structure of Professional councils established over the next five years.
- A Joint Professional Council with decentralized supervisory authorities established and operationalised over the next five years.

### **Implementation**

The MoH will continuously identify emerging health issues, conditions and interventions that require

legislation and policy guidance and shall work with the Ministry of Justice and other relevant law enforcement institutions to draft laws and policies. The MoH will lobby for the allocation of more resources from the MoF for the review and development of legislation. The MoH shall work with appropriate health professional associations to inspect health care and related services. The local governments at district level shall be responsible for implementing the legislation as well as developing their respective bylaws relating to health and health care.

#### ***5.2.5.5 Effectively build and utilize the full potential of the public and private partnerships in the health sector***

While structures to make the PPPH fully functional are present to a greater extent at national level, such structures are established to a lesser extent at district and lower levels. Realizing the importance of the private sector in health care the MoH and HSSIP shall encourage and institutionalize the involvement of the private sector in the provision of preventive, promotive and curative health care to all Ugandans.

### **Strategies and interventions**

- *Strengthen the policy and legal environment conducive for the PPPH*
  - Finalise and approve the National Policy on PPPH.
  - Establish appropriate legislative frameworks and guidelines to facilitate and regulate the private sector in line with existing laws and regulations, taking care to reflect appropriate measures to protect the rights of the marginalized and vulnerable.
  - Disseminate the PPPH Policy and test the Implementation Guidelines.
- *Operationalise the public private partnership in health.*
  - Ensure continued participation of the private sector in the process of policy development, planning, implementation and quality assurance with the aim of building consensus and sharing ownership of policies and plans.
  - Establish PPPH structures at district and lower levels necessary to facilitate coordination and consultation among stakeholders.
  - Support CSOs to streamline organization, coordination and regulatory mechanisms to strengthen their role in policy formulation, funding, and service delivery.
  - Develop and implement in consultation with the PNFP, a MoU which would link level of subsidies to agreed service outputs with the objective of increasing access to health services for most vulnerable population
  - Propose, in consultation with the PHP, innovative incentive mechanisms, such as fiscal exemption, to promote the establishment of private health practitioners in under-served and difficult to reach areas.
  - Assure the participation of the private sector representatives at the quarterly meetings of the District Health Management Team at the annual District Health Planning and conduct regular joint public-private supervision.
  - Develop and train PHP to provide HMIS data to improve completeness of national data, planning, and health financing.
  - Support CSOs to adopt the VHT community HIMS reporting system.
  - Develop mechanisms to facilitate access of the private sector (PNFP, PHP, and CSO) to development capital, and supplies for health care vital to service expansion to the population.
  - Support the establishment of a basket fund for essential medicines and health supply to guarantee

the delivery of the UNMHCP by the PNFP subsector.

### **Indicators with targets**

- The National Policy on PPPH is approved by the Cabinet by 2011
- Implementation Guidelines tested at district level.
- Approval of traditional medicine regulatory bill by 2011.
- All PPPH District Desk Officers appointed by 2012.
- Number of districts signing service level agreement with the PNFP, PHP and the CSOs, with definition of targets and outputs.
- Number of districts which have developed a joint public-private District Health Plan
- Number of districts in which PHP sub-sector contributes to the HMIS.
- Number of districts reporting disaggregated output data by public-private contribution.

#### **5.2.5.6 Strengthen collaboration between the health sector and other government ministries and departments, and various public and private institutions (universities, professional councils, etc.) on health and related issues**

Currently, intersectoral collaboration with other government ministries and departments is weak. During the implementation of HSSIP the MoH shall strengthen the collaboration with other ministries and departments whose responsibilities have an impact on the health of the people of Uganda. The MoH shall take a leading role in advising, mobilising and collaborating with other government ministries and departments on health matters.

### **Strategies and interventions**

- *Strengthen the partnership between MoH and other government Ministries and Departments*
  - Develop inter-ministerial clusters for cross-cutting thematic areas.
  - Involve other GoU Ministries and departments during the NHA and JRM and any other relevant for a.
  - Conduct Health Impact Assessments (HIA) as a tool for measuring the potential impact of new policies in other sectors.

### **Indicators with targets**

- The structures and methods of consultation with other government Ministries and Departments are defined by 2011.
- All new government policies assessed using the HIA tool.

#### **5.2.5.7 Implement the national health policy and the Health Sector Strategic Plan within the Sector wide Approach and IHP+ framework, through a single harmonized in country implementation effort, scaled up financial, technical and institutional support for health MDGs and ensuring mutual commitment and accountability**

Uganda has implemented the Sector Wide Approach (SWAp) in health for the previous ten years with support from HPDs. The Uganda Health SWAp is a sustained partnership whose goal is achieving improvement in people's health through a collaborative programme of work, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sectoral performance against jointly

agreed milestones and targets. The SWAp has generally been working well and GoU intends to strengthen this framework and harmonise the external funding as a signatory of the IHP+. The MoH has a MoU with the HPDs and this will be further elaborated and operationalised through a compact arrangement.

### **Strategies and interventions**

- *Strengthen the partnership between MoH and HPDs within the spirit of the Paris Declaration and IHP+ and the Accra Agenda for Action.*
  - Harmonise and align aid delivery following the spirit of the Paris Declaration (2005) and the Accra Agenda for Action to accelerate progress in implementation.
  - Generate consensus with all HPDs on key development objectives, health priorities and the main strategies for achieving them including a clear resource allocation formula.
  - Institute a joint budget support framework.
  - Integrate on-going donor funded programmes and projects into HSSIP.
  - Conduct joint reviews and monitoring to avoid unnecessary workload and extra burden of logistics on the government.
  - Develop and implement a country compact among the MoH, the HDPs, the CSOs and the private sector.
- *Strengthen the capacity at national and district levels for effective co-ordination of all development partners in health, eliminating duplication of efforts and rationalizing HDP activities to make them more cost-effective.*
  - Defining measures and standards of performance, accountability and transparency in financial management, procurement, and program implementation in line with accepted good practices.
  - Orient national and district level staff on donor coordination and aid effectiveness among other issues.

### **Indicators with targets**

- A Country Compact signed by the MoH, HDP, CSOs and the private sector.
- A joint budget support framework instituted.
- Annual joint reviews and monitoring conducted.

### **Implementation arrangements**

During the implementation of the HSSIP attention will be paid to strengthening partnerships at different levels. This will be achieved at national level with the approval of the National Policy on PPPH, at district level institutionalizing the structures of partnership and with the formulation of joint district planning involving public and private sector, under the leadership of DHO. The process should be bottom-up and result in the definition of district plan which incorporate all different sub-sectors related to health. The Department of Planning in the MoH shall be responsible for coordinating the creation and strengthening of partnerships with other Government agencies, the private sector, CSOs and communities. It will also be responsible for the partnership with HDPs which shall be based on the IHP framework and compact.

The MoH shall maintain an advisory role toward other sectoral ministries, revitalizing and creating inter-ministerial structures of coordination and consultation. At the community level the existing community structures (HUMC and VHTs) shall be mobilised to ensure community participation and their involvement in the implementation of health activities.



## 6. INVESTMENT FOCUS

Achievement of the HSSIP calls for critical investments in different sector areas to attain the objectives set out. Sector investments are in four critical areas (a) Human Resources for Health, (b) Health Infrastructure, including buildings, equipment, Communication, Transport, (c) Medical Products, Vaccines, Supplies and Technologies, and (d) Management support, including planning, supervision, training, monitoring.

In this section, we only summarize the critical investments the sector intends to make, in order to attain the goal and objectives of the HSSIP. The more comprehensive information on actual investments is contained in respective System strategic plans. These include:

- Human Resources for Health strategic plan
- Health infrastructure strategic plan
- National Pharmaceutical Sector Strategic Plan
- Health Management and Information System Strategic Plan

### 6.1 *Service Delivery Priorities for investment*

Priorities for implementation during the HSSIP are those interventions for for implementation will have 1<sup>st</sup> priority above other investments, by both Government, and donors. These priority intervention areas are:

- Sexual and reproductive health: In recognition of the slow progress being made towards attaining good health outcomes relating to this area of services
- Child Health: In recognition of the need to accelerate implementation of cost effective interventions to improve child health
- Health Education: In recognition of the critical role addressing health risk factors play, in attaining the overall health goals, and
- Control and prevention of communicable diseases (HIV/AIDS, Malaria and Tuberculosis): In recognition of the major contribution they provide to the overall disease burden.

Investments made during the HSSIP period are geared at enabling the system deliver, at a minimum, the above interventions.

### 6.2 *Human Resources for Health Investments*

During the period of the HSSIP, the sector priority in Human Resource Investments will be to attain a minimum of 75% of the expected norms. While attainment of 100% of the norms would be ideal, improvement in the numbers of Health Workers to 75%, from the current 52% of expected norms is a target more within reach.

Attainment of this 75% of norms on its own will be a challenge. As such, improvements in staff numbers will be staggered across the years as highlighted below.

**Table 6.1: Targeted Human Resource investments during HSSIP**

Strategy / key focus	2010/11	2011/12	2012/13	2013/14	2014/15
Specialist Training	8.29	-	10.37	-	12.96
Systems and Partnerships	24.07	26.96	31.62	37.75	45.28
In-Service Training	12.54	13.42	14.36	15.37	16.44
Implement HDMC Business Plan	0.55	1.22	1.94	1.77	1.64
Current salaries (with some additional recruitment)	243.40	264.36	275.44	282.70	285.12
Retention/motivation Interventions	85.27	91.60	97.45	104.17	111.36
UCI - training of specialists	2.50	2.68	2.86	3.06	3.28
UHI - training of specialists	4.73	5.21	5.73	6.30	6.93
Radiotherapy - training of specialist	3.75	1.87	0.64	0.79	0.02
Mulago - training of specialists	48.00	52.80	58.08	63.89	70.28
<b>TOTAL</b>	<b>433.11</b>	<b>460.11</b>	<b>498.48</b>	<b>515.81</b>	<b>553.31</b>

The bulk of the new recruitments are planned in the early years of the HSSIP, to allow them contribute adequately in service provision, and therefore facilitate attainment of the targeted Service Delivery priority targets.

The new recruitments are also aimed at catering for attrition out of the workforce, to ensure numbers of health workers are improving each year, towards the desired norms.

The new recruitments will be focused on mid level staff (Doctors, nurses, etc) who form the backbone of the health workforce. The ratio of senior staff : mid level staff : support staff recruited will be 1 : 5 : 2 respectively.

Additional interventions to strengthen productivity of the existing, and new health workforce have already been defined elsewhere.

### 6.3 Health Infrastructure Investments

Health infrastructure (buildings, equipment, ICT and transport) represents a critical bottleneck in the ability of the sector to attain its service delivery priorities. Health infrastructure is diverse, and includes physical infrastructure, equipment, supplies, ICT, transport, amongst other investments.

The sector will prioritise matching infrastructure with health workforce across the country to limit inefficiencies in use of these two critical investments. As a result, the sector will prioritise investments that will ensure at least 75% of the total infrastructure requirements are available and in use.

Targeted major investments towards attaining this are highlighted in the figures below

Figure 6.1: HSSIP infrastructure Investments for nationally coordinated services

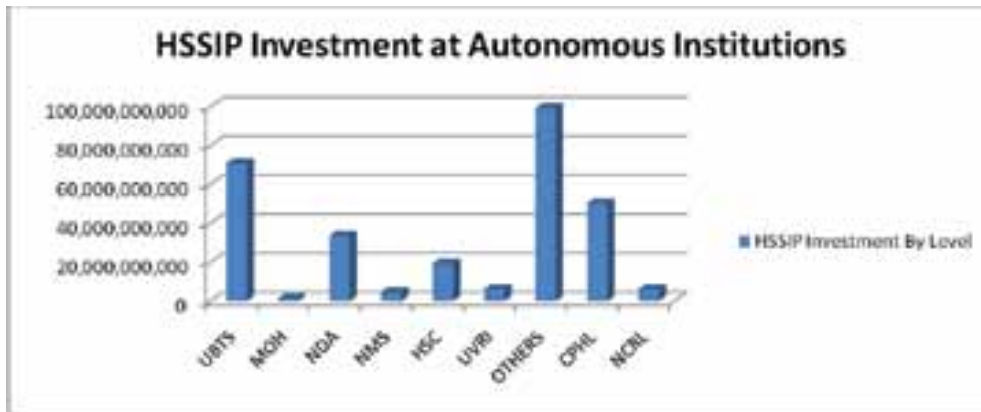
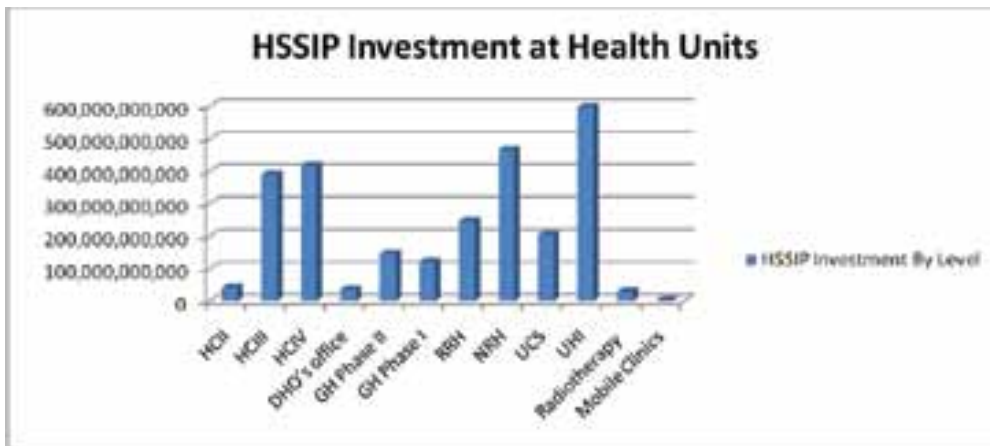


Figure 6.2: HSSIP infrastructure Investments for nationally coordinated services



The sector will target upgrading of physical infrastructure in 190 HC II's, 120 HC III's, 190 HC IV's, 17 general hospitals, 3 regional referrals and one national referral. The regional referrals will have their physical infrastructure upgraded, though investments in Medical buildings, staff houses, water supply and sewerage, external works, medical equipment & furniture, plus transport and ambulatory services (each provided with 1 ambulance, minibuses, 1 truck, 1 mobile workshop and double cabin pick up). In addition, each shall have required infrastructure provided to accommodate the proposed Regional Structure for sub national coordination of service delivery.

In addition, 38 facilities will have their physical infrastructure upgraded to the general hospital norms, though investments in the above areas (with the exception of a truck and mobile workshop). Capital investments shall be done in the 4 national referrals, 10 regional referrals, and 35 District Health Offices during the HSSIP.

For the HC I, the sector will aim at providing at least 3,400 mobile clinics annually, plus purchase of 559,110 bicycles, provide 96,250 medicine boxes, and the required supplies for these.

Provision of laboratory supplies shall be scaled up, according to the expected standards and norms for each level. At least 75% of all the laboratories should have supplies as per the norms by the end of the HSSIP.

### 6.4 Medical Products Investments

Medical products constitute a wide range of different investments. The Pharmaceutical Sector Strategic Plan, and the Annual procurement plans contain details of actual quantities required for the different Medical Products.

The medical product requirements are dependent on the level of care, and expected numbers of clients expected to be serviced. Annual estimates of essential medicines are highlighted in the table below. The needs for Coartem, being a high cost, but priority medicine, are also presented for illustration and comparison.

**Table 6.2: Annual investments in pharmaceuticals**

<b>Billion shillings</b>	<b>2010/11</b>	<b>2011/1</b>	<b>2012/13</b>	<b>2013/14</b>	<b>2014/15</b>
Essential medicines & health supplies	107.00	118.00	130.00	144.00	159.00
ACTs	36.37	27.38	26.35	54.23	55.87
ITNs	8.24	15.44	21.59	24.28	26.83
IRS	23.13	57.74	58.67	37.70	41.12
RDTs	12.91	15.95	24.31	31.22	38.74
SP for IPTp	0.48	0.50	0.55	0.60	0.65
Traditional Vaccines (incl Pentavalent)	36.62	39.03	41.80	42.42	46.17
New vaccines (Rotavirus + PCV)	25.06	108.23	87.11	94.32	159.92
Vaccines supplies	4.20	5.13	5.17	5.51	6.33
ARVs + OI drugs (incl. PMTCT drugs): 1st & 2nd line drugs	111.94	216.77	257.91	304.90	314.91
Anti TB and Leprosy drugs	6.95	4.47	4.70	4.93	5.18
Contraceptives	41.40	44.05	45.06	50.69	56.73
RH commodities	110.57	96.28	115.11	123.20	131.77
Condoms	7.51	8.11	8.77	9.49	10.26
UBTS supplies	3.70	4.00	4.33	4.68	5.06
Laboratory supplies & consumables	52.40	56.59	61.12	66.01	71.29
Anti-Cancer drugs	3.46	3.81	4.19	4.61	5.07
Medicines and consumables for HC I / VHT/ community	28.51	29.48	30.25	31.27	32.09
Mulago III (additional health supplies)	24.00	26.40	29.04	31.94	35.14
<b>TOTAL</b>	<b>644.45</b>	<b>877.37</b>	<b>956.03</b>	<b>1,065.99</b>	<b>1,202.14</b>

Requirements vary between public, and PNFP facilities, with the unit requirements higher in the public facilities due to the larger number of clients seen there.

## 6.5 Management Support Investments

Management support represents a wide range of supportive functions that need to be provided, to enable smooth provision of available health services. These functions are provided at the national, regional, and district levels, and relate to planning, supervision, monitoring, and research functions. Investments are needed to sustain these management functions.

It is expected each management unit will undergo a planning process at least once each year. This is to ensure it is providing input into the overall sector annual operational plan.

Each management unit should have at least 4 supportive supervision visits for the units it is managing. This corresponds to one visit per quarter.

Each management unit will also undergo one monitoring and review process each year, to follow up on its performance against its annual operational plan.

Finally, training and / or research is a critical function of the service – oriented management units, and will need to be invested in each year. National level directorate investments in research include the various surveys required to generate health impact information.

These respective investment areas for management support are highlighted in the table below.

### Annual investments in management functions required in HSSIP

An annual average of 331 billion is required in the sector for day-to-day operations by the different key players (service providers and management entities). Over the 5-year period, a total of **1,657 billion** is required for operational costs, to cover expenses relating to strategic planning and policy development, administrative items, utilities, travel, relevant meetings and workshops, etc. Of this total, 35% is required at lower level units (HC I – HC IV), 19% for MOH headquarters, 15% at national referral hospitals, 11.5% is required at general and regional referral hospitals, and 10% for autonomous institutions.

**Table 6.3: Operational costs (administrative items, travel, meetings, office maintenance) – Billion shillings**

	2010/11	2011/12	2012/13	2013/14	2014/15
HC I	48.00	51.36	54.96	58.80	62.92
HC II	14.49	16.28	18.29	20.54	23.06
HC III	28.37	31.42	34.79	38.53	42.67
HC IV	6.60	6.60	6.60	6.60	6.60
General Hospital	23.36	26.43	29.89	33.06	36.57
Regional Ref hospital	6.78	7.49	8.27	9.14	10.10
National Ref Hospital	12.76	42.24	46.63	51.50	56.92
NRH - Psychiatric	6.27	6.93	7.65	8.46	9.35
UBTS	7.80	10.23	8.00	8.27	8.73
UHI	6.09	6.70	7.37	8.11	8.92
UCI	4.35	4.39	4.42	4.47	4.51
DHO offices	5.01	5.51	6.07	6.70	7.39
Regional level	4.34	4.78	5.26	5.80	6.41
MOH headquarters	51.33	56.60	62.42	68.83	75.89
HSC	2.78	4.30	4.68	5.05	5.47
UNHRO + UVRI	-	-	-	-	-
NMS	9.64	10.31	11.03	11.80	12.63
UAC	2.10	2.25	2.40	2.57	2.75
CPHL	13.03	13.94	14.91	15.96	17.08
<b>TOTAL</b>	<b>253.11</b>	<b>307.74</b>	<b>333.66</b>	<b>364.19</b>	<b>397.96</b>



# **SECTION 3:**

## **IMPLEMENTATION ARRANGEMENTS**





## 7. GOVERNANCE, AND COORDINATION OF THE HEALTH SECTOR

**B**etter coordination of service delivery is a key element required to maximize the outputs the Ministry is able to deliver to the people of Uganda. Improvement in coordination and management of the delivery of Health and Health related services is therefore a key strategic deliverable for the Ministry.

Guidance on coordination and governance is provided through three oversight structures

- **The management structure:** This guides internal Ministry coordination, to guide implementation of defined interventions and activities at the different levels.
- **The governance structure:** This looks at defining the guiding strategic direction, and following up on the operation of interventions. It is largely defined through formal legislation, with members and functions formally gazetted by the Government.
- **The partnership structure:** This guides external coordination of service delivery by all stakeholders at the respective levels of care. All partners providing services at a given level of care engage with each other through this structure.

The governance, and partnership structures described in this chapter intend to establish a substantive sector-wide governance mechanism, to foster agreement on other common procedures for consultation and decision-making. Among the measures are annual planning, procurement and disbursement mechanisms, monitoring and reporting, and review and evaluation. Others are audits, financial management and the exchange of information in this collaboration.

The existing partnership instrument – the compact – will serve as the formal instrument to guide the functioning of the partnership in health. It is guided by interpretation of the principles of the 2005 Paris Declaration on Aid Effectiveness.

### 7.1 Governance and Partnership Structures

Specific structures for coordination of the sector will be made functional, to guide implementation of the HSSIP. These are illustrated in the figure overleaf.

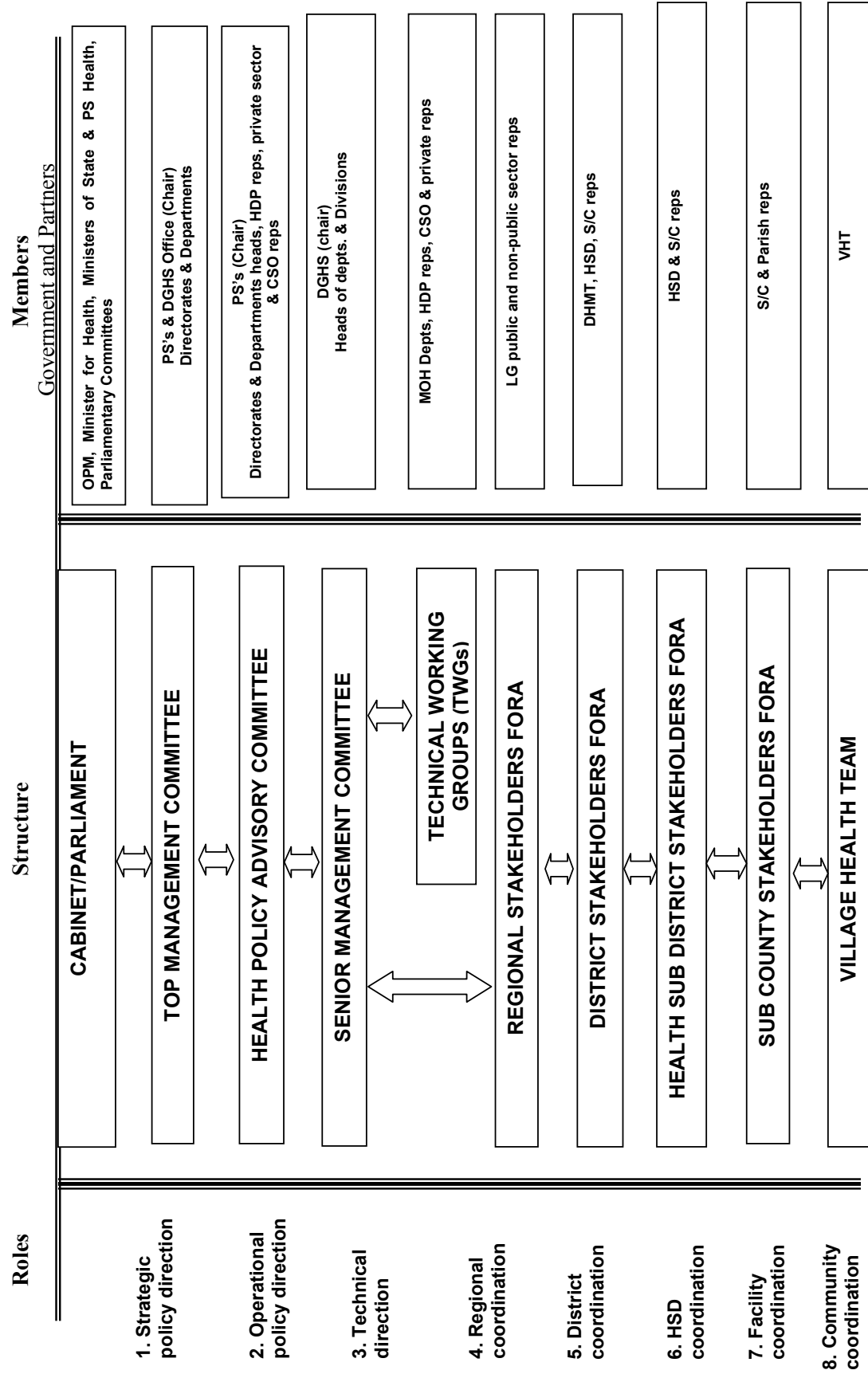
#### 7.1.1 Cabinet/Parliament

The Sector shall close with the relevant committees of parliament and cabinet for overall political, and policy oversight this structure shall provide governance and partnership oversight to the sector. Its key role is political and policy coordination, ensuring the sector is working towards its policy objectives as set out in the National Health Policy, and the country's National Development Plan (NDP). The HF is therefore responsible for development and monitoring of the overall policy direction for the sector. This function includes:

- Articulating the policy direction for the sector, taking broader Government objectives into consideration.
- Monitoring adherence to the policy direction of the sector.
- Mobilizing resources for achievement of the sector policy direction.

This sector shall interface with parliament and cabinet whenever necessary but in any case, following the Joint Review Mission of the Health Sector. The focus of the meetings shall be to review sector progress in the past year (based on the AHSPR), against the policy imperatives set out in the NHP, and contribution towards the NDP.

Figure 7.1: Government and Partnership Coordination



### 7.1.2 Health Policy Advisory Committee

The Health Policy Advisory Committee (HPAC) is a forum for the Government, Development Partners and other stakeholders to discuss health policy and to advise on the implementation of the Health Sector Strategic and Investment Plan. HPAC is a donor/ stakeholder coordination mechanism. and works through the established Technical Working Groups. It provides a forum for information and experience sharing, and resolution of disagreements or conflicts among health sector stakeholders. HPAC identifies tasks that need to be undertaken through special assignments and approves terms of reference for each such assignment. HPAC approves the work plan, budget and other project expenditures for the Health sector.

HPAC membership consists of:

- Ministry of Health, Chair of HDP, Co-Chair of HDP and two selected members of HDP, Ministry of Local Government, National Medical Stores, Ministry of Finance, Planning and Economic Development, Ministry of Education and Sports, Ministry of Public Service, Private not-for profit representative, Civil Society Representative

**HPAC co-opts members to address specific issues that may arise. HPAC is chaired by the Permanent Secretary, who is the accounting officer of the Ministry of Health. In the absence of the Permanent Secretary vice chair of HPAC or other designated representative will act in his/her place.**

### 7.1.3 Technical Working Groups and (sub)committees

Actual technical coordination will be through the technical working groups , each focused on specific technical areas. These will be the forum through which technical issues are debated and agreed and specific recommendations and actions are implemented. The committees shall be both standing, and ad hoc. Standing committees exist all the time, while the ad hoc ones will be formed to address a particular task, then disbanded when the task is completed. Standing committees shall primarily relate to Health Services, while the ad hoc ones shall focus on different Health System challenges.

All the technical working groups and committees will be managed through the Senior Management Committee and reports from these shall be a standing HPAC agenda. Furthermore, HPAC and MoH Senior Management may task TWGs with specific issues to resolve.

Two or more technical stakeholder committee can cooperate to address particular issues that cut across them. In such instances, they will define the modalities of cooperation. One functioning example is the Global Fund Country Coordinating Mechanism (CCM), which brings together Global Fund related issues from the malaria, TB and HIV technical stakeholders committees.

### 7.1.4 Regional stakeholders fora

A regional level mechanism is being discussed to ease coordination, quality assurance and support for health service delivery at the decentralized level. Once agreed and adopted the regional level stakeholders shall come together to discuss health and health related issues affecting their region at least once a year (prior to finalization of HSD / district performance reports). The fora shall discuss performance within the region, and agree on priorities to guide districts and RRHs in their respective planning and implementation processes. These stakeholders include

- Public, and non public health providers operating within the region
- Development Partners supporting, or facilitating activities within the region
- Critical civil society / NGO groups operating within the region
- Members of Parliament, and other eminent persons of the region
- Community, and / or cultural leaders with a significant influence within the region
- Representatives of health related sectors

The detailed structure at the regional level shall be determined based on an authentic and agreed process that will be determined by HPAC.. Additional capacity in planning, supervision and monitoring will be provided to the region , to facilitate its coordination A standard planning , and reporting format for the regional team, tools and process shall be provided to all the regions, to guide them in their stakeholders fora. These reports and plans shall be what will be collated together at the national level.

#### **7.1.5 District stakeholders fora**

Stakeholders in the districts shall come together to discuss health and health related issues affecting their region quarterly . These stakeholders include

- Political, administrative and technical leadership within the districts
- Public, and non-public health providers operating within the district
- Development Partners/implementing partners supporting, or facilitating activities within the district
- Critical civil society / NGO groups operating within the district
- Representatives of health related sectors

The fora shall discuss performance within the HSD's in the district, and agree on priorities to guide HSD's in their respective planning and implementation processes.

The stakeholders fora shall be coordinated through the DHO's office. A standard planning, and reporting format, tools and process shall be provided to all the districts, to guide them in their stakeholders fora. These reports and plans shall be what will be collated together at the regional, and national levels.

#### **7.1.6 Health Sub District stakeholders fora**

Stakeholders in the HSD's shall come together to discuss health and health related issues affecting their HSD quarterly . These stakeholders include

- Political, administrative and technical leadership within the HSD
- Public, and non public health providers operating within the HSD
- Development Partners/implementing partners supporting, or facilitating activities within the HSD
- Critical civil society / NGO groups operating within the HSD
- Representatives of health related sectors in the HSD

The fora shall discuss performance within the HSD, and agree on priorities to guide facilities and other service providers in their respective planning and implementation processes.

The HSD stakeholders fora shall be coordinated through the facility heading the HSD. A standard planning, and reporting format, tools and process shall be provided to all the regions, to guide them in their stakeholders meeting. These reports and plans shall be what will be collated together at the district level.

#### **7.1.7 Health Facility Management Committee**

Each facility in the country shall have a defined catchment area, for which it will be responsible for coordinating delivery of services to implement the HSSIP. All stakeholders in the catchment area of the facility shall come together to discuss health and health related issues affecting them quarterly each year. These stakeholders include

- Other NGO's operating within the facility catchment area
- Development Partners/implementing partners supporting, or facilitating activities within the catchment area

- Representatives of health related sectors in the catchment area of the facility
- Community and / or political leaders from the catchment area of the facility.

The fora shall discuss performance of health within the catchment area, and agree on priorities to guide the facility and other service providers in their respective planning and implementation processes.

The Committee meetings shall be coordinated by the head of the Health Facility. A standard planning, and reporting format, tools and process shall be provided to all the regions, to guide them in their stakeholders meeting. These reports and plans shall be what will be collated together at the HSD level.

#### **7.1.8 Village Health Committee**

The final coordination team is the Village Health Committee. This is defined for each village in the country, to guide discussion on health and health related issues affecting their community.

The Committee shall discuss performance within the community, and agree on priorities to focus on. A standard planning, and reporting format, tools and process shall be provided to the VHC, to guide them in their deliberations. These reports and plans shall be collated at the facility level.

## **7.2 Management structure for stewardship**

As earlier highlighted, the Government possesses both service delivery, and stewardship functions in Health. The stewardship function is exercised by the management, while the service delivery function is exercised by the facilities, and coordinated by the HSD's and districts. The management structure of the Ministry lays emphasis on responsiveness to the requirements of the NHP and this HSSIP. It clearly defines the levels of operation and management and it offers the best prospect for a lean, effective system. The organization is such that there is a clear communication linkage among the national, regional and district level for ease of planning, operations, monitoring and evaluation.

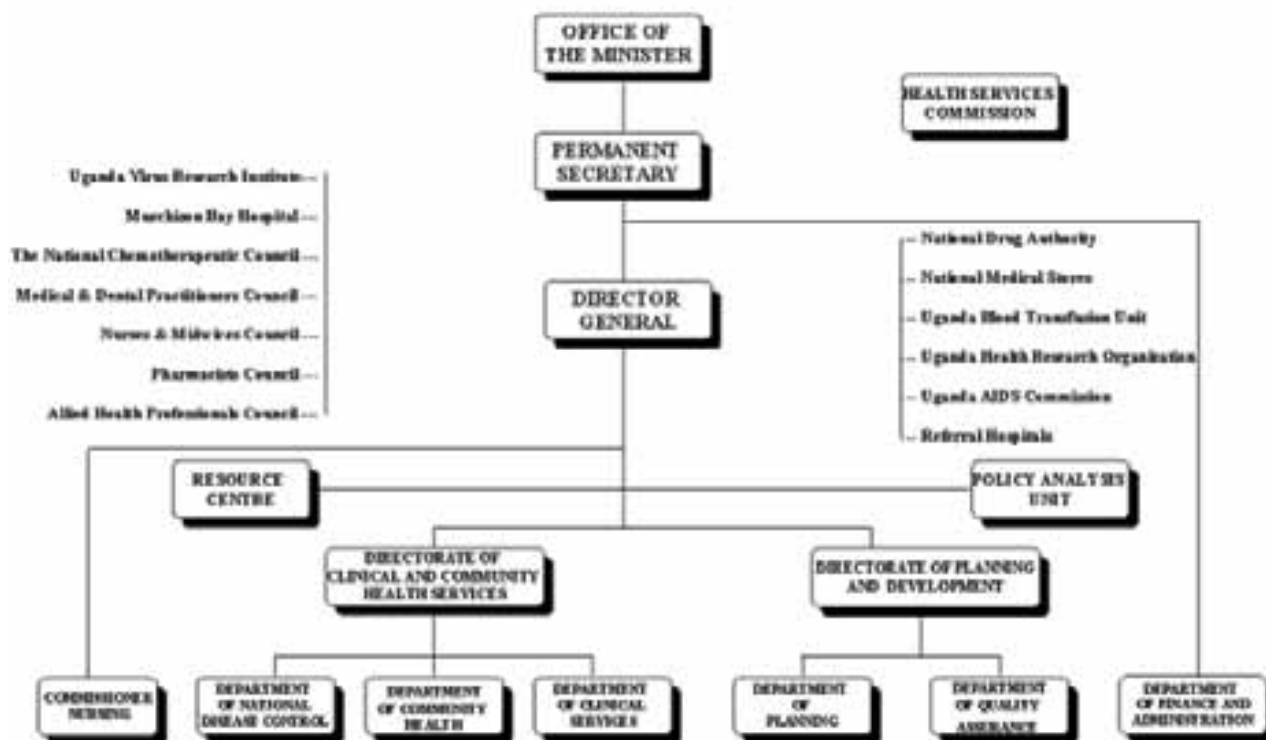
At the district level the District Medical Officer is in charge of health services at the district level with his team, addressing both the management and governance issues at the district. At the regional level, the management function will be held by the Medical Superintendent of the regional hospital, where they focus on coordination, support to district planning, supervision and monitoring of health services in the region on behalf of the Director General of Health Services.

### 7.2.1 Management structure at the national level

The figure overleaf shows the full Ministry structure.

Figure 7.2: Ministry of Health Organogram

## MACRO STRUCTURE OF THE MINISTRY OF HEALTH



The key oversight functions will be managed through the Minister and the Ministers of State. Duties of these have been defined by Government.

#### 7.2.1.1 Office of the Permanent Secretary

The Permanent Secretary coordinates resources for effective management of Health Funds. The work of the Permanent Secretary will be supported through the following units:

- Internal Audit
- Finance, and Accounting

He will work through the Office of the Director General for Health Services (and for HIV) for guiding technical direction.

#### 7.2.1.2 Office of the Director General of Health Services

The Director General of Health Services coordinates technical functions for delivery of Health.

The work of the DGHS will be coordinated through two directorates:

- Directorate for Planning & Development, and
- Directorate of clinical & Community Health services

Several semi autonomous government agencies complement the work of the Ministry in discharging its core functions through service delivery, research and training, and procurement and distribution of drugs. These include both parastatals, and statutory institutions responsible for quality control. These are:

- Parastatals
  - National Research, and Teaching hospitals– Curative services and teaching
  - National Medical Stores (NMS) – Procurement and distribution of commodities
  - Uganda Virus Research Institute (UVRI) – Research
- Statutory institutions:
  - Health Services Commission
  - National Drug Authority
  -
- Other semi autonomous bodies
  - Uganda National Health Research Organization
  - Joint Clinical Research Centre
  - National Clinical Research Laboratories
  - Uganda Blood Transfusion Services

## 7.2.2 Health related Ministries

Overall the MoH is the line GoU agency responsible for health sector stewardship. In order to achieve the objectives of the HSSIP it is important that the MoH works in partnership with other government Ministries to address challenges relating to health.

### 7.2.2.1 Ministry of Finance, Planning and Economic Development

The Ministry of Finance and Economic Development mobilizes resources for GoU and has the overall responsibility of allocating resources to different sectors according to priorities set by the GoU. In addition to this, the Ministry oversees national policy development including the development and coordinating the implementation of the National Development Plan, the overall development agenda for Uganda. The implementation of the NHP II and the HSSIP contributes to the achievement of the overall goal of the National Development Plan.

### 7.2.2.2 Ministry of Local Government

With decentralisation, the Ministry of Local Government is responsible for the management and delivery of health services at district and lower levels including the development and implementation of community health initiatives. It monitors and supervises health services delivery at this level. In addition, the Ministry of Local Government recruits and deploys staff at district and lower levels and mobilises resources at that level. The General Hospitals, HSDs, HC III and HC II should be responsive to the needs of the community and members of the community, through HUMCs and VHTs shall participate actively in the management and delivery of health services.

### 7.2.2.3 Ministry of Education and Sports

The level of education is an important social determinant of health; hence the MoE has the overall responsibility of ensuring that Uganda has an educated population that understands health and how to maintain it. The MoE will also work with the MoH to implement the School Health Policy. . It is envisaged that, amongs others,

the MoE will be responsible for the recruitment of school health nurses at all public schools in Uganda.

#### ***7.2.2.4 Ministry of Lands, Water and Environment***

The Ministry will ensure that water is available in all health facilities in Uganda. It will work very closely with the MoH to ensure that new facilities are located where water can easily be sourced. It has the overall responsibility of developing water sources and provision of sanitation facilities including communal toilets. It will also be responsible for protection of the environment in general.

#### ***7.2.2.5 Ministry of Agriculture, Animal Industry and Fisheries***

The Ministry is responsible for food production in Uganda which is essential for normal growth and development and prevention of malnutrition. It is also responsible for preservation and storage of food.

#### ***7.2.2.6 Ministry of Gender, Labour and Social Development***

The Ministry is responsible for mainstreaming human rights and gender in all government policies and plans including advocacy for awareness and prevention of gender based violence which is an important component of this strategic plan. The Ministry also implements safety and health programmes in the workplace in order to ensure a healthy workforce. Meaningful and close collaboration with this ministry can enhance performance in the health sector, especially with regards to issue of gender equality and health equity.

#### ***7.2.2.7 Ministry of Public Service***

It maintains the payroll of all civil servants in Uganda including health workers and it has overall responsibility of determining hard to reach allowance and other incentives which is quite crucial for civil servants including health workers.

### **7.2.3 Management Structure and Functions at the Sub-national Level**

The DGHS coordinates management functions at the national level with those at the sub-national level. These management structures are in place at district level, and will be established at regional level during the implementation of this HSSIP, as illustrated in the figure overleaf.

#### ***7.2.3.1 Management at the regional Level***

The detailed structure at the regional level will be outlined after it has been determined through an authentic and agreed process.

Additional members can be co-opted, depending on the particular tasks being addressed. .

The team will have the overall objective of coordination of Health, and health related service provision in the region, by ensuring the following functions:

- Liaison between national level, and the districts on Health, and health related issues
- Supporting the development and implementation of the annual operational plans of the districts and regional referral hospitals in the region;
- Supervising, monitoring and reviewing the implementation of the annual operational plans in the region by compiling and analysing quarterly and annual reports
- Initiate and support research activities

#### ***7.2.3.2 The sector will closely monitor, document and share these experiences with relevant stakeholders***



*and aim at being prepared for the establishment of a comprehensive regional health administration by government.*

### **7.2.3.3 Management at the District Level**

District health services will be coordinated by the District Health Management team. This will consist of the following:

- District Health Officer
- Assistant District Health Officer
- Senior Environmental Health officer
- Senior Health Educator
- Biostatistician
- Cold Chain technician
- Stores assistant
- Stenographer
- Office attendant
- Driver

The team will have the overall objective of coordinating Health Services provision in the subdistricts under their responsibility, by ensuring the following functions:

- Liaison between regional level and the HSD's on Health Services issues
- Planning for delivery of Health Services in the district through development of annual operational plans for HSD's and the DHMT
- Monitoring and review of delivery of Health Services in the district by compiling and analysing quarterly, and annual reports
- Coordination of integrated supportive supervision for Health Services in the district



## 8. SUPERVISION, MONITORING & REVIEW OF HSSIP

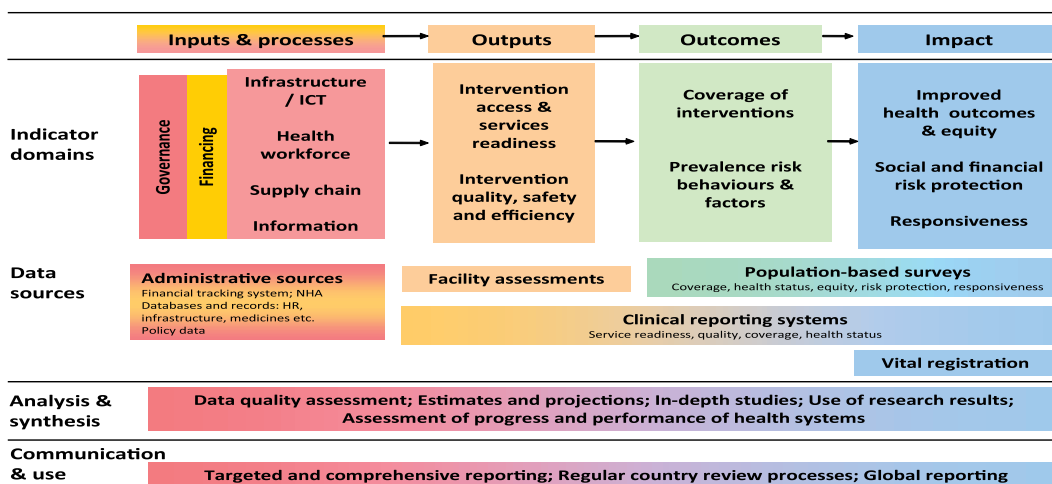
The ability to plan, supervise, monitor and evaluate in the health sector is essential if we are to correctly target interventions and assess whether they are having the desired impact. Different methods, and indicators are available to guide performance in health. It is critical to emphasize the distinction between program based, and sector based monitoring, and the use of indicators for each. Program based monitoring is able to inform on progress being made at the program level, at a level of detail sufficient to target implementation of available interventions. As such, many indicators are usually employed, each providing specific information, on its own, about a different aspect of the program. On the other hand, sector monitoring is higher level monitoring of whether the multitude of activities being carried out are having the desired impact on the sector goals. A single indicator on its own is insufficient to inform on sector progress – rather a number of different indicators are employed, with change, or lack of it, being based on movements seen with most / all the indicators. The sector expects improvements in the whole set of indicators used for progress to be recognized.

This chapter describes the sector monitoring process that will be used, to guide HSSIP monitoring and review.

### 8.1 Framework for monitoring and reporting

The monitoring framework for tracking progress is informed by the need to comprehensively monitor, and review sector progress. The framework for the analysis is based on the common steps of the monitoring and evaluation (M&E) logical framework, which shows the way in which inputs may lead to desirable health impact. The framework is an adaptation of the Country Health System Surveillance (CHeSS) framework used for comprehensive Monitoring and Evaluation of Health Strategies, intended to ensure that all indicator areas - from inputs to impact - are considered in the analysis, and pathways of influence are clarified (see figure below).

Figure 8.1: Monitoring and Evaluation of health systems reform/strengthening



For this, it is important to have indicators to guide analysis of sector progress, at all the indicator domains – input / process, output, outcome, and impact. Core indicators are defined, and structured to inform on and

compare trends across the different domains. This approach takes into consideration that the respective indicators are not viewed in isolation, but rather are intricately linked to provide information on overall progress.

## **8.2 Indicators for monitoring progress**

The sector has defined specific indicators for informing progress in critical elements of the Health Sector framework. The selected core indicators are based on the following critical variables:

- They reflect all domains presented in the M&E conceptual framework
- Having broad information on important components of the indicator domain and
- Alignment to existing sector monitoring commitments

Equity considerations cover all 'indicator domains, from investments to impact, and are in the first place addressed by disaggregating data by district. However, the disaggregation of data by certain 'poverty dimensions' (income, security) provides additional information for equity analyses.

Based on these, the HSSIP core indicators are shown in the figure overleaf.

This ensures the sector is up to date on issues affecting different elements of the framework, to enable corrective action be taken.

### **8.2.1 Health Impact indicators**

Five impact indicators are selected, to guide analysis of impact. These measure different aspects of health impact.

- Measure of the distribution of health across different life cohorts: four measures are used
  - o Infant mortality rate
  - o Maternal Mortality ratio
  - o Under 5 mortality rate
  - o Neonatal mortality rate
- Measure of financial risk (protection): proportion of household experiencing catastrophic payments.

Table 8.1: HSSIP Core Performance indicators

Indicator domain	Indicator	Related reports	Source of data	Baseline, (year)	2010/11	2011/12	2012/13	2013/14	2014/15
Health Impact	Maternal Mortality Ratio (per 100,000 live birth)	MDG, NDP, JAF	UDHS	435 (2006)					131
	Neonatal Mortality rate (per 1000)		UDHS	70 (2006)					23
	Infant Mortality Rate (per 1000)	MDG, JAF	UDHS	76 (2006)					41
	Under 5 mortality rate (per 1000)	MDG, NDP	UDHS	137 (2006)					56
	% of households experiencing catastrophic payments	-	HH survey	28 (2009)	25	22	19	16	13
	% clients expressing satisfaction with health services (waiting time)	-	MoH survey	46 (2008)	50	55	60	65	70
	% pregnant women attending 4 ANC sessions	--	HMIS	47 (09/10)	50	53	55	57	60
	% deliveries in health facilities (public and PNFP)	NDP, JAF	HMIS	33 (09/10)	40	50	65	75	90
	% children under one year immunised with 3 <sup>rd</sup> dose Pentavalent vaccine	NDP, JAF	HMIS	76 (09/10)	80	82	83	84	85
	% one year old children immunised against measles	MDG	HMIS	72 (09/10)	75	80	85	90	95
Coverage for Health Services	% pregnant women who have completed IPT 2	-	HMIS	47 (09/10)	50	55	60	65	70
	% of children exposed to HIV from their mothers accessing HIV testing within 12 months	-	HMIS	29 (08/09)	35	45	55	65	75
	% USs with fever receiving malaria treatment within 24 hours	MDG	HMIS	13.7 (09/10)	20	40	60	70	85
	% eligible persons receiving ARV therapy	NASP	HMIS	53 (2009)	55	60	65	70	75
	% of new smear + cases notified compared to expected (case detection rate)		NTP reports/HMIS	56 (09/10)	60	65	70	70	70
	% of households with a pit latrine	-	HMIS, UDHS	69.7 (09/10)	68.5	69.5	70.5	71.5	72
	% U5 children with height /age below lower line (PR)	MDG	UDHS	38 (2006)	36	34	32	30	28
	% U5 children with weight /age below lower line (PR)	MDG	HMIS, UDHS	16 (2006)	15	14	13	12	10
	Contraceptive Prevalence Rate	MDG, JAF	UDHS	24	25	28	31	33	35
	Per capita OPD utilisation rate (m/f)	NDP	HMIS	0.9 (09/10)	1.0	1.0	1.0	1.0	1.0
Health System outputs (availability, access, quality, safety)	% of villages with trained VHTs, by district		HMIS	31 (09/10)	50	60	75	90	100
	% of health facilities without stockouts of any of the six tracer medicines in previous 3 months (1st line antimalarials, Depopovera, Sphadoxine/pyrimethamine, measles vaccine, ORS, Cotrimoxazole)	JAF	Annual MoH survey (Drug availability)	41 (09/10)	50	55	60	70	80
	% of functional Health Centre IVs (providing EMOC)		HMIS	23 (09/10)	28	33	38	43	50
	Annual reduction in absenteeism rate (m/f)?	JAF	Panel survey	-	20	20	20	20	20
Health investments	% of approved posts filled by trained health workers	JAF	HMIS	56 (09/10)	60	65	70	72.5	75
	General Government allocation for health as % of total government budget	NDP, JAF	MoFPED	9.6 (09/10)	8.8	8.6	9.8	10	10

### **8.2.2 Health Services coverage indicators**

These provide information on the overall contribution the health services being provided are having on the available health stock. Selected proxy indicators for health services are:

- % pregnant women attending 4 ANC sessions
- % deliveries in health facilities
- % children under one year immunised with 3<sup>rd</sup> dose Pentavalent vaccine
- % one year old children immunised against measles
- % pregnant women who have completed IPT 2
- % of children exposed to HIV from their mothers accessing HIV testing within 12 months
- % UFs with fever receiving malaria treatment within 24 hours from VHTs
- % eligible persons receiving ARV therapy

The average achievement in terms of coverage for all the health services indicators chosen is captured in a Health Services Coverage Index. This provides, in a broad manner, information on whether the Health Service Coverage's are improving, without limiting the analysis to a single, or small group of indicators. The trends in the Index over the years will serve as a proxy for overall trends in Health Services – improving index suggests improving Health Services, and vice versa. In line with the need to attain universal coverage with health services, the sector will work towards attaining 80% achievement for the index. This will be achieved by ensuring at least 80% coverage for all the health service coverage indicators selected.

### **8.2.3 Coverage's with other health determinants**

These provide information on the overall contribution coverage's for services addressing other health determinants are having on the available health stock. Selected proxy indicators are:

- % of households with a pit latrine
- % U5's new visits with height /age above lower line (PR)
- % children under 5 with weight /age above lower line (PR)

As with the health services, average achievement for all the other health determinants is captured in a Health Determinants Index. This provides, in a broad manner, information on whether the services addressing other health determinants are improving, without limiting the analysis to a single, or small group of indicators. The trends in the Index over the years will serve as a proxy for overall trends in services addressing other health determinants – improving index suggests improving services for health determinants, and vice versa. . In line with the need to attain universal coverage with services addressing the other health determinants, the sector will work towards attaining 80% achievement for the index. This will be achieved by ensuring at least 80% coverage for all the indicators selected.

### **8.2.4 Risk factors indicators**

These provide information on the overall contribution the services addressing critical risk factors to health are having on the available health stock. The selected proxy indicator is:

- Contraceptive Prevalence Rate

### **8.2.5 Health Investment Indicators**

These provide information on the amounts of investments available for Health Services. Only Health Service investments are captured, as these are the only investments primarily made to improve health, and decisions on managing the health investments can be made from analysing their impact. Investments in other health determinants are not primarily made to improve health – decisions on how to invest there is therefore not primarily driven by the expected impact on health. Selected proxy indicators are:

- % of approved posts filled by trained health workers
- General Government allocated on health as % of total government budget

The proxy indicators provide information on investments in different inputs needed for delivery of the health services.

### 8.2.6 Health quality and output indicators

These provide information on the direct output from the investments made in Health Services. They are a measure of the improvements made in access, quality, and safety of health services attained. By improving these, the health coverage's should be improved. Selected proxy indicators are:

- Per capita OPD utilisation rate (m/f)
- % of villages with trained VHT, by district
- % of health facilities without any stockouts of six tracer medicines
- % of functional HCs IV with a functioning theatre (providing EMOC)
- Annual reduction in absenteeism rate (m/f)
- % of clients expressing satisfaction with services

## 8.3 Process of supervision, and monitoring of sector progress

### 8.3.1 Process of Supervision

Supervision of Ministry of Health Headquarters: The supervision of the Ministry of Health Headquarters will be revamped in the implementation of HSSIP. The role of TMC and other stakeholders involved in this process will have to be strengthened through a performance assessment tool to be developed during the HSSP period.

Supervision of Central Level Programmes, National Referral Hospital and Institutions: During HSSP II supervision of central level programmes, national referral hospitals and other autonomous institutions (e.g. NDA, YBTS, NMS, UVRI, UCI, etc) was to be carried out within the long term institutional arrangements but this was not achieved. Supervision at this level is still inadequate thus need to set up a clear supervision mechanism.

Supervision and Mentoring of Regional and General Hospitals (GHs): Clinical supervision of RRHs will be carried out quarterly by Senior Consultants from NRHs and GHs will be supervised by Consultants from RRHs. In addition integrated supervision will be carried out to NHRs and GHs by the Area Teams on quarterly basis. During HSSIP supervision guidelines and tools for supervision of hospital will be developed and disseminated.

Supervision and Mentoring of Local Governments / Districts: As was the case over the HSSPII, Area Teams will be responsible for conducting integrated support supervision, mentoring and inspection to Local Governments/Districts during the HSSPIII. The Area Teams shall be composed of Technical officers of the MoH, Health Development Partners (HDPs), Civil Society Organizations (CSOs), Health Service Commission (HSC), Central Level Institutions such as National Medical Stores (NMS), and other MDAs such as Ministry of Public Service and Office of the President. The Area Teams shall carry out the supervisory visits to districts quarterly and they will produce written reports that will be discussed by SMC, HPAC and TMC and feedback given to the districts. During the HSSPIII, there shall be Political Supervision/inspection of Local Governments by the sector Ministers and Members of Parliament.

Members from TMC shall continue conducting support supervision, mentoring and inspection visits to Districts on a regular basis every year to iron out issues identified by other routine supervision mechanisms. In addition there will be other forms of supervision such as Technical support supervision by technical programmes and emergency support supervision like in case of epidemics and disasters.

Supervision of Public and PNFP Health Facilities: District Health Teams shall be responsible for supervision and mentoring of HSDs on quarterly basis. Likewise HSDs shall be responsible for supervision and mentoring of lower level health facilities (Public & PNFP) on quarterly basis. The YSP as the strategy within the quality improvement framework will be reviewed and promoted to improve on internal supervision within districts.

Supervision of Private for-Profit (PFP) Health Providers and Institutional Clinics: In order to deepen stewardship of the MoH, districts in conjunction with the Professional Councils and NDA shall be responsible for supervision of PFP clinics, institutional clinics, pharmacies and drug shops. Appropriate tools shall be developed and disseminated to all stakeholders.

Supervision of CSOs/ NGOs: Supervision of health related CSOs / NGOs is not coordinated. The national supervisory framework will include modalities for supervision of CSOs / NGOs at national, district and community level.

Supervision and mentoring of VHTs: VHTs will receive regular follow up and supervision from their trainers and In-charges of the health facilities within their areas of operation. HSDs in collaboration with the district will coordinate the overall supervision.

### 8.3.2 Monitoring of Sector Progress

Methods, tools and processes for the performance assessment and annual planning and reporting shall be provided in the HSSIP Monitoring and Evaluation plan. These represent the framework for guiding information on the quarterly and annual reviews.

The monitoring and review process will be interlinked across the different planning entities. Service delivery information to feed the monitoring and review process will be derived bottom up. This implies that information at each level will be provided from the planning entities below it. Management support, on the other hand, as well as governance/partnership information will be analysed at the same level it is to be provided.

Respective reviews will be guided by information developed by the Government management structures at each level. These will compile the review information with inputs from the other implementing partners.

All reviews will be presented and endorsed at the respective management and partnership structures for the level. Annual district and hospital performance monitoring will continue to be used for measuring performance, with the indicators and scoring methodology reviewed to be in line with HSSIP.

Indicator information will be used to inform different sector processes. These are illustrated in the table below.

**Table 8.2: Monitoring and review process**

Methodology	Frequency	Output	Focus	Level of monitoring and review
Performance Assessment	Quarterly	Quarterly progress reports; transmitted to next higher level of supervision	Done by Joint (public + private) Performance Assessment Teams and peers, and planning entity. A review of progress against targets and planned activities.	Inputs, process, output and outcome (indicator trends in coverage) levels
Joint Annual review and planning	Annually	Annual progress reports, transmitted to next higher level of supervision; District and hospital performance league tables	Done by sector, and planning entities as from sub-district level onwards. - Review progress against set targets outcomes	Input, process, output, and outcome levels
Mid Term Review	After 2-3 years	Midterm analysis report	Done by sector Review progress against planned impact	Input, process, output, outcome and impact levels
End term Review	At end of HSSIP	End Term Analysis report	Independent review of progress, against planned impact	Input, output, outcome and impact levels



## 8.4 Interpretation of progress

Basic indicator information shall be the national average achievement. This is obtained from collating all the available information from all reporting units into the national figure.

Sub analyses of the indicator information shall be carried out, to provide information on the impact of multi-dimensional poverty on actual coverage, and health status and financial risk protection achievements. This shall enable better targeting of strategies to address the multi dimensional poverty issues impacting on the results being sought.

Table 8.3: Data Disaggregation and poverty analysis.

Poverty dimension	Data disaggregations to be made
<b>Income poverty</b>	Disaggregation of achievements by poverty index
<b>Illiteracy</b>	Disaggregation of achievements by literacy levels
<b>Gender</b>	Disaggregation of achievements by gender index
<b>Poverty of security</b>	Regional analysis of data, to compare secure, with less secure regions

The required levels of disaggregation may not be possible on an annual basis. As a proxy, therefore, the sector will use district rankings for the different poverty dimensions to separate districts with high and low attainment of the respective index. The indicator achievements for the top quintile of districts will be compared with the achievements of the bottom quintile of districts to illustrate any differences. The districts in the top and bottom quintiles will be determined at the beginning of the HSSIP.

Information on these indices, therefore, will be provided annually to compile the following table, which will be part of the Annual Health Sector Performance Report.

**Table 8.4: Indicators to be reported on the Annual Health Sector Performance Report**

Indicator domain	Indicator	National achievement	Income disaggregation		Literacy level disaggregation		Gender disaggregation		Security level disaggregation	
			Top districts	Bottom districts	Top districts	Bottom districts	Top districts	Bottom districts	Top districts	Bottom districts
Health Impact	Maternal Mortality Ratio (per 100,000 live birth)									
	Neonatal Mortality rate (per 1000)									
	Infant Mortality Rate (per 1000)									
	Under 5 mortality rate (per 1000)									
	% of households experiencing catastrophic payments									
	% clients expressing satisfaction with health services									
Coverage for Health Services	% pregnant women attending 4 ANC sessions									
	% of deliveries in health facilities									
	% children under one year immunised with 3 <sup>rd</sup> dose Pentavalent vaccine									
	% one year old children immunised against measles									
	% pregnant women who have completed IPT2									
	% of children exposed to HIV from their mothers accessing HIV testing within 12 months									
	% UFs with fever receiving malaria treatment within 24 hours									
	% eligible persons receiving ARV therapy									
	% of new smear + cases notified compared to expected (case detection rate)									
Coverage's for other health determinants	% of households with a pit latrine									
	% U5's new visits with height /age above lower line (PR)									
	% children under 5 with weight / age above lower line (PR)									
Coverage's for risk factors	Contraceptive Prevalence Rate									
Health System outputs (availability, access, quality, safety)	Per capita OPD utilisation rate (m/f)									
	% of villages with trained VHTs, by district									
	% of health facilities without any stockouts of six tracer medicines									
	% of functional Health Centre IVs (providing EMOC)									
	Annual reduction in absenteeism rate (m/f)?									

Indicator domain	Indicator	National achievement	Income disaggregation		Literacy level disaggregation		Gender disaggregation		Security level disaggregation	
			Top districts	Bottom districts	Top districts	Bottom districts	Top districts	Bottom districts	Top districts	Bottom districts
Health investments	% of approved posts filled by trained health workers									
	General Government allocation for health as % of total government budget									

NB: Not all 'cells' will have annual data, as indicators obtained from studies and surveys (in particular, impact and risk coverage indicators) will not be collected annually.

Information on indicators will therefore be analysed in the following lines

- Overall national achievement
- Disaggregation of achievement, by
  - o Region, and district
  - o Level of poverty
  - o Literacy level
  - o Gender
  - o Level of security

This shall primarily apply to coverage information for health services, risk factors, and other health determinants. As such, the respective Index shall also be disaggregated.



## 9. COSTS AND FINANCING OF SERVICES

The HSSIP planned interventions represent a strategic shift in the sector approach to addressing the health challenges in the country. The financial implications of this shift are outlined in this chapter. We review the estimated costs of the investments planned, then look at the possible financing scenarios to cover these costs.

### 9.1 Resource implications for the HSSIP

Costing has been undertaken using the ingredients approach. This means that all 'ingredients' (i.e. inputs) required or used in the process of 'producing' and delivering health services have been considered in the costing. The methodology to be used followed the international standards for costing. The standard costing procedures involve: identification, quantification and valuation of inputs. More specifically, the costing covered only the "supply" side of the equation which involves the **production and delivery** of health services. Therefore, costing has been undertaken from the *Provider's perspective*. In the case, the 'provider' is the Government of Uganda. By focusing on the provider's perspective alone, it means that the users'/consumers' perspective is excluded. Given the integrated nature of service delivery, this costing exercise **has not** estimated costs of individual programs (e.g. maternal health and child survival) or individual diseases (e.g. HIV/AIDS, malaria, etc.).

The costing has been done at two levels, namely: (a) costing the UNMHCP by level of care (using the ingredients approach), and (b) by costing of key investment inputs. The list of inputs costed includes:

**Table 9.1: List of items for costing**

RECURRENT ITEMS	CAPITAL ITEMS
Human resources	Buildings (medical and non-medical)
Medicines & Vaccines	Equipment (medical and non-medical)
Medical Supplies	Vehicles (medical and non-medical)
Laboratory supplies & reagents	Communication equipment
Administrative and office supplies	Long-term training
Facility maintenance	
Utilities	
Hotel costs	
Health Education	
Transport and travel costs	
Hotel costs	
Support supervision	
Monitoring and evaluation	
In-service training	

Six broad categories of key investment inputs are costed:

1. Pharmaceuticals and health supplies
2. Health infrastructure
3. Health Education and Promotion
4. Health information systems and, Monitoring and Evaluation
5. Human resources for health
6. Management and operations

The key strategies and interventions under each of these broad areas are already discussed in great detail in the draft HSSP document. In this section, we present a brief overview of the key elements highlighted for each input, and the related cost estimates over the 5-year period of the HSSIP.

### 9.1.1 Pharmaceuticals and health supplies

For this input, cost estimates were made for essential medicines and health supplies, antimalarials and related malaria control commodities, anti-TB medicines, antiretroviral drugs and related medicines for opportunistic infections, anti-cancer drugs, vaccines, contraceptives, reproductive health commodities, condoms, supplies for blood transfusion services, and laboratory-related reagents and supplies. Information on the needs quantification and cost of commodities were obtained from the relevant MOH divisions/departments and/or institutions. Table 2 provides the total annual cost estimates for these items.

**Table 9.2 Estimated total annual cost of medicines and related health commodities (Billion shillings)**

<b>Billion shillings</b>	<b>2010/11</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>	<b>2014/15</b>
Essential medicines & health supplies	107.00	118.00	130.00	144.00	159.00
ACTs	36.37	27.38	26.35	54.23	55.87
ITNs	8.24	15.44	21.59	24.28	26.83
IRS	23.13	57.74	58.67	37.70	41.12
RDTs	12.91	15.95	24.31	31.22	38.74
SP for IPTp	0.48	0.50	0.55	0.60	0.65
Traditional Vaccines (incl Pentavalent)	36.62	39.03	41.80	42.42	46.17
New vaccines (Rotavirus + PCV)	25.06	108.23	87.11	94.32	159.92
Vaccines supplies	4.20	5.13	5.17	5.51	6.33
ARVs + OI drugs (incl. PMTCT drugs): 1st & 2nd line drugs	111.94	216.77	257.91	304.90	314.91
Anti TB and Leprosy drugs	6.95	4.47	4.70	4.93	5.18
Contraceptives	41.40	44.05	45.06	50.69	56.73
RH commodities	110.57	96.28	115.11	123.20	131.77
Condoms	7.51	8.11	8.77	9.49	10.26
UBTS supplies	3.70	4.00	4.33	4.68	5.06
Laboratory supplies & consumables	52.40	56.59	61.12	66.01	71.29
Anti-Cancer drugs	3.46	3.81	4.19	4.61	5.07
Medicines and consumables for HC I / VHT/ community	28.51	29.48	30.25	31.27	32.09
Mulago III (additional health supplies)	24.00	26.40	29.04	31.94	35.14
<b>TOTAL</b>	<b>644.45</b>	<b>877.37</b>	<b>956.03</b>	<b>1,065.99</b>	<b>1,202.14</b>

On average, HIV/AIDS drugs and commodities take up significant proportion (25.4%) of the total costs of pharmaceuticals, as does vaccines and related costs (15%) and essential medicines and health supplies (14%). Malaria drugs and commodities altogether take up 13.5% of total costs.

### 9.1.2 Health infrastructure (Buildings, Equipment & vehicles)

Cost estimates for infrastructure (buildings, equipment, ICT & transport) development and related maintenance were obtained from the Health Infrastructure Division of Ministry of Health. The cost of civil works, equipment and transport were estimated for health facilities. The costs considered involve remodelling/rehabilitation of existing health infrastructure. Costs captured include medical buildings, equipment, staff housing, transport, VAT. Where as plans are on annual basis, actual construction will be staggered over the HSSIP period. The

equipment costs include the medical and non-medical equipment. Costs of ICT equipment are excluded from the infrastructure cost estimates, because they have been captured under the HMIS costs. The transport costs include the ambulances and other vehicles needed by health facilities, as well as motorcycles and bicycles for the lower level facilities. The cost of civil maintenance of buildings and equipment (for both existing and new facilities) is included as a stand-alone cost item.

- 1 Detailed unit costs and assumptions of health infrastructure plans are provided in a separate detailed report. A summary is provided below.
- 2 Table XXX below provides Unit costs for Health Infrastructure by level of care (based on 2010/11 prices)

**Figure: 9.1: Cost estimates for infrastructure development and maintenance**

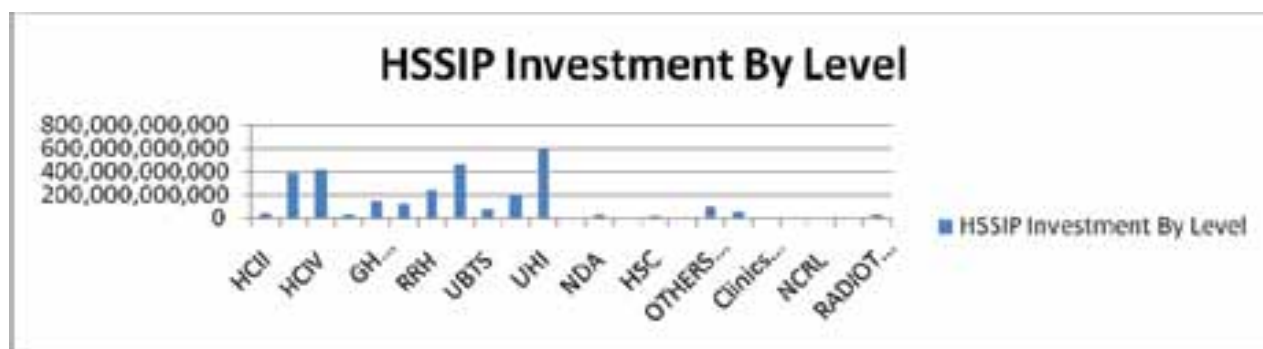


Table 9.3 Unit costs for Health Infrastructure by level of care (based on 2010/11 prices)

Level	Amount	Units	Total
HCII	192,222,860	215	41,327,914,900
HCIII	1,248,686,438	312	389,590,168,656
HCIV	2,197,779,540	190	417,578,112,600
DHO's office	654,780,123	56	36,667,686,888
GH Phase II	5,413,365,920	27	146,160,879,840
GH Phase I	7,099,585,920	17	120,692,960,640
RRH	22,416,081,840	11	246,576,900,240
NRH		4	466,733,000,000
UBTS			70,675,979,550
UCS			204,406,840,000
UHI			598,570,424,000
MOH	1,200,000,000	1	1,200,000,000
NDA			33,453,499,200
NMS			4,461,590,000
HSC			19,268,000,000
UVRI			6,000,000,000
OTHERS(WORKSHOPS, STORES, ETC)			99,000,000,000
CPHL	1		50,075,508,590
Clinics for mobile communities			3,400,000,000
NCRL			6,000,000,000
UNEPI	1		7,000,000,000
RADIOTHERAPY			30,000,000,000
<b>Total</b>			<b>3,166,922,933,304</b>

GH Phase one: General Hospitals built before 1970

GH Phase two: General Hospitals built after 1970

### 9.1.3 Supervision, monitoring, evaluation & knowledge management

Information on cost estimates for health information systems, supervision, monitoring and evaluation and knowledge management were obtained from MOH/Resource Centre and MOH/Quality Assurance Division. Over the 5-year period, a total of **119 billion** shillings would be spent on information systems and supervision, monitoring and evaluation. Of this 5-year total, operational research would take up 23%, and technical supervision and mentoring would take 19%. Further, HMIS tools (registers, HMIS manuals, and databases) take up 17% of total estimated costs, while ICT costs (which include computers for health facilities and national level) take up 15%.

**Table 9.4 Cost of health information systems (supervision, M&E and knowledge management)**

Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
HMIS: District level - HMIS tools	3.73	3.85	3.96	4.08	4.20
HMIS: District level -Other expenses	0.67	1.61	1.49	1.12	1.92
HMIS: National level HMIS and other related costs	1.59	1.72	1.68	1.64	1.77
HMIS: ICT costs	3.29	3.40	3.45	3.62	3.80
Supervision and Mentoring	4.55	4.77	4.43	4.51	4.70
Monitoring	2.39	3.23	2.34	2.43	2.40
Evaluation	-	-	0.22	-	0.25
Knowledge management	0.51	0.54	0.43	0.47	0.47
Operational Research / Studies	13.82	7.00	0.07	0.08	6.99
TOTAL	30.56	26.10	18.09	17.95	26.50

### 9.1.4 Health Education and promotion, Environmental health & Nutrition

Cost estimates for this input were obtained from various departments in MOH (including Health Education and Promotion, Environmental health and Nutrition divisions). Based on findings from key informant interviews, the sector plans to focus on the following key areas for investment:

- a) promoting early health seeking behaviour at household level,
- b) adopting health promotion and disease prevention behaviour and practices at household and community levels,
- c) community participation and involvement in health matters, and
- d) strengthening capacity for health promotion
- e) improving environmental management and sanitation
- f) promoting appropriate nutrition for children and other key populations.

The key vehicle for implementation of these strategies is the Village health teams. Information shows that under the planned activities for the 5-year period, VHT implementation and supervision would take up to 12% of total cost of activities (**335.2 billion** over the 5-year period). On average, the activities of VHTs (mainly household and community mobilisation and sensitisation) would take up the biggest proportion (45%) of the total cost, while the promotion awareness and printing and distribution of key IEC materials would take up 20% of total cost. Environmental health and nutrition take up 15% and 3% of total costs of planned activities, respectively.

**Table 9.5 Cost estimates for health education and promotion at household and community levels**

Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
VHT Implementation and Maintenance	3.73	4.46	1.29	1.33	1.37
Printing of VHT Materials	13.45	13.84	-	-	-
Support Supervision of VHT and other Health Promotion activities	1.96	2.06	2.16	2.27	2.38
Promotion of health awareness and early health seeking behaviour	6.58	6.91	7.25	7.62	8.00

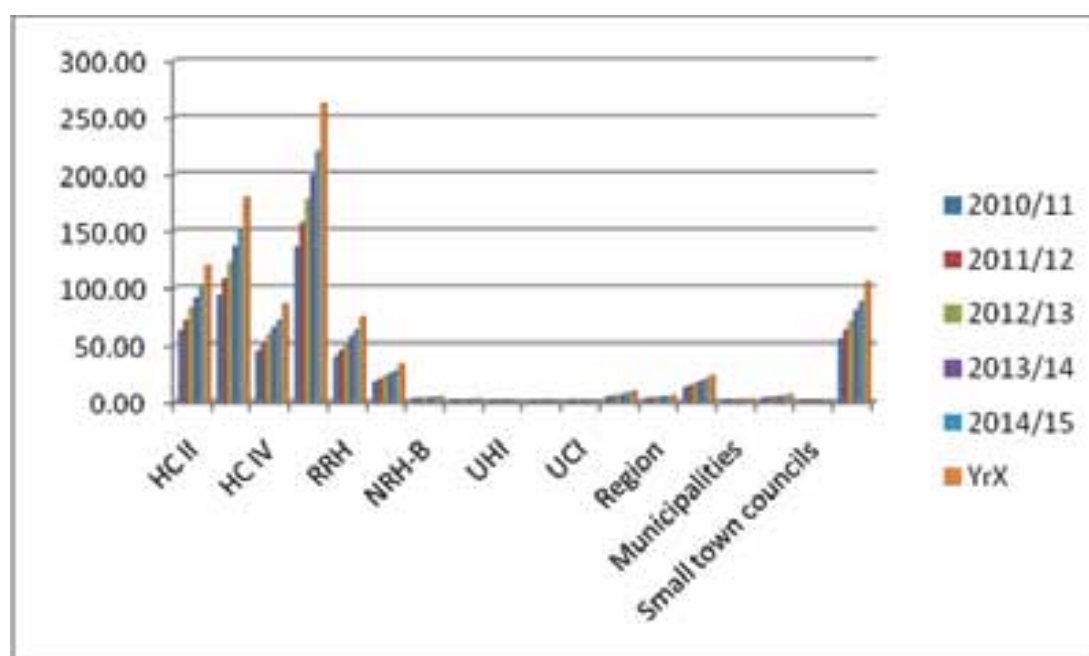


Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
Production of IEC Materials for 10 priority Areas	1.13	1.18	1.24	1.30	1.37
Building capacity, school health visits & distribution of materials	4.18	4.39	4.61	4.84	5.08
Community and household mobilisation and sensitisation by VHTs and follow up	15.89	30.94	32.49	34.11	35.82
Training, advocacy, procurement of vans & vehicles	2.07	2.18	2.29	2.40	2.52
Environmental Health	13.30	12.93	10.78	6.65	6.12
Nutrition	1.83	2.11	1.63	1.52	1.63
<b>TOTAL</b>	<b>64.13</b>	<b>81.00</b>	<b>63.73</b>	<b>62.04</b>	<b>64.28</b>

### 9.1.5 Human resources for health

The Scenario shown below is the likely and preferred option for the sector for investing in Human resources.

**Figure 9.2: Preferred option for HRH investments in HSSIP**



Given the varied nature of the strategies for improving the HRH situation, there are additional scenarios of combined interventions, in order to ensure efficiency and effectiveness. The scenarios are briefly presented in turn.

#### **Scenario 1: increased salaries + 100% recruitment (based on norms)**

This strategy considers a combination of two key interventions: (a) increasing salaries significantly with the view to retain, motivate and attract HRH, and (b) increase the number of HRH by filling all posts, as according to the norms and standards, to ensure effective delivery of services. The intervention of significant increases in salaries is already under discussion and the proposal has already been tabled to Cabinet, pending approval. The proposed salaries are based on findings of a study among health workers. The salaries for this intervention are considered significantly high enough to take care of all other retention and motivation challenges currently noted for HRH in Uganda. In other words, if this intervention is implemented, there wouldn't be a need for further interventions addressing motivation and retention, but there would still be a need to target interventions for hard-to-reach areas. The costs associated with this scenario are presented in Table 7 below. The total cost for Scenario 1 is 812 billion in 2010/11 (excluding 'other costs') and 917 billion (including 'other costs'). 'Other costs' include costs for training various super specialist cadres, in-service training, HRH systems and partnerships, and other HRH development and management activities.

**Table 9.6 Cost of HRH with improved salary scales + increased recruitment (scenario 1)**

Billion Shillings	2010/11	2011/12	2012/13	3013/14	2014/15
HC IIs	119.92	127.73	136.03	144.83	154.17
HC IIIs	179.47	188.44	197.86	207.76	218.14
HC IVs	85.38	89.65	94.14	98.84	103.79
General Hospitals	261.21	280.75	301.59	316.67	332.51
Regional Referral hospitals	75.09	78.85	82.79	86.93	91.28
National Referral Hospitals	32.36	101.94	107.03	112.38	118.00
NRH – Psychiatric (Butabika)	4.88	5.13	5.38	5.65	5.94
Uganda Blood Transfusion Services	2.61	2.74	2.88	3.03	3.18
Uganda Heart Institute	1.50	1.57	1.65	1.73	1.82
Uganda Cancer Institute	1.29	1.35	1.42	1.49	1.57
MOH headquarters	8.55	9.15	9.79	10.47	11.21
Regional offices	5.88	6.18	6.48	6.81	7.15
DHOs office	23.04	24.19	25.40	26.67	28.01
Municipalities	2.79	2.93	3.07	3.23	3.39
Big town councils	6.11	6.42	6.74	7.08	7.43
Small town councils	2.10	2.21	2.32	2.43	2.55
Other HRH dev't& management costs	104.45	104.15	125.59	128.93	156.83
<b>GRAND TOTAL</b>	<b>916.65</b>	<b>1,033.38</b>	<b>1,110.18</b>	<b>1,164.94</b>	<b>1,246.94</b>

**Scenario2: current salaries + 100% recruitment (based on norms)**

Under this scenario, we consider one intervention, namely: significant increases in the number of HRH (to reach the 100% of the norms and standards), while maintaining current salary scales. The costs for this scenario are presented below. The total cost for Scenario 2 is 392 billion in 2010/11 (excluding 'other costs') and 622.3 billion (including 'other costs'). The 'other costs' in this scenario (230.21 billion) are relatively higher than those presented for scenario 1 (104.45 billion), because there would be an additional need for motivation and retention packages for scenario 2, given that salaries are considered not to be attractive enough.

**Table 9.7 Cost of HRH with current salary scales + increased recruitment (Scenario 2)**

Billion Shillings	2010/11	2011/12	2012/13	3013/14	2014/15
HC IIs	46.78	49.82	53.06	56.49	60.13
HC IIIs	84.00	88.20	92.61	97.24	102.11
HC IVs	39.90	41.89	43.99	46.19	48.50
General Hospitals	130.86	140.65	151.09	158.64	166.58
Regional Referral hospitals	40.09	42.09	44.20	46.41	48.73
National Referral Hospitals	15.79	49.75	52.24	54.85	57.59
NRH – Psychiatric (Butabika)	2.31	2.43	2.55	2.67	2.81
Uganda Blood Transfusion Services	2.61	2.74	2.88	3.03	3.18
Uganda Heart Institute	1.50	1.57	1.65	1.73	1.82
Uganda Cancer Institute	1.29	1.35	1.42	1.49	1.57
MOH headquarters	4.85	5.19	5.55	5.94	6.36
Regional offices	2.82	2.96	3.11	3.26	3.43
DHOs office	12.89	13.54	14.21	14.92	15.67
Municipalities	1.54	1.61	1.70	1.78	1.87
Big town councils	3.78	3.97	4.17	4.37	4.59
Small town councils	1.11	1.17	1.23	1.29	1.35
Other HRH dev't& management costs	230.21	239.08	269.42	282.72	321.28
<b>GRAND TOTAL</b>	<b>622.33</b>	<b>688.02</b>	<b>745.06</b>	<b>783.04</b>	<b>847.55</b>

**Scenario3: increased salaries +minimal improvement in recruitment**

Under this scenario, we consider a combination of two interventions: (a) an increase in recruitment to fill up all “established posts” (i.e. up to 46,985 employees in the health sector), and (b) the proposed attractive salary scales (as those used in scenario 1). The total cost of remuneration for this scenario would be **267.4 billion** shillings (excluding the hard-to-reach benefits) and **307.5 billion** shilling (including the hard-to-reach benefits) for FY 2010/11. If we consider “other HRH development and management costs” (i.e. 104.5 billion shillings in 2010/11), the total cost for Scenario 2, would be **412 billion** (including the hard-to-reach benefits).

The cost for scenario 1 is double the cost for scenario 3. The difference in costs for these two scenarios is explained by the number of HRH employed, with scenario 1 having 100% of HRH (according to norms) and scenario 3 having only up to 46,985 employees in the health sector.

**Scenario4: current salaries+ minimal improvement in recruitment**

This scenario considers only one intervention, namely: increasing the number of HRH, and maintaining the current salary levels. The total cost for Scenario 4 in 2010/11 is **243.4 billion** (excluding hard-to-reach benefits) and **284.2 billion** (including hard-to-reach benefits). When we include “other HRH development and management costs”, the cost for Scenario 3 becomes **473.9 billion** in 2010/11.

**Table 9.8 Cost of HRH – Scenario 3**

Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
Specialist Training	8.29	-	10.37	-	12.96
Systems and Partnerships	24.07	26.96	31.62	37.75	45.28
In-Service Training	12.54	13.42	14.36	15.37	16.44
Implement HMDC Business Plan	0.55	1.22	1.94	1.77	1.64
Current salaries (with some additional recruitment)	243.40	264.36	275.44	282.70	285.12
Retention/motivation Interventions	85.27	91.60	97.45	104.17	111.36
Hard to reach	40.80	43.66	46.71	49.98	53.48
UCI - training of specialists	2.50	2.68	2.86	3.06	3.28
UHI - training of specialists	4.73	5.21	5.73	6.30	6.93
Radiotherapy - training of specialist	3.75	1.87	0.64	0.79	0.02
Mulago - training of specialists	48.00	52.80	58.08	63.89	70.28
<b>TOTAL</b>	<b>473.91</b>	<b>503.77</b>	<b>545.19</b>	<b>565.79</b>	<b>606.79</b>

In summary, the cost of the different scenarios is presented below. These costs take into consideration motivation and hard-to-reach benefits, as well as other HRH development and management interventions.

**Table 9.9: Comparison of HRH scenarios**

SCENARIO	Description	2010/11	2011/12	2012/13	2013/14	2014/15
1	Increased salaries + 100% recruitment (based on norms)	916.7	1,033.4	1,110.2	1,164.9	1,246.9
2	Current salaries + 100% recruitment (based on norms)	622.3	688.0	745.1	783.0	847.6
3	Increased salaries + increase recruitment up to 46,985	412.0	461.4	496.0	520.9	562.5
4	Current salaries + minimal improvement in recruitment	473.9	503.8	545.2	565.8	606.8

While the choice of the scenario to implement is highly dependent on the resources available to the sector, it is important to remember that the sector is severely challenged as a result of inadequate numbers and poor

motivation of HRH. In turn, these HRH problems have a negative influence on service delivery and thus sector performance, and also have negative implications for the absorptive capacity of the whole sector. Therefore, the starting point for improving sector overall sector performance should be improving the staffing levels, as well as HRH motivation.

### 9.1.6 Management, coordination and other operations

Cost estimates for these inputs were obtained from various sources. For health facilities and DHO offices, a small survey was undertaken to establish actual need (based on budgeted amounts and actual spending). The estimates from the survey were triangulated with information from relevant source (e.g. the MTEF and Budget Framework papers). Total costs presented in Table 11 were calculated as unit cost for each level of care multiplied by the number of health facilities (over the 5-year period).

On average, an annual average of 345 billion is required in the sector for day-to-day operations by the different key players (service providers and management entities). Over the 5-year period, a total of **1,725 billion** is required for operational costs, to cover expenses relating to strategic planning and policy development, administrative items, utilities, travel, relevant meetings and workshops, etc. Of this total, 33% is required at lower level units (HC I – HC IV), 25% is required at hospitals, 18% for MOH headquarters, 5% for the proposed Mulago III, and 10% for autonomous institutions.

**Table 9.10 Operational costs (administrative items, travel, meetings, office maintenance, etc)**

Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
HC I - HC IV	97.47	105.66	114.64	124.47	135.25
Hospitals	49.18	83.08	92.44	102.16	112.94
UBTS, UCI and UHI	18.24	21.31	19.80	20.84	22.16
DHO offices	5.01	5.51	6.07	6.70	7.39
Regional level	2.71	2.98	3.29	3.63	4.00
MOH headquarters	51.33	56.60	62.42	68.83	75.89
Mulago III	12.82	14.12	15.64	17.20	18.92
Autonomous institutions	27.54	30.80	33.03	35.39	37.92
<b>TOTAL</b>	<b>264.30</b>	<b>320.07</b>	<b>347.33</b>	<b>379.21</b>	<b>414.47</b>

## 9.2 Financing of the HSSIP

- (i) **Government budget and donor budget Support:** This includes both government funds and donor budget support. The mode of funding preferred by the sector for donor resources shall remain the donor budget support. This is a flexible funding source where the government has control to allocate resources to agreed priorities. The GoU budget support remains far the most efficient financing mechanism at turning financial resources into health outputs.
- (ii) **Donor Project Funding:** The Health Sector Budget Working group shall review, approve and align project funding to sector priorities. A systematic and comprehensive analysis of the donor projects with respect to funding composition, flow of funds, compatibility towards HSSIP and others will continue to be done. The preferred mode of administration of the project shall remain the Long Term Institutional Arrangements (LTIA). The sector shall accept donor contributions that address the HSSIP priorities under the MTEF and HSFS. For district level projects, the role of the District Director of Health Services as a coordinator shall be emphasized.
- (iii) **Global funding initiatives:** The sector shall continue to prioritize mobilization of resources from global funding initiatives like PEPFAR, GFATM, GAVI, schistosomiasis and filariasis control initiatives

and Global Sanitation Fund as a way of addressing global health concerns. Accountability of these funds shall be strict and according to management of other public funds. These funds shall be over above the current budget funding level of the sector.

- (iv) National Health Insurance Scheme (NHIS): After extensive comprehensive stakeholder, a bill has been drafted by the First Parliamentary Counsel. It provides for social health insurance for formal sector, private commercial health insurance and community health insurance schemes. The sector shall table the bill in the Cabinet and Parliament. The scheme is expected to be launched during the the HSSIP period. Initially, the scheme shall generate Ug shs 72 Bn annually. The scheme shall work in harmony with other social security benefits and regulatory mechanisms under development in other government sectors.
- (v) User fees: The government's policy of scrapping cost sharing (user fees) for minimum package services in GoU health units (except private wings in hospitals) shall remain enforce. The guidelines for management of private wings shall be the basis for management of user fees in the private wings of public units. However, the private sector shall continue to charge fees. The health sector shall work with other sector and all key stakeholders to fix tariff rates for seeking care. Access for indigent shall form a work program of the sector where there are no public owned health units. Also most of the private out of pocket shall be through prepayment schemes so as to reduce on out of pocket payment and catastrophic expenditure. Modalities for partial autonomy and privatisation will be undertaken so as to increase efficiency and expand the scope of services

### Health Sector Budget Working Group

The Health Sector Budget Working Group (HSBWG) shall continue to oversees the management of the annual health sector budget process, maintains internal mechanisms that would determine and ensure operationalization of the budget and also ensures timely production of the Budget Framework Paper for the sector. It will continue to offer opportunity for key stakeholders to review new health sector projects to ensure that all new investment in the sector are within the framework of the HSSIP and that new projects represent good value for money.

Further financing of health services shall be elaborated on in a Health Services Financing Strategy (HSFS) which is a work program of HSSIP.

It remains a challenge to derive accurate estimates of existing resources available to finance the HSSIP, due to difficulties in projecting available funds in the future. Government resource projections are only limited to the MTEF period, while donor resource projections only are limited to the life of the current programs and projects. However, best estimates have been made to identify the financing situation for the HSSIP, to better guide targeting of priorities based on the funding situation.

Three costing scenarios are : (a) the ideal situation, (b) a situation that takes into consideration anticipated future envelope based on the current resource envelope, and (b) a situation that takes into consideration medium increases in the resource envelope.

#### 9.2.1 Known programs and projects

A number of existing projects, and programs are currently in place, to facilitate financing of the HSSIP. These are shown in the table below.

**Table 9.11 Existing projects supporting HSSIP implementation**

PROJECT	FUNDING AGENCY	STAGE OF IMPLEMENTATION	OBJECTIVE	MAJOR PURPOSE	Total Project Amount
Strengthening Reproductive and Mental Health Care	African Development Bank (ADB)	Ongoing (Project in Implementation Stage) Project is in 3 <sup>rd</sup> Year of implementation	Improve Maternal and Mental Health	Infrastructure Development	US \$ 33.3 over 5 years
Mulago Hospital Complex	GOU	Ongoing (Project in Implementation Stage)	improve the infrastructure of the Hospital	Infrastructure Development including Equipment (oxygen)	Shs 4.016 bn annually
Imaging and Theatre Equipment Project Phase	Netherlands and GOU	Project in last year of Implementation Stage	improve the diagnostic capability of the health system	Equipment	EUR 11.5m for 5 years
Butabika Health Centre Remodeling/Construction	GOU	Ongoing (Project in Implementation Stage)	maintenance of Hospital infrastructure	Hospital infrastructure maintenance	Shs 1.325bn Annually
Primary Health Care Development	GOU District Grant	Ongoing (Project in Implementation Stage)	improve quality and quantity of health infrastructure in all Districts	Infrastructure Development	U Shs 39.18bn FY annually including PRDP .
District Infrastructure Support Programme	GOU	Ongoing (Project in Implementation Stage)	improve the infrastructure of the health system	Infrastructure Development	4.623bn annually
Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	GFATM	Ongoing (Project in Implementation Stage)- Project is in 5 <sup>th</sup> Year of Implementation	Mitigate the negative effects of the 3 diseases	Logistics, Supply of Medicines and Disease Prevention	US\$ 103.182m for FY 9/10
Health Service Commission	GOU	Ongoing (Project in Implementation Stage)	Provide the necessary logistics	Transport Equipment	0.347bn annually
Laboratory Strengthening Project	World Bank & GOU	Project Design	Establish network of Efficient and Functional Public Health Laboratories	Functional Laboratories in the RRHs	UGX 19,900,017,000
Health Infrastructure Development	GOU	Ongoing	Improve Health Infrastructure at Decentralized Level	Infrastructure Development	UGx 39,300,000,000
UBTS	GOU	Ongoing	Improvement of Blood transfusion services	Safe Blood and Blood products	UGx 81,000,000
Construction of Women,s Hospital (Mulago III)	IDB & GOU	Design Stage	Contribute to attainment of MDG 5	Improve Maternal Health Services	USD \$ 30,000,000
Improving medicines & HSS for PNFP units in post Conflict region of NU	DFID	Design	Improve Health service delivery in post conflict regions	Improve health service delivery	7 million pounds for 3 years
Health Services Capacity & Infrastructure Development	JICA	Bilateral agreements signed	Capacity & Infrastructure Development	Improve service delivery	17.44 Yen
Development of Social Health Initiative (SHI)	GOU	Ongoing (Project in Implementation Stage)	establishing a SHI scheme	Preparatory activities for alternative Financing	U Shs 1.4bn annual
Rehabilitation of Regional Referral Hospitals	GOU	Ongoing (Project in Implementation Stage)	Improve infrastructure at regional referral hospitals	Infrastructure Development	U Shs 17bn
Institutional Support to Ministry of Health	GOU	Ongoing (Project in Implementation Stage)	Provide Additional office space and other service rooms	Infrastructure Development	1.45bn annually
Uganda Cancer Institute Project	GOU	Ongoing (Project in Implementation Stage)	develop the Uganda Cancer Institute	Infrastructure Development	U Shs 3 bn Annually
Uganda Heart Institute Project	GOU	Ongoing (Project in Implementation Stage)	develop the existing Uganda Heart Institute	Infrastructure Development	U Shs 1.5 bn Annually
Health Systems Strengthening	World Bank and GOU	Design stage	strengthen Health systems (Human Resource, Management and infrastructure)	Infrastructure, Human Resource Development, Reproductive Health	Us \$ 130 m. Us \$ For 3 Years Us 1.6 M Secured For Project Preparation

PROJECT	FUNDING AGENCY	STAGE OF IMPLEMENTATION	OBJECTIVE	MAJOR PURPOSE	Total Project Amount
Support to the Health Sector	DANIDA	Project ends in July 2010 (Completion Stage)	Improve the infrastructure of the health system, capacity for planning, availability of drugs and health care delivery.	infrastructure, availability of drugs	US\$ 38.314m for FY 2009/10
Construction of Naguru 100 bed Hospital	CHINA	Design stage- Project Implementation begins in FY 2010/11	Improve Health Care Delivery in Kampala	Infrastructure Development	UsD 9.5 m ( 18 months)
Support to Mulago & Kampala City Council Health Services	ADB	Design stage- Project Implementation begins in FY 2011/12	Improve Health service Delivery in Kampala	Infrastructure Development	US \$ 105,931,321.45 m
Avian & Human Influenza Preparedness & Response- Health Sector Component	WB	Project became effective December 2009 to run for 4 years	Reduce the threat by and prepare for control of avian and human influenza	Prepare and effectively respond to avian, human influenza and other disease emergencies to livestock and humans	US \$ 2.06 for the Health component. Project is nationally coordinated by OPM
GAVI HSS	GAVI	Project Design	Health Systems Strengthening	Improve service Delivery	USD \$ 19m
Global Sanitation Fund	Global Sanitation Fund	Project Design	Improve Sanitation	Improve Sanitation	US \$ 5 m for 5 years
Rural Energy	GOU	Ongoing (Project in Implementation Stage)	Improve service delivery in remote areas	Provide solar systems in health centres without connection to electricity supply	Shs 200m annually
UNFPA Support to Reproductive Health	UNFPA	Ongoing (Programme in Implementation Stage)	Improve Reproductive Health Supplies	Support family planning	US \$ 1.7m annually
. SURE PROJECT, Securing Uganda's Right to Essential	USAID	Start September 2010	Logistical Support Pharmacy	Improve infrastructure	US \$ 40M for 5 years
Rehabilitation of General Hospitals in Central Region	BADEA	Project Design	Improve Health service Delivery in Central Region	Rehabilitate 2 Hospitals Nakaseke and Kiryandongo	US \$5M
Capacity building in Planning, Management and Leadership	Belgium	Project Design	Capacity building in Planning, Management and Leadership	Build capacity of health workers and institutions	Total 13 Billion Ugx for the next 3 years
Food Fortification project	WFP	Project Design	Nutrition improvement programme	Improve institutional nutrition	US\$2.3M for
Global Alliance for Vaccine Initiative	GAVI	Project Design	Improve preventive care services	Supplies of Vaccines	740.55 Billion UGX for the next 5 years.
Support to Uganda AIDS Commission Secretariat	GFTAM	Project Design	Improved HIV/AIDS care services.	Coordination of HIV/ AIDs activities	3.02 Billion UGX for the next 3 years
Support to Karamoja	Italian cooperation	Start September 2010	Staff houses in HC111'S	Hard to reach package	4.2M Euros.
UNHRO	WORLD BANK	December 2010		Research	300M UGX
Butabika Hospital	GAVI	October 2010		Office and stores for UNEPI	7.2 bn UGX

IN addition to these, are Government – specific projects facilitating improvement in services for the marginalized populations in the country. These include the Northern Uganda reconstruction project (NURP) targeted at the populations in Northern Uganda affected by the past insurgency. More recent is the Luwero Rwenzori Development Program

The LRDP (under the office of the Prime Ministers' office) is operating in 40 districts in the central and western Uganda that suffered the effects of the NRM liberation war 1981 – 1986 (the Luwero triangle) and the ADF

insurgency of 1996 – 2003 that affected the Rwenzori region. The programme attempts to revamp the social economic status of the population especially in the areas of: production, marketing, education, health and household incomes which have remained low over the years from time / since the war / insurgencies ended. Programme has several objectives, but those objectives related to health aim at among other things:

1. Increasing the safe water coverage of the 11 districts which are below the National coverage to at least 65% by 2015.
2. To improve the health service delivery to the communities of the region.

The programme uses a two – prolonged approach: The community and sectoral intervention approaches.

The LRDP works to specifically address the service delivery gaps to enable districts under the programme to attain national level standards. In the districts of operation LRDP will focus on rehabilitating HCIIIs, IVs, and upgrading some HC IVs to general hospital status.

## 9.2.2 Financing scenarios

### Scenario 1: The ideal

The *Ideal Scenario*, assumes financing would be available to facilitate the implementation of all sector interventions to full scale, as planned for the period 2010/11 – 2014/15. Specifically, this scenario would include the provision of resources to cover the costs of all inputs (capital and recurrent) required for the delivery of health services. Of critical importance, this scenario would ensure increased recruitment of HRH, up to 100% of the current staffing norms. It is believed that such increases in recruitment levels would significantly boost the absorptive capacity of the entire sector, hence enhancing efficiency of use of other resources (especially the infrastructure and medicines resources). This scenario would also provide for interventions focusing on staff attraction, retention, motivation, including interventions for hard-to-reach areas. The most ideal option would be to increase salary levels to match those within the East African region (as one of the key interventions to minimising HRH attrition). The second most ideal situation is that of maintaining the current salary levels and beefing it up with additional retention, motivation and hard-to-reach benefits. Furthermore, this scenario would allow for consolidation and closing of gaps in infrastructure, which would make all health facilities more functional. Lastly, this ideal scenario should provide adequate resources for other operational costs and the supportive interventions (as presented earlier in section C.2). The estimated costs for the Ideal Scenario are presented below.

**Table 9.12 Scenario 1(a) - Total cost of package (recurrent & capital costs) – desired salary scales**

Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
HC I	77.19	105.39	86.67	91.60	96.60
HC II	248.88	285.38	302.50	333.40	388.17
HC III	300.02	370.34	391.47	423.60	557.47
HC IV	175.70	267.85	305.32	315.33	227.39
General Hospital	527.42	599.01	608.57	613.94	662.54
Regional Referral hospital	222.77	235.41	254.27	279.28	300.04
National Referral Hospital	283.88	533.80	547.40	600.61	639.06
NRH – Psychiatric (Butabika)	32.34	39.75	40.22	44.35	47.39
UBTS	112.16	124.82	133.85	146.47	160.51
UHI	41.19	45.19	49.59	54.02	59.87
UCI	12.18	12.78	13.43	14.13	14.89
MOH headquarters	59.88	65.75	72.21	79.30	87.10
Regional level activities	12.79	10.95	13.58	12.61	16.54
DHOs office	31.13	32.94	34.87	36.93	39.14
Municipalities & Town councils	11.00	11.55	12.13	12.74	13.37



Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
Other	294.45	319.12	357.76	332.90	355.44
Maintenance (buildings & equipment)	42.29	35.93	36.80	40.48	44.53
<b>TOTAL</b>	<b>2,485.26</b>	<b>3,095.96</b>	<b>3,260.61</b>	<b>3,431.69</b>	<b>3,710.04</b>

**Sub-scenario 1(a)** is the most ideal one, taking into consideration increased salaries to match those in the region, and its costs are presented. For this scenario, an annual total of about 3,197 billion would be required to cover both capital and recurrent costs. Out of this total, about 52.3% would be spent on community and district level service provision; 32% would go to regional and national level service provision; 1.5% would go to district level management entities; 2.7% would go to regional and national level management entities; the remaining 10.4% would go to supportive interventions that are implemented at all levels (community, district, regional and national), and 1.3% would go to maintenance of buildings and equipment.

**Table 9.13 Scenario 1(b) - Total cost of package (recurrent & capital costs) – current salary scales**

Billion Shillings	2010/11	2011/12	2012/13	2013/14	2014/15
HC I	77.19	105.39	86.67	91.60	96.60
HC II	175.73	207.47	219.53	245.06	294.13
HC III	204.55	270.10	286.22	313.09	441.43
HC IV	130.21	220.09	255.17	262.67	172.10
General Hospital	397.07	458.91	458.06	455.91	496.61
Regional Referral hospital	187.77	198.65	215.67	238.76	257.49
National Referral Hospital	267.31	481.62	492.60	543.08	578.65
NRH – Psychiatric (Butabika)	29.77	37.05	37.38	41.37	44.26
UBTS	112.16	124.82	133.85	146.47	160.51
UHI	41.19	45.19	49.59	54.02	59.87
UCI	12.18	12.78	13.43	14.13	14.89
MOH headquarters	56.18	61.79	67.97	74.77	82.25
Regional level activities	9.73	7.74	10.21	9.07	12.81
DHOs office	20.98	22.28	23.68	25.19	26.81
Municipalities & Town councils	6.43	6.75	7.09	7.44	7.81
Other	420.52	453.55	500.19	484.30	516.39
Maintenance (buildings & equipment)	42.29	35.93	36.80	40.48	44.53
<b>TOTAL</b>	<b>2,191.25</b>	<b>2,750.11</b>	<b>2,894.11</b>	<b>3,047.41</b>	<b>3,307.15</b>

**Sub-scenario 1(b)** is the second most ideal option, taking into consideration current salaries and covering 100% of staffing norms and standards, and its costs are presented. For this scenario, an annual total of about 2,838 billion would be required to cover both capital and recurrent costs. Out of this total, about 45.3% would be spent on community and district level service provision; 32.7% would go to regional and national level service provision; 1.1% would go to district level management entities; 2.8% would go to regional and national level management entities; the remaining 16.7% would go to supportive interventions that are implemented at all levels (community, district, regional and national), and 1.4% would go to maintenance of buildings and equipment.

Cost per capita is about \$40 for scenario 1(a) and \$35 for scenario 1(b) in the first year, but this increases significantly in the subsequent years to \$47 - \$51 and \$42 - \$45, respectively for these scenarios.

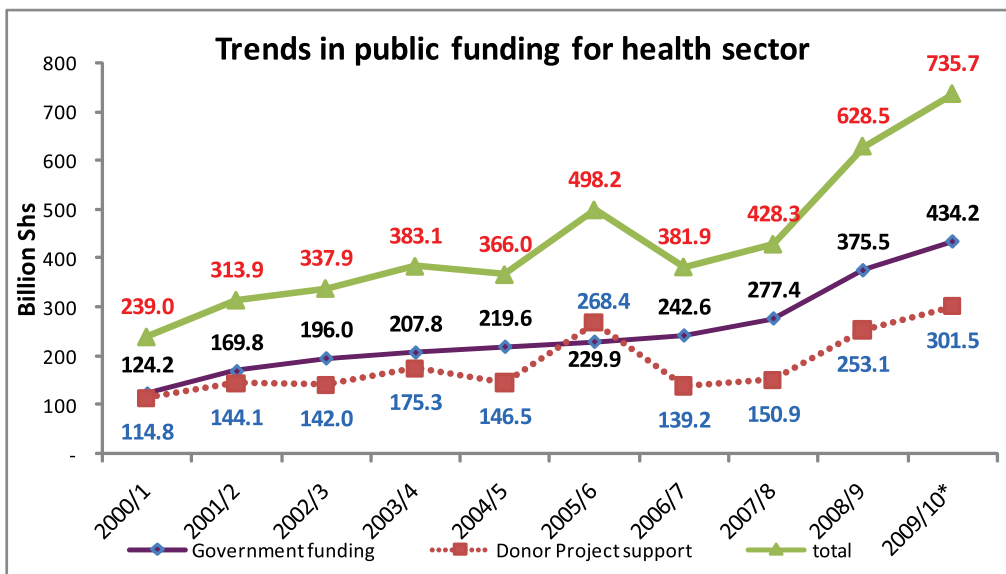
### **Scenario 2: Realistic (based on current Resource Envelope)**

Uganda has a plural health financing system with an array of different financing options. Funding for Uganda's

health sector comes from both public and private sources, with very little pooling and risk-sharing mechanisms beyond that implied by a taxation-funded service. The private sources include households (through user fees in private sector), private firms and not-for-profit organisation. Resources from Government and external sources (development assistance) together constitute the biggest proportion of funds for the health sector.

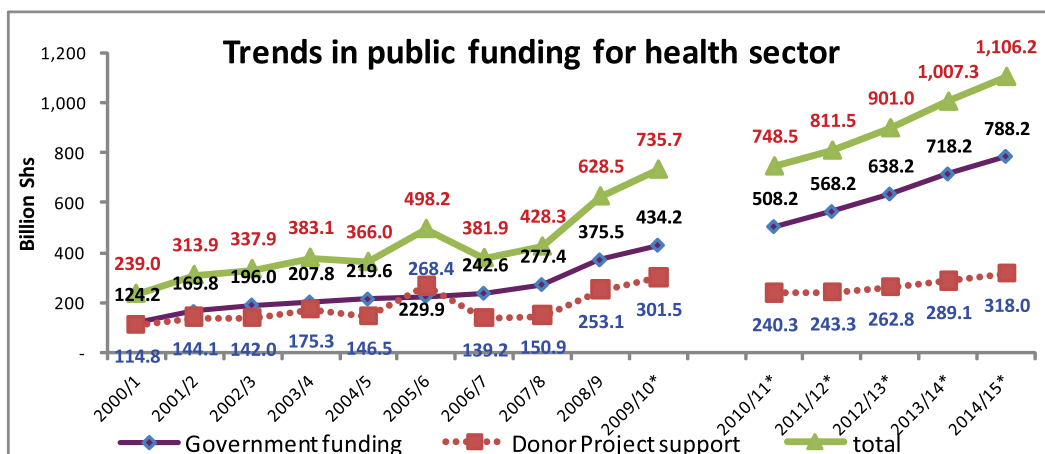
Despite fairly steady growth in the past, the overall level of funding for health remains inadequate in Uganda to meet its sectoral and national targets. A recent Health Financing Review (conducted by MOH and its partners) noted that limited opportunities exist to mobilize new substantial financing for the health sector. The conclusion from the Health Financing Review indicated that is unlikely that Uganda can dramatically increase its share of health spending beyond the present level. The past trends in public financing for the sector are presented below.

Figure 9.3: Past public health financing trends for health sector



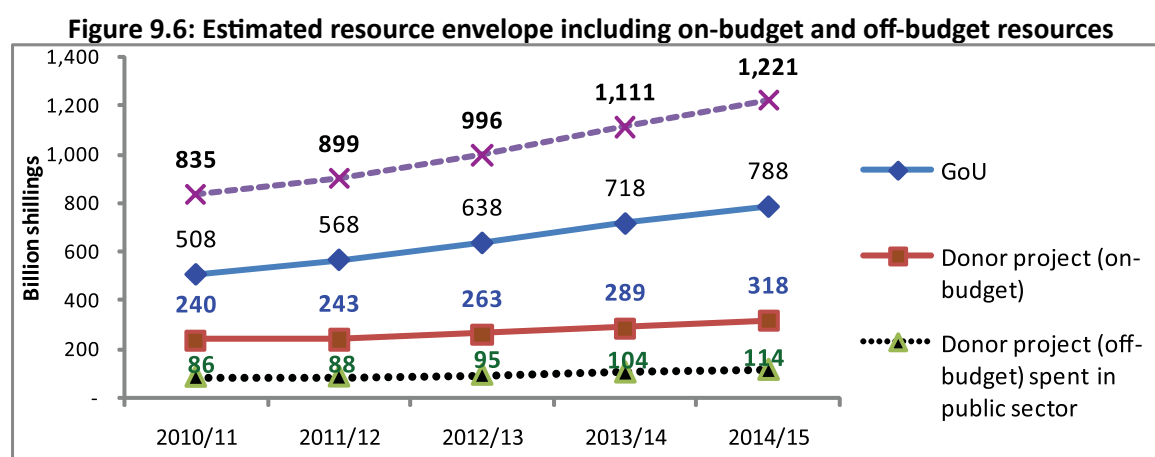
In the short-term, increases in government health spending is expected to mainly come from budgetary increases and development assistance. The magnitude of these increases depends on overall economic performance, and assumes that government health spending will continue to receive the same commitment is has been receiving in the past 5 years (see Figure 3). These assumptions holding, the conservative resource envelope estimates anticipate nominal increase of between 60 – 80 billion shillings per year for GoU resources. Further, an average increase of between 8% and 10% is anticipated for donor project funds. The total resource envelope that combines GoU and donor project funds is presented in Figure 4. The total amounts indicated for the period 2010/11 – 2014/15 are well within the planned MTEF figures (as indicated in National budget Framework Paper 2009/10 – 2014/15).

Figure 9.4: Anticipated resource envelope for HSSIP (2010/11 – 2014/15) – on budget resources



A significant proportion of donor project funding remains off-budget. It is noted that only 41% of donor project expenditure is reflected in the MTEF. Overall, off-budget donor project expenditures remain predominantly in the private sector at 74% compared to 26% spent in the public sector. USAID accounts for the biggest percentage of expenditure in the private sector, spending 90% of its funding which represents 50% of total off budget project expenditure.

Based on these indications, we can anticipate an additional off-budget funds spent in the public sector. While there are no hard-fact figures for off-budget funding in the country, simple estimates of these amounts are necessary as a starting point. Assuming 41% of estimated donor project funds are spent off-budget and that 25% of these are spent in the public sector, an annual estimate of about 85 billion is estimated for 2010/11, increasing to about 115 billion by 2014//15. The figure below provides information on the estimated resource envelope for public funds from the different sources.



**Table 9.14 Assessment of funding gap under Scenario 2 (realistic resource envelope)**

	2010/11	2011/12	2012/13	2013/14	2014/15
Anticipated resource envelop (on- and off-budget) - Billion shillings	835	899	996	1,111	1,221
Resource envelope per capita - US \$	13.17	13.70	14.65	15.80	16.77
Total Funding need for UNMHCP: Scenario 1(a) - Billion shillings	2,485	3,096	3,261	3,432	3,710
Funding Gap (scenario 1a) - billion shillings	1,650	2,197	2,265	2,320	2,489
Resource availability (scenario 1a)	34%	29%	31%	32%	33%
Cost per capita (scenario 1a) - US \$	39.19	47.17	47.99	48.80	50.98
Gap (per capita) - scenario 1a - US \$	26.02	33.47	33.34	33.00	34.21
Total Funding need for UNMHCP: Scenario 1(b) - Billion shillings	2,191	2,750	2,894	3,047	3,307
Funding Gap (scenario 1b) - Billion shillings	1,356	1,851	1,899	1,936	2,087
Resource availability (scenario 1b)	38%	33%	34%	36%	37%
Cost per capita (scenario 1b) - US \$	34.55	41.90	42.60	43.34	45.44
Gap (per capita) - scenario 1b - US \$	21.39	28.20	27.95	27.54	28.67

Considering the anticipated resource envelope and the required cost for delivering the entire range of health services, the funding gap is quite significant, whether we consider current salary scales or increased salary scales for HRH.

Under Scenario 2 (the realistic funding scenario), it is clear that service provision will continue to be severely impeded by inadequate funding. In fact, with a fast growing population, the levels and quality of service provision will be significantly weakened if funding trends remain as indicated in Figure 5.

Resource allocation under Scenario 2 could be viewed under two options.

- **Option 1:** With the estimated funding levels under Scenario 2, resources would be available to cover services for HC I – HC IV and management entities (district, regional and national level), with HRH being remunerated at current levels. This implies that services at all hospitals levels (including general hospitals that provide basic services) would have no funding, as well as all interventions or activities implemented at all levels (such as health promotion, education, environmental health, nutrition, technical supervision, sector monitoring and evaluation, indoor residual spraying and insecticide treated nets). This means that these services would have to be financed outside the anticipated public resource envelope, e.g. from private sources or other arrangements. Obviously, this is not a very desirable option.
- **Option 2:** The estimated funding for Scenario 2 could be shared between all levels of care. This option basically refers to current funding situation, where, all levels of care get some degree of funding, albeit a very inadequate one that only allows poor quality services that are limited in scope, and with all the challenges of poor HRH motivation and persistent stock out of medicines and health supplies. Once again, this “business as usual” option has long been decried for its inability to adequately address the health problems of the population and to meet key health targets, including the health-related Millennium Development Goals. If, however, this option was chosen, and assuming that the resources available were allocated proportionately to all level of care (so that the inadequacies are proportionately shared out), the resource allocation figures would approximately look like the ones presented in the table below. Once again, this type of resource allocation has severe challenges because some levels/institutions would be significantly under-funded to the extent that such levels would become non-functional. In this case, it might make more sense to have resources channelled away from some levels/institutions and channelled to critical areas of service provision, as deemed fit.

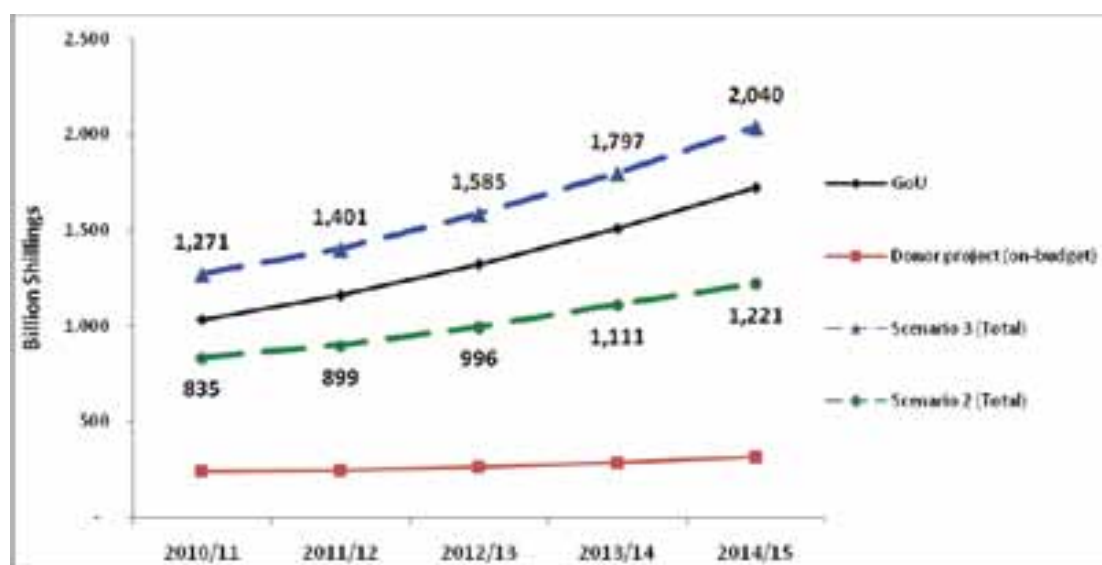
**Table 9.15 Example of resource allocation for Scenario 2 resource envelope (Billion shillings)**

RESOURCE ENVELOPE	835	899	996	1111	1221
HC I	29.4	34.5	29.8	33.4	35.7
HC II	67.0	67.8	75.5	89.4	108.6
HC III	77.9	88.3	98.5	114.2	162.9
HC IV	49.6	72.0	87.8	95.8	63.5
General Hospital	151.3	150.0	157.6	166.3	183.3
Regional Referral hospital	71.5	64.9	74.2	87.1	95.0
National Referral Hospital	101.9	157.5	169.4	198.0	213.6
NRH – Psychiatric (Butabika)	11.3	12.1	12.9	15.1	16.3
UBTS	42.7	40.8	46.0	53.4	59.2
UHI	15.7	14.8	17.1	19.7	22.1
UCI	4.6	4.2	4.6	5.2	5.5
MOH headquarters	21.4	20.2	23.4	27.3	30.4
Regional level activities	3.7	2.5	3.5	3.3	4.7
DHOs office	8.0	7.3	8.1	9.2	9.9
Municipalities & Town councils	2.4	2.2	2.4	2.7	2.9
Other	160.2	148.3	172.1	176.6	190.6

### Scenario 3: Progressively moving to 4% of GDP allocation to the health sector

Scenario 3 considers some medium-level increases in the resource envelope. Okwero et al (2010) correctly note that increases in the resource envelope can be achieved through increasing national revenues, increasing sovereign debt, accepting higher levels of development assistance, increasing efficiency and reducing waste within the health sector. They further estimate that the elasticity of government health expenditure with respect to GDP (with donor funds included) is 1.44, which means that a 1% growth in GDP is associated with an average increase in government health spending of about 1.44%. Assuming that the elasticity with respect to GDP remains at 1.44 and the ratio of health to GDP remains constant over the period 2010/11 – 2014/15, then the health sector resources are likely to reasonably increase if the projected economic growth is achieved. Okwero and others (2010) estimated funding levels between 1,031 billion and 1,722 billion between 2011 and 2015.

Figure 9.6: Estimated resource envelope for Scenario 3



Source: GoU estimates adapted from Okwero et al (2010). Donor project (on-budget) estimates included to get the Scenario 3 total resource envelope.

Moving from resource availability of between 34% and 38% (in Scenario 2) to resource availability of 50% – 59% (in Scenario 3) can be considered a medium-level increase in resource availability. Based on the amounts of resource required for a comprehensive package of services (as estimated in the ideal scenario), the resource package estimated for Scenario 3 is obviously able to ‘buy’ a reasonably bigger package compared to the resource envelope estimated for scenario 2.

Table 9.16 Assessment of resource gap under Scenario 3

	2010/11	2011/12	2012/13	2013/14	2014/15
Scenario 3 - Billion shillings	1,271	1,401	1,585	1,797	2,040
Resource envelope per capita - US \$	20.05	21.35	23.33	25.56	28.03
Total Funding need for UNMHCP: Scenario 1(a) - Billion shillings	2,485	3,096	3,261	3,432	3,710
Funding Gap (scenario 1a) - billion shillings	1,214	1,695	1,676	1,635	1,670
Resource availability (scenario 1a)	51%	45%	49%	52%	55%
Cost per capita (scenario 1a) - US \$	39.19	47.17	47.99	48.80	50.98
Gap (per capita) - scenario 1a - US \$	19.14	25.82	24.67	23.25	22.95

	2010/11	2011/12	2012/13	2013/14	2014/15
Total Funding need for UNMHCP: Scenario 1(b) - Billion shillings	2,191	2,750	2,894	3,047	3,307
Funding Gap (scenario 1b) - Billion shillings	920	1,349	1,309	1,250	1,267
Resource availability (scenario 1b)	58%	51%	55%	59%	62%
Cost per capita (scenario 1b) - US \$	34.55	41.90	42.60	43.34	45.44
Gap (per capita) - scenario 1b - US \$	14.51	20.55	19.27	17.78	17.41

With an annual average of 1,618 billion shillings in Scenario 3, one can consider two options of resource allocation (as previously described for scenario 2).

Under Option 1: a comprehensive package of services can be fully financed to cover services provided at HC I to General hospital levels, as well as management services provided at district, regional and national levels. In addition, about 80 billion shillings would remain to be allocated to any other levels, as deemed fit. This implies that services provided at regional and national referral hospitals and those provided by UBTS, UCI and UHI would not be covered by this resource envelope and would have to be financed from other sources. Similarly sector-wide support functions (e.g. health promotion, environmental health, support supervision, monitoring and evaluation) would not be funded using the scenario 3 resource envelope under this option. Once again, this “all and nothing” option is not very desirable or even feasible.

Under Option 2: a similar approach to that described for Scenario 2 would be taken. This means allocating resource to all levels of service provision and management, but each level would receive insufficient amounts that only allow them to be partially functional, in scope and scale of service provision. With more resources available under Scenario 3, we would be able to get relatively better funding levels for each service provider/institution. Once again, there would be need for priority setting that would guide more effective and efficient resource allocation levels, rather than proportionate allocation of resources that might results in very inadequate funding for key interventions/institutions or activities.

## 10. TECHNICAL ACCOUNTABILITY & RISK ANALYSIS

During the implementation of strategic plan the successful implementation itself may be affected by several factors. Clarity on responsibilities, and threats to the attainment of this HSSIP exist and will be actively managed during its implementation. Technical accountability, and risk analysis for HSSIP implementation therefore outline responsibilities and risks during implementation of the HSSIP. Also recognized is the corruption in the health sector with mitigation measures described below.

### **10.1 Strengthening Governance and Tackling Corruption in the Health Sector:**

The attainment of the Minimum Health Care Package (MHCP) and Health Sector goals as contained in the HSSIP is contingent on a number of issues including improved governance and transparency. The Health Sector is faced with a number of governance challenges including leadership and oversight capacity; gaps and overlaps in existing policies and law; weak fiduciary capacity; insufficient human resources; and limited citizen participation and oversight.

These challenges have increased health system vulnerabilities and contributed to inefficiencies, wastage and corruption manifested in a number of ways including informal payments at the frontline for services; absenteeism, neglect of duty and abuse of office; drug stock outs and leakages and ghost workers and health centers among others. The Third National integrity Survey 2008 (IGG, 2008) puts at 43% the percentage of the households that regard health workers as corrupt while the National Service Delivery Survey 2008 (UBOS, 2008) reported a high percentage of patients were paying for drugs in government health facilities.

The health sector has sought to address some of these challenges and mitigate the effects of poor governance and corruption on an already relatively low resource envelope that is currently incapable of meeting the health needs of a rapidly growing population. A number of initiatives are underway to strengthen governance, increase accountability and reduce corruption in the sector including the proposed World Bank supported Uganda Health System Support Project- Governance and Accountability Action Plan.

The need for rationalization of initiatives and greater transparency and leadership on corruption in the health sector and a more comprehensive strategy/ plan as part of HSSIP to address governance and audit issues including a well articulated section on financial management with accountability strategy, and a time bound and costed implementation plan has been noted.

The health sector intends to develop a rationalized Anti Corruption Strategy as part of HSSIP to address the challenges identified. The Anti Corruption Strategy will focus on addressing challenges in a number of key areas including: a) Strengthening Leadership and Administrative Oversight and Capacity; b) establishing Incentives for Human Resources for Health; c) Strengthening Citizen Voice and Participation in External Oversight and d) Increasing Accountability of Health Sector Development Partners to Government and Citizens.

### **Technical accountability**

The different deliverables from the HSSIP have specific divisions or units responsible for these. Overall technical accountability lies with the Director General of Health Services. The table below highlights the different units in the sector responsible for the deliverables from this HSSIP.

**Table 10.1 Responsibilities for HSSIP implementation**

Strategic Objectives	Intervention area	Responsible unit
Objective 1: Attain Universal Coverage	Cluster 1: Health Promotion, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response	Department of Community Health
	Promoting individual and community responsibility for better health	
	Contributing to the attainment of a significant reduction of morbidity and mortality due to environmental health and unhygienic practices and other environmental health related conditions.	
	Reduction of morbidity and mortality due to diarrhoeal diseases	
	Improvement in the health status of the school children, their families and teachers and to inculcate appropriate health seeking behaviour among this population.	
	Ensuring equitable access by people in PRDP districts [in conflict and post-conflict situations] to Health Services	
	Prevention, detection, and promptly responding to health emergencies and other diseases of public health importance.	
	Scaling up delivery of nutrition services	
	Cluster 2: Prevention, Management and Control of Communicable Diseases	Department of National Disease Control
	Contributing to attainment of a good standard of health of the population through prevention of STI/HIV/TB transmission and mitigation of the medical and personal effects of the epidemic.	
	Reduction in the morbidity, mortality and transmission of tuberculosis.	
	Sustaining the elimination of leprosy in all the districts.	
	Reducing the morbidity and mortality rate due to malaria in all age groups.	
	Maintaining the Guinea Worm free status of the country through maintenance of high quality post-certification surveillance.	
	Eradication of onchocerciasis and its vector in all endemic districts in Uganda	
	Achievement of the global target for the elimination of trachoma.	
	Reducing and ultimately interrupting transmission of the disease in all endemic communities through the use of chemotherapy with Ivermectin and albendazole.	
	Elimination of sleeping sickness as a public health problem in Uganda.	
	Reduction in morbidity caused by the worms by decreasing the worm burden among communities	
	Reduction in morbidity and mortality due to Leishmaniasis among the endemic communities	
	Cluster 3: Prevention, Management and Control of Non-Communicable Diseases	Department of National Disease Control
	Prevention of Type 1 and Type 2 diabetes and reduce morbidity and mortality attributable to diabetes and its complications.	
	Prevention of cardiovascular and related diseases and reduce morbidity and mortality attributable to CVDs	
	Establishment of a national framework for cancer control with emphasis on cancer prevention	
	Preventing chronic respiratory diseases and reduce morbidity and mortality attributable to COPD and asthma	
	Reducing the morbidity and mortality associated with sick cell disease.	
	Decreasing the morbidity and mortality due to injuries, common emergencies and disabilities from visual, hearing and age-related impairments.	
	Ensuring increased access to primary and referral services for mental health, prevention and management of substance abuse problems, psychosocial disorders and common neurological disorders such as epilepsy.	
	Improving the oral health of the people of Uganda by promoting oral health and preventing, appropriately treating, monitoring and evaluating oral diseases.	
	Improving the quality of life of terminally ill patients and their families especially the home carers	
	Cluster 4: Maternal and Child Health	Department of Community Health
	Reduction of mortality and morbidity relating to sexual and reproductive health & rights	
Improving newborn health and survival by increasing coverage of high impact evidence based interventions, in order to accelerate the attainment of MDG 4.		
Scaling up and sustaining high, effective coverage of a priority package of cost-effective child survival interventions in order to reduce under five mortality.		
Prevention of morbidity and mortality due to gender based violence.		



Strategic Objectives	Intervention area	Responsible unit
Objective 2: Improve levels, and equity in access & demand	Improve access to equitable and quality clinical services at all levels in both the public and private sectors and institutions.	
	Attain and maintain an adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce matched to the changing population needs and demands, health care technology and financing	
	Increase access to essential, efficacious, safe, good quality and affordable medicines at all times	
	Provide and maintain functional, efficient, safe, environmentally friendly and sustainable health infrastructure including laboratories and waste management facilities for the effective delivery of the UNMHCP, with priority being given to consolidation of existing facilities.	
Objective 3: Improve quality and safety	Ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being.	
	Ensure good quality health services with efficient utilization of available resources	
	Establish dynamic interactions between health care providers and consumers of health care with the view to improving the quality and responsiveness (including gender responsiveness) of health services provided.	
Objective 4: Improve on the efficiency, and effectiveness	Mobilise additional resources to fund the HSSIP	
	Improve management of development assistance for health	
	Ensure effectiveness, efficiency and equity in resource allocation and utilisation	
	Ensure transparency and accountability in resource allocation and management	
	Enhance transparency, and use of agreed management processes	
Objective 5: Deepen stewardship	Improve access to equitable and quality clinical services at all levels in both the public and private sectors and institutions.	
	Attain and maintain an adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce matched to the changing population needs and demands, health care technology and financing	
	Increase access to essential, efficacious, safe, good quality and affordable medicines at all times	
	Provide and maintain functional, efficient, safe, environmentally friendly and sustainable health infrastructure including laboratories and waste management facilities for the effective delivery of services, with priority being given to consolidation of existing facilities.	

## 10.2 Risk Analysis

The strategic direction outlined in this document is considered “medium to high risk”, and potentially of high impact judged against the purpose of achieving the targets of the NHSSP II. Some key risks that may hinder the ability of the Ministry to implement the planned strategies are discussed in the following sections.

Note: Letter designations refer to risks itemized below.

**Table 10.2 The risk assessment is highlighted in the table below:**

	Risk/assumption	Mitigation strategy
Risk A	Continued political stability.	Health sector shall work with all sections of government to ensure buying for its programs
Risk B	Continued political support at both national, district and lower levels	Health sector shall work with all sections of government to ensure buying for its programs
Risk C	Uganda’s economy will continue to grow and Government allocation to the health budget including allocation to PNFPs will also increase and reach the target of 15% as recommended in the Abuja declaration during the implementation of the HSSIP.	The health sector shall continue to work closely with all partners to advocate for allocation of additional resources, t the health sector and promote efficient use of the allocated resources

Risk D	Even if Government expenditure on health reaches 15%, the resources will not be adequate to fully implement the HSSIP. The assumption therefore is that the HPDs shall continue providing additional resources to compliment government funding to the health sector through the SWAp mechanism.	The sector is developing a comprehensive financing strategy that should identify all potential sources of funding and act as a tool for resource mobilization
Risk E	The proposed social health insurance scheme is successfully launched and implemented	The national health Insurance bill is in its advanced stages and shall be rolled within the HSSIP period
Risk F	Prudent financial management, accountability and transparency systems shall be key in order to attract financial and other resources into the health sector	The health sector proposed to address these challenges and mitigate the effects of poor governance and to increase accountability and reduce corruption in the sector.
Risk G	The focus in the health sector shall continue to be the delivery of the UNMHCP free of charge to all people in Uganda which shall be reviewed depending on epidemiological data and other new evidence.	The health financing strategy shall guide the sector on how to sustainably continue to implement the no user fee policy
Risk H	Availability of an effective legal and policy environment conducive for delivery of health services.	The professional councils have started discussing the possibility of starting regulatory health authority to improve the regulatory environment.
Risk I	The MoH with support from HDP shall train, recruit, deploy and retain sufficient HRH for effective delivery of the minimum package.	Investment in Human resources for health a key strategy for HSSIP.
Risk J	GoU succeeds in raising the wage bill for HRH	Investment in Human resources for health a key strategy for HSSIP.
Risk K	The decision makers will remain receptive to new ideas and innovations that can advance the health agenda e.g IHP+	HPAC remains the guiding body and the HSSIP will seek to implement proven cost effective and equity sensitive interventions
Risk L	The conflict resolution procedures of the health partnerships are effective	The compact has outlined conflict resolution mechanisms

These mitigating actions will be part of the implementation process and will be monitored and evaluated to see the rate of progress towards achieving the targets set in the HSSIP.