Joint Assessment of Uganda's Health Sector Development Plan (HSDP 2015/16 - 2019/20)

SEPTEMBER 2015

Final report

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Abbreviations

Abbreviation	Meaning
AIDS	Acquired Immune Deficiency Syndrome
BFP	Budget Framework Paper
BTC	Belgian Technical Cooperation
CBHI	Community Based Health Insurance
CHEW	Community Health Extension Workers
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
DFID	British Department for International Development
DHIS	District Health Information System
DP	Development Partners
EPI	Expanded Program on Immunization
GAVI	Global Alliance for Vaccine and Immunisation
GDP	Gross Domestic Product
GFF	Global Financing Facility
GFATM	Global Fund for AIDS, TB and Malaria
HDP	Health Development Partners
HFS	Health Financing Strategy
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
HPAC	Health Policy Advisory Committee
HPN	Health, Population and Nutrition (group)
HR	Human Resources
HSDP	Health Sector Development Plan
HSC	Health Services Commission
HSS	Health Systems Strengthening
HSSIP	Health Sector Strategic and Investment Plan 2010/11 – 2014/15
HQ	Headquarters
ICU	Intensive Care Unit
IFMIS	Integrated Financial Management Information System
IHP	International Health Partnership
IPT	Intermittent Presumptive Treatment (for malaria)
JANS	Joint Assessment of National Strategies
JRM	Joint Review Mission
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MOFPED	Ministry of Finance Planning and Economic Development
MTR	Mid Term Review

NCD	Non-Communicable Diseases
NGO	Non-government Organization
NTD	Neglected Tropical Diseases
OHT	OneHealth Tool
OOP	Out Of Pocket expenditure
OPM	Office of the Prime Minister
PA	Professional Associations
PBF	Performance Based Financing
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHC	Primary Health Care
PPD	Policy Planning Department
RBF	Results Based Financing
RH	Reproductive Health
RHB	Regional Health Bureau
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA	Skilled Birth Attendance
SBS	Sector Budget Support
SDG	Sustainable Development Goals
SHI	Social Health Insurance
SPA	Service Provision Assessment
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United National Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

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The JANS team

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Introduction

This report presents the findings and recommendations of a Joint Assessment of the Uganda Health Sector Development Plan (HSDP), conducted between 7th and 16th of September 2015. The assessment was carried out by a team consisting of 2 independent consultants and three specialists from WHO, The Global Fund and The World Bank.

Background

During the first half of 2015 The Ministry of Health of Uganda (MOH) with technical assistance from the WHO Uganda Country Office drafted the Uganda Health Sector Development Plan 2015/16 – 2019/20 (HSDP).

The plan is the latest in a series of health sector strategic plans comprising HSSP I, HSSP II and the immediate precursor, the Health Sector Strategic Investment Plan (HSSIP). The plan, which was put together by MOH in consultation with multiple stakeholders, indicates the overarching themes for the period ahead.

Following the finalisation of the draft plan, MOH decided to conduct a joint assessment of the latest version of the HSDP (June 2015 with some revisions of 4 September 2015), using the JANS tool. The JANS uses a shared approach to assess the strengths and weaknesses of the HSDP, and is accepted by multiple stakeholders.

Objectives

According to the TOR (Annex 1), the overall aim of the joint assessment is to review the content and development process of the HSDP, using the JANS tool, with a view to ensuring that the development plan meets the expectations of different actors in the health sector. Specifically, the assessment seeks to:

- Enhance the quality and relevance of the national health strategy (HSDP);
- Increase confidence of Development Partners (DPs) in the strategy and help inform decisions, ensuring that funding is closely aligned to the national health strategy;
- Reduce transaction costs at country level and cut down multiple assessments and review processes by different development agencies;
- Contribute to finalization of the HSDP document.

The assessment is expected to provide independent evidence on the soundness and coherence of the HSDP content as well as the inclusiveness of the development process.

Methodology

The Joint Assessment is unique to each country and is based on the following key principles[1]:

"The JANS will be country demand driven, be country led, and build on existing processes, include an independent element and engage civil society and other relevant stakeholders.
The output is not a yes / no recommendation for funding, but will give an assessment of the strengths and weaknesses of the National Strategy, and give recommendations. Findings can be discussed by national stakeholders and partners and may be used to revise the strategy".

MOH invited a JANS team comprising a mix of consultants and specialists from DPs. The team assessed the draft HSDP against the 16 sets of attributes in the JANS tool, that any high quality and comprehensive national strategy is expected to address. This approach implies that the JANS report is the result of the technical contributions of all the team members, using a "JANS lens".

The participating members of the team were distributed between the five subsets of attributes, based on their experience, expertise and personal preferences. For each subset (generic attribute), one of the team members was assigned to guide the interviews and coordinate the drafting of the presentation. MOH was instrumental in organizing the full agenda of meetings.

The following mix of methods was used in undertaking this JANS:

1. Document review: The most important of the documents made available to the team were the Health Sector Development Plan 2015/16 – 2019/20 dated July 2015, the draft Health Financing Strategy, the Draft Monitoring and Evaluation Plan for the HSDP, the Midterm Review Report of the HSDP 2010/11-2014/15, Volume I and II, and the Uganda Human Resources for Health Strategic Plan 2005-2020: Responding to Health Sector Strategic Plan and Operationalising the HRH Policy. Policies and strategic plans of a number of programs were also consulted. The list of documents for the mission is in annex 3.

2. Interviews were held with the following entities:

- Ministry of Health directors
- Ministry of Finance, Planning and Economic Development (MOFPED)
- Ministry of Gender, Labour and Social Protection
- Office of the Prime Minister
- The Health Service Commission
- The National Planning Authority
- Programs, including those funded through …
- Health Development Partners (SIDA, BTC)
- Private-Not-For-Profit health providers
- NGOs, CSOs and the private sector
- World Bank, UNFPA, Unicef, WHO

1. See Joint Assessment of National Strategy tool (JANS tool, version 3, August 2013)

- Hospital and district health staff at Jinja

The schedule of the team with indications of persons met is in annex 2.

3. Feedback

A presentation of initial findings was made to members of the MoH Senior Management Committee and the JANS Steering Committee at the end of the first week. A presentation was given to the Health Development Partners, and the team leader and the M&E specialist gave a presentation to the Health Policy Advisory Committee on the last day in-country.

Limitations:

- Due to other responsibilities, the whole team was not present in Uganda for the entire period
- Because of intense preparations for the coming elections, political leaders of the MoH were not present in Kampala during the mission
- Late availability of some documents allowed little time for an in-depth study.

JANS Team

- Esben Sonderstrup, team leader, PH specialist and independent consultant, was responsible for assessing the Situation Analysis and Programming of the HDSP (attributes 1-4, cf. the JANS tool)
- Mikael Ostergren, RMNCAH specialist, WHO, was responsible for assessing Process (attributes 5-7)
- Maxwell Dapaah, PFM specialist, the World Bank, was responsible for assessing the Costing and Budgetary Framework (attributes 8-9)
- Frank Terwindt, PH specialist and independent consultant, was responsible for assessing the Implementation and Management arrangements (attributes 10-14)
- Saman Zamani, Public Health and M&E specialist, the Global Fund, was responsible for assessing the Monitoring, Evaluation and Review arrangements (attributes 15-16).

1. Main Observations

1.1 Overall observations and recommendations

The HSDP is a very ambitious plan. It will be implemented at a time when government policy aims at stimulating economic growth through investments in communication, transportation and infrastructure, even if this means less resources for the social sectors. The tight fiscal space is not expected to expand in the plan period, and therefore government health expenditure is likely to remain at the very low level of around 9 USD per capita. On this backdrop the substantial funding gap of the HSDP will, in the view of the JANS team, severely undermine the feasibility of the plan.

1.2 Situation analysis and programming

The situation analysis is comprehensive and provides a good picture of the country's disease burden, including a ranking of the most important health problems and a description of disease trends as well as the social determinants of health. It also assesses strengths and weaknesses in the health system, covering the six generally accepted building blocks of a health system. The analysis is clear on the most important challenges the health sector is facing, namely the critical shortage of qualified health workers and the low level of general government expenditure on health.

The data presented in the situation analysis is not disaggregated by sex and there is little systematic analysis of indicators by wealth quintiles, geography etc. The background analysis does not comprise a systematic review of the experience gained with the HSSIP as a basis for the choice of strategies for the HSDP. One reason is that the end-term review of the HSSIP was not undertaken for financial reasons.

It is clearly stated that the overriding goal is Universal Health Coverage (UHC). The analysis refers consistently to the national policies, strategies and planning documents and positions HSDP goals, interventions and expected results within these confines. However, the HSDP hierarchy of goals, objectives, outcomes and targets is not very clear. The use of many different expressions such as domain areas, key interventions, priority interventions, strategic focus interventions, strategic directions etc. that are little (if at all) different makes it difficult to see clearly what the main priorities are. This is compounded by the exceedingly large number of key priorities/interventions (a total of 518) which are not of a strategic nature and effectively undermine the meaning of priority.

The level of detail in Chapter 3 is almost overwhelming. The HSDP loses focus and fails to give the reader an impression of what is important in the strategy. Although the inclusion of details is understandable – a lot of thought and effort went into formulating them – it defeats the purpose of a strategy document to include them.

The interventions of the HSDP are proven concepts and best practice, and they are considered appropriate for the country. However, the severe underfunding of the HSDP raises the question of whether it is feasible to plan for an expansion of infrastructure and other investments.

One risk, which has medium probability and high impact, namely the one relating to decreased or inadequate government funding due to competing priorities should be discussed further, including an indication of the remaining risk after mitigation efforts have been undertaken. The same goes for the high probability-high impact risk related to emerging or re-emerging health threats and disaster.

Urban health is not mentioned in the analysis. Growing urbanisation is gradually changing the demands on the health system, which builds on rural needs; there is a need to look closer at the opportunities and the challenges posed by urbanisation, which normally drives the NCD epidemic. There would seem to be a need for regulation of urban health services including the growing private sector.

1.3 Process

The development of the HSDP started with the development of the health issues paper which formed the health sector contribution to the NDP II. The health issues paper was developed following a broad consultation with all stakeholders and approvals by the Senior and Top Management of MOH. The elaboration of the HSDP involved further work for the TWGs in detailing out the priority strategies, interventions, indicators and targets for the next five years. Additional consultation was undertaken at local government levels, with universities, professional bodies, private sector and communities. The HSDP was originally expected to be completed by end of May 2015 and approved by Cabinet by June 2015; however, the final draft of HSDP was developed in August 2015. The HSDP drafting team was led by Director Planning and Development MoH.

The HSDP is consistent with the goals of the Uganda Vision 2040 and the National Development Plan II. Subsector plans, such as for instance the plans for RMNCAH, NCDs, HIV, TB and Malaria, have informed the HSDP.

1.4 Cost and budgetary framework

The costing of the HSDP was done with the OneHealth tool, which is well adapted to the Ugandan context. The targets used in the costing tool are consistent with the targets set in the HSDP. The costing used three scenarios with different levels of ambition, but the least ambitious scenario is the one used in the plan.

There is evidence that the costing process was carried out in a participatory manner, although some stakeholders did not feel engaged. The costing output was supported and reviewed by WHO.

The health sector is developing a health care financing strategy with six clear guiding principles: (i) develop comprehensive health financing policy guidelines based on NHP II; (ii) fulfil regional and international commitments on budgetary allocations to the health sector; (iii) ensure that GoU resources DPs prioritize financing of the minimum health care package (UNMHCP) with a clear bias to protecting the poor and most vulnerable populations; (iv) match all capital investment to resources

available for recurrent costs and gradually increase the allocation to non-wage operational costs; (v) improve equity by reviewing the district allocation formula; and (vi) promote alternative health financing mechanisms. The strategy identifies three innovative sources of financing including, national social health insurance (SIH); community-based health insurance mechanisms; and HIV/AIDS Trust Fund.

It is problematic that the HSDP is severely underfunded: the projected per capita health expenditure (CHE) of USD 117 envisaged under the first year of the strategy appears unrealistic given the base year CHE of USD 53. The projected increase represents over 100% increase in spending.

Lack of clear definition of what constitutes an "essential package" under Universal Health Coverage (UHC) means that there are cost implications that have yet to be taken into account in costing the plan. Issues relating to equity and quality of services could impact certain cost drivers, such as infrastructure and human resources strategies, once UHC is defined.

The projected increase in government's health sector budget allocation from the current 8.7% to 10%-15% over the life of the plan is quite ambitious, unless backed by clear strategies to obtain increase allocation from the national budget. Further, the projection does not appear to be informed by overall priorities of government in terms of growth in spending. The government has prioritized agriculture, tourism, infrastructure, and oil and gas in the 2015/16 Budget Framework Paper as well as the Budget Call Circular for growth in investments. Last but not least, recent trends show declining health sector budget as a percentage of the total budget in the past four years despite a slight increase in 2014. Neither the strategic plan nor HSF is clear on how the significant financing gap, in excess of 50% per year, will be financed.

Financing of the plan, as shown in the HFS, is fragmented; a situation that may create structural bottlenecks and inefficiencies during implementation. Separate pools will be created for the four sources of financing, namely unearmarked budgetary revenue, earmarked budgetary revenue, household out-of-pocket spending, and development partner funding. In an addition, an HIV/AIDS Trust Fund will be created.

1.5 Implementation and Management

The HSDP contains a wealth of good, evidence-based strategic orientations. The total volume of these strategic developments in the plan is very ambitious. The concepts for some of them have not yet been fully worked out. Areas such as the establishment of a CHEW network, the creation of a NHIS, the transition towards Resource Based Financing, as well as the idea of creating an intermediate administrative MOH structure at regional level are complex undertakings that will have to be broken down into phases of concept development, studies, tests and implementation steps.

A system and routines are in place for sector-wide bottom-up operational planning. This work is phased, organized, supported and validated by MOH, and the ministry consults with various stakeholder groups

in view of comprehensive, integrated planning. Norms and standards as well as service packages exist for all levels, and responsibilities at service level are clearly defined. While a resource allocation formula exists for PHC (local government) block grants, resource allocation criteria for the overall sector do not yet exist.

The 2007 HR Strategy has been updated for addressing the serious and persisting problems in HR development.

MOH has decided to address the need for a stronger presence at community level in PHC. To that end, the establishment of a network of Community Health Extension Workers is being planned. For addressing capacity weaknesses in areas such as M&E, inspection and drug management, capacity building measures are proposed. Vacant positions are to be filled, new positions are to be created and training organised.

Institutional capacity in procurement, PFM and auditing has been strengthened, and procurement systems meet national and international standards. Independent internal and external audits and parliamentary oversight are in place and function. Internal audit teams are seconded Ministry of Finance staff. Audits include assessment of value for money, and mechanisms for following up audit findings are in place and functional.

Bottom-up planning is done based on priority orientations by MOH and with its guidance. Still, district plans are often not yet comprehensive, with various vertical inputs. Validation of 112 district plans by MOH, while assuring equitable resource distribution, is a huge challenge. Districts use resources from a variety of nongovernmental funding partners and these are often managed in parallel set-ups. This entails risks for rational, equitable and efficient utilisation of such resources and for accountability.

It is commendable that MOH is planning to re-establish a SWAp environment and that HDPs are currently exploring options. Pooled funding would facilitate comprehensive sector development through integrated implementation modalities and could be the starting point for strengthening a culture and organisation for stakeholder collaboration and dialogue.

Although GoU has stressed the importance of strengthening inspection and has provided guidelines, in practice it has been mixed up with the role district level M&E units, in spite of the fact that inspection is a different function than M&E.

In the area of HR development many structural insufficiencies persist, notably in terms of HR production, recruitment, distribution and management. (Poor motivation and absenteeism were often mentioned to the team). However, the HR strategic plan does not yet spell out how reform and strengthening will be organised in the HSDP period.

The regional administrative level no longer exists, but the number of health districts increases steadily. This will make steering, support, control and review directly by central level MOH increasingly challenging.

Maintenance (of infrastructure, medical and other equipment, etc.) is one of several areas that are known for persistent weaknesses but for which no clear strategic orientations exist. The high % of facilities that are not (completely) functional severely hampers service delivery.

In Procurement there is a need to standardise specifications for equipment and infrastructure and for ensuring that installation and training of users is part of the supplier's contract. Procurement for big DP-funded programmes is done by PIUs that apply their own methods and standards. With growing confidence in a well performing public procurement system, these parallel systems and PIUs could be phased out.

The HSDP would become more effective if it included an ambitious agenda for addressing essential challenges such as the need for resource allocation criteria and formulas in budgeting in order to assure rational and equitable distribution. Another example is the need to clarify on what basis (norms and standards) newly created districts will be organised in terms of infrastructure, equipment and staffing.

1.6 Monitoring, Evaluation and Review

The HSDP includes a comprehensive M&E Plan which reflects the goals and objectives of the national strategy. The Plan includes 42 indicators, a manageable number, and specifies data sources and collection methods. It also identifies and addresses data gaps and defines information flows. The M&E Plan describes data analysis and synthesis processes, and Data Quality Assurance mechanisms are explained. Furthermore, the Plan includes steps to be followed for data dissemination and communication, including analytical reports for performance reviews and data sharing.

The national health management information system (HMIS) uses the District Health Information System (DHIS2) platform. DHIS2 is well-functioning with good coverage. However, while progress has been made with regards to reporting completeness, improvements are still required for timely reporting and accuracy of data captured into the system. Data can be disaggregated by gender, age and geography or administrative level. It can also be disaggregated by facility, level and ownership of the facility. The piloting of the Community Health Information System (CHIS) is a positive initiative.

The HSDP M&E Plan proposes establishing an M&E Unit at the MoH. Given the large number of M&E activities that need to be coordinated between different stakeholders, and the fact that sub-optimal coordination of the M&E activities has been a particular concern, much attention will be needed in defining roles, responsibilities and coordination mechanisms of the proposed M&E Unit.

As the HSDP considers establishment of Community Health Extension Workers (CHEWs) program as one of its strategic focus and priority interventions for service delivery systems, it is important that their

roles and responsibilities in relation to data collection and reporting, as well as participation in coordination of the community interventions vis-à-vis the existing VHTs be clarified.

There has been no formal Final Review of the HSSIP to assess success of the national plan in achieving intended objectives. The HSDP should ensure that a comprehensive final review will be implemented on time, and the lessons learnt from implementation of the HSDP will be systematically incorporated into the development or updating of the health sector strategies

1.7 Main Recommendations

- It is suggested that the document be subjected to further editing, trimming away those sections and subsections and tables that are deemed non-productive in a strategy and condensing the text by bundling interventions, especially in Chapter 3. This could be done through a gentle reformatting along the lines suggested in annex 3
- With a financing gap in excess of 50% for each year of the plan, realization of many of the outcomes of HSDP will be significantly undermined if it is not clear how the gap will be financed. Lack of clear strategies to bridge the funding gap, and to mitigate risks from identified funding sources, remains a major area of weakness. Addressing the funding gap issue is all the more important because of perennial government underfunding of the health sector (USD 9 CHE), and the fact that the health sector is still not prioritized as a sector for growth in investments in the 2015/16 budget framework paper. To strengthen the reliability of the budgetary and funding projections, further work will be needed to provide clarity on how the gap will be funded, and the associated risks of the identified sources of financing.
- The four vertical pools proposed in the HFS, and the HIV/AIDS Trust Fund to be set up will further fragment funding of the sector, and add to existing complexity. Vertical funding of the health sector, driven mostly by development partner funding (45%), is inherently complex. This has given rise to opaque funding mechanisms as well as structural and operational inefficiencies in financing service delivery. Against this backdrop, it is important to re-examine the proposed HFS, and move towards a more simplified and efficient pooling arrangement that minimizes fragmentation.
- Essential gaps in HSDP implementation arrangements should be filled by indicating how and when they will be addressed: Examples: resource allocation criteria, norms or standards for newly created districts, PBF roll-out, effective inspection, multi-sector cooperation, the need for a regional MOH level.
- Medium-term roll-out for the strategic development of each priority area should be briefly indicated: components, phases and responsible levels. This counts for systems that suffer from longstanding structural weaknesses, such as HR development and maintenance, as well as for new complex systems to be developed (NHIS, PBF, CHEW).
- Effective coordination of M&E activities for provision of timely and accurate information, effective use of statistical data (including sub-national analysis) and health research at all levels are critical issues to be considered in the HSDP.

2. Assessment Findings by each JANS Sub-theme

2.1 Situation Analysis and Programming

Situation Analysis & Programming Clarity and relevance of priorities and strategies selected, based on sound situation analysis
STRENGTHS
Attribute 1: Strategy based on sound analysis
• The situation analysis is comprehensive and thorough. It has a good description of Uganda's health determinants and disease burden, and it includes a ranking of the most important health problems • It includes description and analyses of disease trends and describes the social determinants of health, and it looks at risk factors and their contribution to disease burden • The situation analysis describes how the health system addresses the health problems and assesses strengths and weaknesses in the health system, covering the six generally accepted building blocks of a health system. • It checks the status of MDG targets and provides a clear overview of the progress, and it refers (in the HSDP introductory section) to the global health agenda and the future SDGs • The analysis is clear on the most important challenges the health sector is facing, namely the critical shortage of qualified health workers and the low level of general government expenditure on health • It provides a frank description of the sector partnerships • It points out that frequent changes at management levels and in technical departments is an impediment to the functioning of the MOH
Attribute 2: Clear goals, policies, objectives, interventions and expected results
• The overriding goal of UHC is commendable • The analysis refers consistently to the national policies, strategies and planning documents and positions HSDP goals, interventions and expected results within these confines
Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence
• The interventions of the HSDP are proven concepts and best practice, founded in prevention and disease control programme strategies developed by international bodies • They are appropriate for the country • They build on the experience gathered in the previous health sector strategic plans
Attribute 4: Risk assessment and proposed mitigation strategies in place
• The risk analysis in the HSDP document is commendably short and to the point. There is only one risk with high probability and high impact
WEAKNESSES

Attribute 1: Strategy based on sound analysis

- YLLs are used as the basis for burden of disease analysis. If DALYs had been used, the rise in the prevalence of NCDs would have come out more clearly as a cause of concern because the disability component of NCDs is more prominent than the premature mortality component. Some diseases with low mortality (but high burden of disease) such as major depressive disorder, which is one of the fastest growing diseases, disappear in the results of the analysis and are therefore not given much attention in the plan
- The data presented in the situation analysis is not disaggregated by sex and there is little systematic analysis of indicators by wealth quintiles, geography etc.
- The background analysis does not comprise a systematic review of the experience gained with the HSSIP as a basis for the choice of strategies for the HSDP. One reason is that the end-term review of the HSSIP was not undertaken for financial reasons
- The analysis does not point out that the referral system is not functioning well, and that mechanisms to ensure treatment at the lowest appropriate level do not work. This leads to inefficiencies that can hardly be afforded in a severely underfunded plan
- The basic health care package is not clearly defined; this hampers meaningful analysis of the possibilities for reaching UHC
- Despite growing importance of the private sector the situation analysis does not provide much information on the opportunities and challenges of this development. PNFP facilities are part of the national HMIS, but the non-inclusion of data from private sector hospitals and clinics may be a problem
- Urban health is not mentioned in the analysis. Growing urbanisation is gradually changing the demands on the health system, which builds on rural needs; there is a need to look closer at regulation of urban health services including the growing private sector

Attribute 2: Clear goals, policies, objectives, interventions and expected results.

- The HSDP hierarchy of goals, objectives, outcomes and targets is not very clear. The use of many different expressions such as domain areas, key interventions, priority interventions, strategic focus interventions, strategic directions etc. that are little (if at all) different makes it difficult to see clearly what the main priorities are. This is compounded by the exceedingly large number of key priorities/interventions (a total of 518) which effectively undermines the meaning of priority
- The level of detail is almost overwhelming. The HSDP loses focus and fails to give the reader an impression of what is important in the strategy. Although the inclusion of details is understandable – a lot of thought and effort went into formulating them – it defeats the purpose of a strategy document to include them
- The introduction of (a very large number of) flagship projects before the objectives and targets of the HSDP have been made clear is confusing
- The mortality reduction targets in the HSDP are very moderate: The SDG target of ending preventable child death would require a U5 mortality of 25/1000 LB or less by 2030. Interpolating the Uganda U5 mortality rate from 69/1000 in 2011, the target for 2020 should at least be 48/1000 LB. The current target is 51/1000 LB. Likewise, the MMR planned reduction is

very small (from 438/100.00 LB in 2011 to 375/100.00 LB in 2020). If continuing this trend in annual average mortality reduction rate, the MMR would be about 300/100.000 LB in 2030, very far from the SDG target of a global average of less than 70/100.000 LB

Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence

- Although interventions are generally feasible as indicated above, the severe underfunding of the HSDP raises the question of whether it is feasible to plan for an expansion of infrastructure and other investments.

Attribute 4: Risk assessment and proposed mitigation strategies in place

- The medium probability–high impact risk relating to decreased or inadequate government funding due to competing priorities should be discussed further, including an indication of the remaining risk after mitigation efforts have been undertaken
- The same goes for the high probability-high impact risk related to emerging or re-emerging health threats and disaster. Although the best insurance against health disaster is a resilient and adequate health system (as learnt through the recent ebola outbreak in West Africa) , other measures such as adherence to the International Health Regulations need to be prioritised

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- Targeting of interventions and allocation of funds may overlook opportunities and challenges in providing more equitable health care if data is not segregated according to sex, socio-economic group and geography. Targeting of key population groups becomes difficult if proper routine data or research data is missing
- If the HSDP is not edited and trimmed to become a more clear and straightforward guidance document, it is less likely to become an effective strategic plan that will indicate how the sector should move forward.
- If the current discussions on a new pooled funding arrangement with key DPs should come to fruition, the HSDP has to be able to convince DPs of what the most important objectives of the MoH are and how they will be achieved in order to attract funding

SUGGESTED ACTIONS

- It is suggested that the document be subjected to further editing, trimming away those sections and subsections and tables that are deemed non-productive in a strategy and condensing the text by bundling interventions, especially in Chapter 3. This could be done through a gentle reformatting along the lines suggested in annex 3. Furthermore, some of the exhaustive descriptions of interventions could be transferred to an annex in order not to lose the valuable information contained therein.
- In a severely underfunded plan, thorough planning and management of scarce human resources assumes major importance, and special attention must be given to this health system building block. There should be a plan for strengthening the HR Department, which has been without stable (i.e. with interim) management for many years, so that it is enabled to secure effective HR

management • Severe underfunding also means that high-impact and preventive PHC interventions must be prioritized over costly hospital interventions with little burden of disease reduction such as ICU and super-specialisation • The severe underfunding means that extra resources will have to be found through efficiency; hence, issues such as the non-functional referral system, maintenance of infrastructure, support supervision etc. will have to be given attention by management • Include in the situation analysis sex- disaggregated data and analysis of indicators by wealth quintiles, geography etc, preferably with time trends, ie are equity gaps being reduced over time or the opposite

2.2 Process

Process Soundness and inclusiveness of development and endorsement of HSSP III
STRENGTHS
Attribute 5: Multi-stakeholder involvement
• The draft HSDP has been developed through a process that has included a meeting for stakeholders in May, at which the draft HSDP was presented. Comments from CSOs sent by e-mail informed the subsequent draft. MoH has had political consultations with parliament. The plan was formulated by an HSDP Task Force (headed by DGHS) and an HSDP drafting secretariat (headed by CHS-P). Some TWGs have contributed to specific parts of the plan, and the HDPs have been involved through platforms such as HPAC.
Attribute 6: Political Commitment
• The Second National Development Plan 2015/16 – 2019/20 (NDPII) prioritizes investment in three key growth opportunities including Agriculture; Tourism; Minerals, Oil and Gas as well as two fundamentals: Infrastructure and Human Capital Development. Health is a key priority area within the Human Capital Development the following priorities are set: mass malaria treatment; National Health Insurance scheme; universal access to family planning services; health infrastructure development; reducing maternal, neonatal and child morbidity and mortality; scaling up HIV prevention and treatment; and developing a centre of excellence in cancer treatment and related services
Attribute 7: Consistent with higher and lower level strategies and plans
• The priorities set in the HSDP are consistent with the goals of the NDPII. Subsector plans, ie for reproductive, maternal, child and adolescent health, NCD's, HIV, TB , and Malaria have informed the HSDP.
WEAKNESSES
Attribute 5: Multi-stakeholder involvement

- Key informant interviews with other Ministries (Min of Gender, Labour and Social Services) did not give the impression of close interaction in developing the HSDP and coordinated planning between the sectors.
- Donor funding remains a main source of funding of the Total Health Expenditure (45%), but most is off budget indicating that technical and financial alignment between DP's and MoH leaves room for improvement. This was also confirmed in interviews with DP's
- The HSDP has been presented to DP's but there was not unanimous agreement among the DP's that it has been a fully participatory consultation with active engagement throughout the process

Attribute 6: Political Commitment

- Although a healthy population and workforce is a stated as a priority in the National Development Plan, the allocation to health as percentage of the total Government budget has reduced from 9.6 percent in 2003/2004 (AHSPR, 2013/14) to 8.7 percent in 2014/15 of the total Government budget, equaling approximately 9 USD /capita/year (NDPII). While recognizing that investments in other sectors may contribute to overall health, the allocation to the health sector is far below any required funding for a minimum benefit packages and will critically impede reaching the overall goal of the HSDP of Universal Health Coverage

Attribute 7: Consistent with higher and lower level strategies and plans

- Reviewing the Reproductive, maternal, newborn and child health sharpened plan for Uganda, it appears that the HSDP and this sub-sector plan are not fully consistent, for example, based on LiST analysis and scale up of essential interventions the RMNCH plan projects by 2017 a reduction of MMR to 211/100.000 LB, whereas the HSDP targets by 2020 are much lower: MMR: 375/100.000 LB. Furthermore, the RMNCAH plan (2013-17) is not synchronized time wise with the HSDP (2016-20)

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

SUGGESTED ACTIONS

- Considering the perception of the DPs that they were not sufficiently consulted in the process leading up to the HSDP, it is suggested that the DPs get engaged in the dialogue on adjustment of the document and that a dialogue is opened on the possibilities of establishing a pooled funding mechanism as part of the finalisation of one of the strategies underpinning the HSDP, namely the Health Care Financing Strategy.
- To review and adjust maternal and child mortality reduction targets to align with NDPII, the Reproductive, maternal, newborn and child health sharpened plan for Uganda and the SDGs

2.3 Cost and Budgetary Framework

Costs and Budgetary Framework Soundness and feasibility
STRENGTHS
Attribute 8: Expenditure Framework including comprehensive budget/costing
• The OneHealth Tool used for costing the plan is very well adapted to Uganda context. The tool is consistent with and aligned to the service delivery structure and health systems. Service delivery and health system components are well captured in the tool. The program management cost of each of the service delivery programs and health systems have been estimated. Overall the targets used in the costing tool are consistent with the targets set in the HSDP both in the strategic initiatives and in its M&E framework • The costing was estimated using three scenarios: Plan, Moderate Scale-up and Ambitious Scale-up scenarios. The scale and timing of infrastructure and human resources investments identified as key drivers of the scenarios are appropriate given their share of the health expenditure. The Plan scenario was based on the service coverage targets as proposed in the HDSP • There is evidence that the costing process was carried out in participatory manner, although some stakeholders did not feel engaged. Our interviews with the sub-program managers reflected consultations were held that they were involved in providing targets and validating the unit costs • The "ingredients approach" used for costing the plan was comprehensive. Under the approach, inputs necessary for an activity or service, the quantities of the input, and the unit cost for each input were imputed to the input. The total cost for the input was determined according to the equation: cost of services = number of services * unit cost of the service. The number of services required in the total was determined using the formula: number of services = target population * population in need * coverage • Finally, the costing output was supported and reviewed by WHO
Attribute 9: Realistic budgetary framework and funding projections
• The health sector is working towards developing a health care financing strategy with six clear guiding principles proposed: (i) develop comprehensive health financing policy guidelines based on NHP II and addressing resource mobilization, pooling and purchasing efficiency (allocative, technical and administrative) and equity; (ii) fulfil regional and international commitments on budgetary allocations to the health sector to which the Government of Uganda is a signatory; (iii) ensure that public resources from Government of Uganda and health development partners prioritize financing of the UNMHCP with preferential allocation to the priorities in the package and with a clear bias to protecting the poor and most vulnerable populations; (iii) match all capital investment to resources available for recurrent costs; within recurrent expenditure, gradually increase the allocation to non-wage operational costs; (iv) improve equity in the allocation to districts by reviewing

the district allocation formula; and (vi) promote alternative health financing mechanisms other than government budgetary provisions

- The HSF identifies three innovative sources of financing including, national social health insurance (SIH); community-based health insurance mechanisms; and HIV/AIDS Trust Fund
- The strategy identifies seven areas for financial sustainability: (i) mobilization of private resources from the private sector under the PHH arrangement; (ii) mobilization of community contributions; (iii) increasing efficiency in management of current resources; (iv) exploring grant opportunities; (v) building capacity of planning department to prepare international grant applications; (vi) advocate for increase in health sector budget from MTEF and making health a higher priority in existing government spending; (vii) providing adequate levels of financial risk protection; and (xi) improving efficiency in the utilization of funds.

WEAKNESSES

Attribute 8: Expenditure Framework including comprehensive budget/costing

- No recurrent cost budget is provided in the cost estimates to operate and maintain existing health facilities, and those to be constructed under the current strategic plan.
- The projected per capita health expenditure (CHE) of $117 envisaged under the first year of the strategy appears unrealistic given the base year CHE of $53. The projected increase represents over 100% increase in spending.
- There is a discrepancy in the CHE figures shown in Table 27 in the strategic plan and those shown in the Table 10 of the HFS.
- The use of fixed inflation rate of 5% during the entire HSDP time period needs to be re-examined to provide realistic costing of the plan.
- Lack of clear definition of what constitutes an "essential package" under UHC means that there are cost implications that have yet to be taken into account in costing the plan. While the plan envisions a transition from Primary Health Care (PHC) to Universal Health Coverage (UHC), what constitutes an "essential package" is not defined. Issues relating to equity and quality of services could impact certain cost drivers, such as infrastructure and human resources strategies, once UHC is defined

Attribute 9: Realistic budgetary framework and funding projections

- The projected increase in government's health sector budget allocation to 10%-15% over the life of the plan is quite ambitious, unless backed by clear strategies to obtain increase allocation from the national budget. Further, the projection does not appear to be informed by overall priorities of government in terms of growth in spending. The government has prioritized agriculture, tourism, infrastructure, and oil and gas in the 2015/16 Budget Framework Paper as well as the Budget Call Circular for growth in investments. Last but not least, recent trends show declining health sector budget as a percentage of the total budget in the past four years, albeit a slight increase in 2014:

Table 1. Financing trends 2003 – 2014

FY	GOU funding	Donor projects	Total	Per capita expend. UGX	Per cap. exp. USD	GOU health exp. % of tot. govt. exp.

2009/10	435.8	301.8	737.6	24,423	11.1	9.6
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.1	799.11	25,142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.8
2013/14	710.82	416.67	1127.48	32,214	12	8.7

Source: HSDP 2015/16-2019/2020

- Neither the strategic plan nor HSF is clear on how the significant financing gap, in excess of 50% per year, will be financed. The gap already takes into account increased revenue projections for the three major sources of financing of health care costs: government funding, multilateral partner funding and household out-of-pocket spending.
- The issue of sustainable financing has not been adequately discussed, despite being one of the major strategic issues in the HSDP. This is critical in light of the fact that currently Uganda's dependency on external funding remains high at 45%. There is no risk assessment of potential DPs withdrawal and risk mitigation measures in neither the HSDP nor the HFS.
- Financing of the plan, as shown in the HFS, is fragmented; a situation that may create structural bottlenecks and inefficiencies during implementation. Separate pools will be created for the four sources of financing that include, unearmarked budgetary revenue, earmarked budgetary revenue, household out-of-pocket spending, and development partner funding. In an addition, an HIV/AIDS Trust Fund will be created to address severe disease burden in this area.
- Projections of fees retained at the hospital and facility levels have not been reflected in the resource projection exercise.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

Sound and feasible costing of HSDP will help provide the basis for translating the aspirations and targets of the government into reality. Uncertainty about feasible cost estimates may cast doubt on the feasibility of achieving the plan. Proper financial projection about future availability of funding will create confidence for both the government and partners to use the document for sector budget support and performance based funding

SUGGESTED ACTIONS

- Explicitly address the issues of how the financing gap will be bridged, and sustainability financing, and include a risk analysis / mitigation measures
- Ensure linkage with the resource projections for health on the overall national macro-economic projections and the commitment shown in the macro-economic framework in the 2015/16 budget framework paper (BFP).
- Align inflation rate used in costing with projections in the BFP as shown below:

Table 2: Annual Headline Inflation Targets

Fiscal Year	2015/16	2016/17	2017/18	2018/19	2019/2020
Annual Headline Inflation (average)-%	5.5%	5.8%	6.0%	6.3%	6.3%

Source: National Budget Framework Paper -2015/16

- Include elements missing in the cost and revenue projects such as, recurrent cost for infrastructure and revenue generated at the facility level
- Address the issue of vertical financing. Pooling of financing sources should be the goal. It simplifies the funding approach, and hence provides one of the best vehicles for operational cost efficiency gains in implementing the HSDP, enhancing transparency of funding sources, and minimizing bottlenecks in funds flows for service delivery across the entire program. It is will therefore be useful to clarify, either in the HSF or in the HSDP, ; analyze the reasoning behind the current policy choice of vertical financings, binding constraints, and a clear path towards minimizing pooling of financing sources. The future state of pooling arrangements, sequencing of institutional, process and operational changes to be made as part of the transition plan, and the time frames thereto should be clearly articulated in the HSF. fragmentation, and enhancing efficiencies
- Validate proportion development partner projected contribution over the life of the plan through adequate consultations with relevant partners, as this will continue to be a major source of funding over the medium term. The 2012 National Health Accounts data used is rather old, and does not contain projections for years relevant to the plan.
- Revisit the calculations on CHE and correct discrepancies between projections in HSF and the HSDP on this.
- Take into account equity and quality of services considerations in costing the plan once UHC is defined. Equity is a key guiding principle in the HSF.

2.4 Implementation and Management

Implementation and Management Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy
STRENGTHS
Attribute 10: Operational plans are regular and detail how the strategy will be achieved
• A system and routines are in place for sector-wide bottom-up operational planning. This work is phased, organised, supported and validated by MOH • MOH consults with various stakeholder groups in view of comprehensive, integrated planning. • MOH urges HDPs to make efforts towards coordination in strategy development and alignment in resource allocation (on-budget contributions)
Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity
• Norms and standards as well as service packages exist for all levels. Responsibilities at service

level are clearly defined. Resource allocation is based on validated plans

- A set of parameters exist in combination with history-based budgeting
- Resource allocation formula exists for PHC (local government) block grants
- MOH plans to evolve from an input-based system to an output-based system

Attribute 12: Adequacy of institutional capacity

- The 2007 HR Strategy has been updated for addressing the serious and persisting problems in HR development
- MOH has decided to address the need for a stronger presence at community level in PHC. To that extent, the establishment of a network of Community Health Extension Workers is being planned
- For addressing capacity weaknesses in areas such as M&E, inspection and drug management, capacity building measures are proposed. Vacant positions are to be filled, new positions are to be created and training organised

Attribute 13: Financial management and procurement arrangements are appropriate

- GoU and MOH, in close cooperation with DPs, have made efforts to improve management transparency and performance through amendment of acts and review of regulatory and management tools. Institutional capacity has been strengthened. This counts for procurement, PFM as well as auditing
- Procurement systems meet national and international standards and are in the hands of seconded Ministry of Finance staff. Oversight and control are assured through by regulators and auditors. It is a centralised system; only drug supply is decentralised under the National Medical Store. No specific areas have been identified for strengthening, apart from the training of procurement staff and training of asset users
- All Government financing is managed through the PFM system
- Successful implementation of an Integrated Financial Management Information System

Attribute 14: Governance, accountability, management and coordination mechanisms specified

- The HSDP document highlights the need for strengthening SWAp
- Independent internal and external audits and by parliamentary oversight is in place and functions. Internal audit teams are seconded Ministry of Finance staff. Audits include assessment of value for money. Mechanisms for following up audit findings are in place and functional. Pre-auditing is practiced and may weaken risk-based auditing. On the other hand, there are robust arrangements for assuring follow-up of audit recommendations. Asset management is centralised and this makes tracking and planning easy

WEAKNESSES

Attribute 10: Operational plans detail how the strategy will be achieved

- Feasibility of HSDP implementation can be better verified when for each priority intervention responsible levels and structures are indicated
- The HDSP identifies a too large number of strategic priority areas and the feasibility of all these

items is questionable. From this list, goals, targets and routine activities can be removed. But even then, the priority areas vary hugely in their dimension, complexity and need for preparation

- Successful HSDP implementation will to a large extent depend on the soundness and clarity of strategies for dealing with old crippling problems. However, medium term development of some of these areas has not yet been sufficiently defined in terms of key operational objectives, stages and resource requirements. This counts, for instance, for improving social risk protection through establishment of a NHIS and for the creation of a CHEW network. For the area of HR development, a strategy is in place, but a medium term plan is still missing
- Bottom-up planning is done based on priority orientations by MOH and with its guidance. Still, district plans are often not yet comprehensive, with various vertical inputs. Validation of 112 district plans by MOH, while assuring equitable resource distribution, is a huge challenge. This may in part explain the low resource mobilisation (around 80%). If Performance/Resource-based financing is introduced, this will further complicate MOH's arbitrage role
- HSDP is to become effective in the next fiscal year. For many of the priority strategies and areas for reform and strengthening the description in the document is too general to allow for immediate translation into operational plans. Therefore the document should clarify the timing of next steps

Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity

- MOH plans to establish in the near future a vast network of CHEWS to improve village level PHC. This is a major undertaking, inspired by experiences in Ethiopia. However, the feasibility and potential of such a scheme have not yet been sufficiently researched for the Uganda setting. A wealth of lessons learned from experiences in other countries document sustainability challenges, notably concerning integration, financing, supervision and motivation
- Apart from allocation formula for PHC grants, resource allocation criteria and formula do not yet exist for the sector as a whole, though the need for these is acknowledged by MOH. Since for many HSDP priority areas details on strategy implementation and phasing are not yet available, costing can only be indicative. Resource needs for innovative strategies, system strengthening plans and reforms may then easily evolve in the course of HSDP implementation. This entails a considerable risk that sector financing will become skewed at the cost of equitable service delivery
- Due to weaknesses in the past, old pooling mechanisms for health financing no longer exist. Fortunately, MOH is planning to re-establish a SWAp environment, built on mutual trust and firm national leadership. Some form(s) of pooling would then become possible again. A few HDPs are currently exploring options. Pooled funding would facilitate comprehensive sector development through integrated implementation modalities. Transaction costs could be reduced
- Allocation of resources (human as well as financial) is still largely done through history-based budgeting. For some aspects, standards and norms are not in place or not updated. This counts e.g. for infrastructure needs in newly created districts. Districts use resources from a variety of nongovernmental funding partners and these are often managed in parallel set-ups. This entails risks for rational, equitable and efficient utilisation of such resources and for accountability

- Inspection assures enforcement, which is currently a well-known systemic weakness in the sector. This critical function is currently fully decentralised at the level of local government. Although GoU has stressed the importance of strengthening inspection and has provided guidelines, in practice it has been mixed up with the role district level M&E units, in spite of the fact that inspection is a different function than M&E. The need for capacity building has been mentioned

Attribute 12: Adequacy of institutional capacity

- In the area of HR development many structural insufficiencies persist, notably in terms of HR production, recruitment, distribution and management. (Poor motivation and absenteeism were often mentioned to the team.) MOH and partners are fully aware of the serious threat this poses for HSDP implementation. However, the HR strategic plan does not yet spell out how reform and strengthening will be organised/phased in the HSDP period, while no significant increase of budget for staff positions can be expected
- The number of health districts increases steadily in the absence of an intermediate (regional) administrative level. This will make steering, support, control and review directly by central level MOH increasingly challenging. The renewed debate on the need to create some form of regional directorate is welcomed by many
- Maintenance (of infrastructure, medical and other equipment, etc.) is one of several areas that are known for persistent weaknesses but for which no clear strategic orientations exist. The high % of facilities that are not (completely) functional severely hampers service delivery
- The HSDP hardly makes mention of priority TA needs, does not indicate what are priority TA needs and does not have a strategy for TA planning, coordination and management. In view of the many strategic, reform and strengthening areas that are still to be further developed, as well as of certain capacity weaknesses in central level MOH, some technical support would appear necessary

Attribute 13: Financial management and procurement arrangements are appropriate

- In the course of this last decade, confidence of HDPs in MOH regarding public sector governance decreased. The HSDP document does not specify action plans for addressing remaining issues regarding streamlining/harmonising systems, accountability, assuring compliance and corrective action
- HSDP does not refer to the appropriate legal and regulatory framework governing Financial Management and Procurement for the public sector. Due to insufficient information an independent conclusion about the performance of financial management and procurement in the sector is not possible
- In Procurement, remaining issues to be solved are (i) the need to standardise specifications for (medical) equipment and infrastructure, (ii) ensuring that installation and training of users is part of the supplier's contract. Procurement for big DP-funded programmes is done by PIUs, which apply their own methods and standards. With growing confidence in a well performing public procurement system, these parallel systems and PIUs could be phased out
- Pre-auditing is practiced and may weaken risk-based auditing. The team was not able to verify

actual audit outcomes and how recommendations were followed up.

- Disbursement modalities vary since some of them are linked to programmes that have their own parallel management set-up. Efforts towards their alignment have had mixed results. Moreover, use of country systems for implementing donor financed projects remains low at 43% despite years of public financial management reforms. Unpredictability of available resources and programme specific procedures and conditions for fund release complicate service management

Attribute 14: Governance, accountability, management and coordination mechanisms specified

- Indications on how an effective SWAp environment will be established are missing in the document. The current landscape of programmes, projects, coordination structures, funding flows and management systems is diverse and fragmented. The organisation of the core functions in a SWAp environment need to be reviewed: joint and comprehensive steering and reviewing of sector development, technical and strategic development, planning and M&E, day to day coordination
- Governance insufficiencies have been identified in several areas, such as supervision, norms and standards for establishing infrastructure in new districts, inspection and consolidated bottom-up planning

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- While the HSDP document reflects the ambitions of a joint, sector-wide development of the health system, the current practices of the combined stakeholders do not sufficiently reflect the required culture of strong leadership, effective communication, common focus and joint action. If this barrier is not overcome, the HSDP implementation will cause frustration and the outcome will be disappointing
- The overall volume of priority areas is very ambitious. Moreover, many areas that are to be strengthened, reviewed or developed are complex. The HSDP document does not give enough detailed guidance for operational planning. If the gap between this overall general strategic framework and operational planning is not bridged through phased work plans, there is a distinct risk in joint HSDP implementation of misinterpretations, strategy diversions, omitted interventions and poor coordination
- It is important to understand why it has been so difficult to achieve significant improvement in certain system areas, such as Human Resources, maintenance, service management, infrastructure planning, PPP and drug supply. If the medium term strategic orientation is not based on lessons learned from past experiences, and translated into a phased set of strategic interventions, such systems are likely to continue business as usual and therefore not significantly improve

SUGGESTED ACTIONS

- Addressing essential gaps in HSDP implementation aspects: An important example is the need for resource allocation criteria and formula in budgeting (based on a sector MTEF) in order to assure rational and equitable distribution. Another example is the need to clarify on what basis

(norms/standards) newly created districts will be organised in terms of infrastructure, equipment and staffing. HSDP should include an ambitious agenda for addressing such gaps

- Strategic development for key systems: Strategic priorities for systems that suffer from longstanding structural weaknesses (HR development, maintenance, referral system, …) as well as complex systems that still are to be developed (NHIS, PBF, CHEW ..) will go through several stages in the course of the HSDP period. Even if specific strategy documents already exist for these areas, operational planning will have to be guided by multi-year Programmes of Work
- Performance in governance: Develop indicative medium roadmaps for addressing remaining issues regarding streamlining/harmonising systems, accountability, assuring compliance and enforcement. Roadmaps can include phased strategy implementation for governance aspects such as inspection, procurement, auditing and PFM. Measures of capacity strengthening, institutional and organisational reforms, studies, pilots and evaluations can be phased over the 5 HSDP years
- SWAp environment: Based on a frank debate with stakeholder groups, decide jointly how a climate of mutual trust between MOH and partners can be furthered and what should be undertaken to improve stakeholders' sense of ownership of the plan. An agenda for improving integration and alignment of their contributions can be developed after a review of existing mechanisms for coordination, collaboration and joint decision making, and of the Compact. For example, HDSP can plan a study on realistic options for a phased alignment of finance management modalities and joint funding

2.5 Monitoring, Evaluation and Reviews

MONITORING, EVALUATION AND REVIEW Soundness of review and evaluation mechanisms and how their results are used
STRENGTHS
Attribute 15: The plan for monitoring and evaluation (M&E) is sound, reflects the strategy and includes core indicators; sources of information; methods and responsibilities for data collection, management, analysis and quality assurance
• The HSDP includes a comprehensive M&E Plan which reflects the goals and objectives of the national strategy. The Plan includes 42 indicators including inputs/process (6), output (13), as well as health outcomes (16) and impact (7) indicators. The M&E plan specifies data sources and collection methods, identifies and addresses data gaps and defines information flows • The M&E Plan describes data analysis and synthesis processes, and Data Quality Assurance mechanisms are explained. The Plan also includes steps to be followed for data dissemination and communication, including analytical reports for performance reviews and data sharing • The national health management information system (HMIS) uses the District Health Information System (DHIS2). While significant progress has been made with regards to reporting

completeness, improvements are still required for timely reporting and accuracy of data captured into the system. The collected data can be disaggregated by gender, age and geography or administrative level. It can also be disaggregated by facility, level and ownership of the facility. The piloting of the Community Health Information System (CHIS) is a positive initiative

- Uganda has a progressive Health Facility Assessments profile. Building on the experience of a comprehensive Service Provision Assessment (SPA) conducted in 2007, the MoH in collaboration with the technical partners (including WHO) have conducted Services Availability and Readiness Assessment (SARA) surveys in 2012 and 2013. In 2014, Uganda has completed a census for all 147 hospitals and 188 Health Centres Cat-IV.
- Based on the recommendation of the Mid-Term Review of Health Sector Strategic and Investment Plan (HSSIP), it is proposed that an M&E Unit be established to ensure effective coordination of M&E activities for provision of timely and accurate information, effective use of statistical data and health research at all levels
- The draft HSDP considers the Voluntary Health Teams (VHTs) as a coordination and reporting arm from the community. The VHTs are expected to discuss performance within the community, and agree on communities' priorities to focus on. Standard planning and reporting format are provided, and their reports and plans will be collated at the facility level
- Disease- and program-specific monitoring, evaluation and review are aligned with that of the national health strategy. The monitoring, evaluation and review plan is costed and funded but it should be clarified whether partners support are aligned with it

Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision-making and action.

- Currently, there is a multi-partner review mechanism that inputs systematically into assessing sector or programme performance against annual and mid-term goals. Ministry of Health develops Annual Health Sector Performance Report (AHSPR). Though there was no formal Final Review of the HSSIP, a comprehensive, analytical and multi-stakeholder mid-term review (MTR) of the HSSIP was conducted in 2013, and the findings and observation were used as a basis for policy dialogue and strategic direction of the HSDP
- Going forward, the HSDP emphasizes on joint periodic performance reviews and processes to feedback the findings into decision making and action, and to assess success of the national plan in achieving intended objectives. The Plan aims for conducting a Final Review toward the end of the HSDP implementation period. The review will include comprehensive analysis of progress and performance, incorporating results of specific research and prospective evaluations from the beginning of the HSDP.

WEAKNESSES

Attribute 15: The plan for monitoring and evaluation (M&E) is sound, reflects the strategy and includes core indicators; sources of information; methods and responsibilities for data collection, management, analysis and quality assurance.

- Currently, there is no institutionalized M&E structure at sector level, with the M&E function currently being performed by the Quality Assurance Department. Further to this, there is

insufficient staffing for the M&E function at all levels of the health care system. There are several actors in M&E within the MoH and that makes coordination a critical element for better data collection for actions. The HSDP M&E Plan proposes establishing an M&E Unit at the MoH. Given the large number of M&E activities that need to be coordinated between different stakeholders (including the Resource Centre, the National Programs, technical working groups, district health offices, and technical institutes), and the fact that sub-optimal coordination of the M&E activities has been a particular concern, much attention will be needed in defining roles, responsibilities and coordination mechanisms of the M&E Unit.

- The M&E Plan highlights that data analysis and synthesis will be done at all levels national, sub-national to health facility to enhance evidence-based decision-making. While this approach is highly appreciated, there is little evidence showing that the draft HSDP is indeed based on sub-national analysis and disaggregated data. Sub-national analyses of the already available HMIS data as well as the population-based survey results could have identified challenged regions or sub-populations deserving a targeted approach for achieving higher impact.
- As the HSDP considers establishment of Community Health Extension Workers (CHEWs) program as one of its strategic focus and priority interventions for service delivery systems, it is important that their roles and responsibilities in relation to data collection and reporting, as well as participation in coordination of the community interventions vis-à-vis the existing VHTs be clarified.
- Coordination of M&E activities including support supervision at regional level has not been clearly elaborated in the M&E Plan. While the MoH has rolled out the Regional Performance Monitoring Teams (RPMTs) initiative to mainly support planning, monitoring and supervision of health services delivery, their roles and responsibilities are not described in the draft M&E Plan. Further elaboration on the process of establishing this regional structure in a sustainable manner is needed.
- The M&E Plan falls short in describing the current DHIS2 functionality as well as its current coverage, timeliness, and quality of data reported through this web-based information system.
- The Plan also lacks detailed information on the current pilots of the community-HIS and the MoH plan for further scale up of this initiative linking community level data to DHIS2. The Plan should also explain potential linkage between CHIS and CRVS in improving recording data on births and deaths at community level.
- There is inconsistency between the HSDP document and what is currently measured through the HMIS in terms of Intermittent Presumptive Treatment (IPT) coverage for pregnant women. It should be clarified whether IPT 3 doses coverage for pregnant women is aimed at according to the international guidelines. Additionally, the MTR showed IPTp2 has had slow progress and 2015 target is unlikely to be met. While ambitious targeting for IPTp (IPTp3 in the HSDP draft document) is appreciated, there should be a clear plan on “how” this ambitious target (of 93%) can effectively be achieved.
- Regional disaggregation is not part of planning. This could be very useful for the areas that have not shown expected progress such as MNCH. The MTR highlighted that HMIS products are not being used for RMNCH decisions at all levels. This is related to quality of data, some key RMNCH

indicators not being captured adequately from both the public and private sector and little RMNCH information demand by stakeholders. Targets for several indicators related to MNCH are not ambitious. ANC4 visit is not improving and MoH should lead in conducting an operational research (including qualitative inquiry) to identify barriers against continuation of ANC visit based on its results some interventions be implemented

- The proposed reduction in MMR from 425 to 375 maternal deaths per 100,000 live births between 2015 and 2019 does not seem ambitious, and does not ensure Uganda can reach an SDG target of 70 by 2030. If there is any discrepancies source of information for this indicator, it should be clearly explained in the M&E Plan.
- The performance of health sector in increasing proportion of pregnant women attending ANC 4 times seems to be poor. Additionally, the target of 35% by 2015/16 is even less than the baseline figure of 47% in 2009/10.
- In light of the strategic direction for achieving UHC, it is important that the relevant essential health care package of services be defined.

Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision-making and action.

- While a detailed and analytical mid-term review (MTR) of the HSSIP was conducted in 2013, there has been no formal Final Review of the HSSIP (End Term Evaluation) to assess success of the national plan in achieving intended objectives. Consequently, lessons learnt from implementation of the HSSIP were not systematically incorporated into the development of the HSDP. It should be ensured that sufficient time and resources are allocated for conducting a comprehensive final review (including synthesis of the results of specific research and evaluations) so that the critical lessons learnt during implementation are incorporated into the planning of the next health sector plan
- The HSDP does not differentiate well between its planned three main evaluative approaches, namely: 1) program reviews and evaluations to assess the performance, efficiency and quality of the priority programs; 2) thematic evaluations to assess the success and impact of key initiatives; and 3) Program Reviews and evaluations
- There was slow progress in developing the Comprehensive Support supervision Strategy for the sector, mainly because of procurement delays and inadequate funding. This was expected to be completed in the course of the remaining period of HSSIP, but operationalization of this important strategy should be emphasized from the beginning of the HSDP implementation
- There are quite number of research studies and reviews are being conducted, but M&E Plan does not elaborate how these studies are coordinated and the results are consolidated and synthesized for any strategic decision making

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- Effective coordination of M&E activities for provision of timely and accurate information, effective use of statistical data and health research at all levels is a critical issue that can impact successful implementation of the HSDP.

- Sub-national analyses of the already available HMIS data as well as the population-based survey results could identify challenged regions or sub-populations deserving more targeted approach for achieving higher impact.
- Given the sub-optimal progress of the MNCH domain during HSSIP, it is important that the linkages and potential synergies between MNCH and other programs such as HIV/AIDS, malaria and other cross-cutting health system investments be strengthened, and the existing barriers against delivery and access to MNCH services be adequately addressed.
- There has been no formal Final Review of the HSSIP to assess success of the national plan in achieving intended objectives. The HSDP should ensure that a comprehensive final review will be implemented on time, and the lessons learnt from implementation of the HSDP will be systematically incorporated into the development/updating of the health sector strategies

SUGGESTED ACTIONS

- Roles and responsibilities of the proposed M&E Unit should be clearly defined, with a clear mechanism for coordination of the M&E activities between the key stakeholders (including Resource Centre, National Programs, technical working groups, district health offices, and technical institutes).
- Sustainability of the regional coordinating bodies including Regional Performance Monitoring Teams (RPMTs) can be helpful to support planning, monitoring and supervision of health services delivery.
- Further scale up of the HMIS -DHIS2 to incorporate community health information system as well as to cover private for profit health sectors is essential for successful implementation of the HSDP.
- Apply sub-national analyses to identify challenged regions or sub-populations for a targeted approach for achieving higher impact.
- Operation research (using qualitative and quantitative methodologies) should be focused on understanding of the reasons why key targets (in particular related to MNCH) are not being met, and results be critically discussed and synthesized during mid-tern or final review of the HSDP.
- The HSDP should elaborate differences between its three main evaluative approaches, namely: 1) program reviews and evaluations to assess the performance, efficiency and quality of the priority programs; 2) thematic evaluations to assess the success and impact of key initiatives; and 3) Program Reviews and evaluations. Explain how these complement each other
- The M&E Plan still seems a working document with several sections to be completed (pages 16, 19, 27, and 37). A couple of inconsistencies between figures in the text and tables should be edited
- There are inconsistencies in timing for conducting mid-term and final review of the HSDP document. It would be good to conduct the mid-term review after two years of implementation of HSDP, and sufficient time and resources be allocated for conducting a comprehensive Final Review toward completion of the HSDP term and incorporate critical lessons learnt into the planning of the next health sector plan
- Provide additional details of the CHEWs program vis-à-vis the existing VHTs, in particular deliberate on potential overlaps in roles and responsibilities, as well as sustainability of these two

programs at community level

- It is recommended that the exact definition and method of measurement for the selected indicators be checked against the WHO Global Reference List of 100 Core Health Indicators, and where needed targets be adjusted/updated.

Annexes

Annex 1 Terms of reference

TERMS OF REFERENCE
AGREEMENT FOR PERFORMANCE OF WORK

CONDUCTING THE JOINT ASSESSMENT OF UGANDA'S HEALTH SECTOR DEVELOPMENT PLAN (HSDP) 2015/16-2019/20

1. BACK GROUND

Uganda signed the International Health Partnership+ (IHP+) Global Compact in February 2009. At the heart of IHP+ is a commitment to get better health results by increasing support for national health strategies and plans in a well-coordinated way. The Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2014/15 is coming to an end and Uganda is developing its new Health Sector Development Plan (HSDP) 2015/16-2019/20. The new HSDP closely aligns with the second National Development Plan 2015/16-2019/20.

Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy, that is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. In Uganda, the main perceived added value of joint assessment is to create an opportunity for strategic discussion and thus strengthen the plan. Related expectations are that the assessment will increase confidence in the plan; help to get more partners on-plan and on-budget, and reduce at least some of the burden of separate appraisals / proposal preparations. The independent element is desired in order to provide a fresh, systematic perspective on the plan. The inclusion of more partners in a joint assessment is also expected to reduce transaction costs associated with multiple separate assessment and reporting processes.

The Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2014/15 was subjected to a Joint Assessment from 24th June to 2nd July 2010. The results were used to improve the quality of the plan as well as building partners' confidence in the plan.

The JANS assessment will, with other frameworks (Vision 2040, NDP, HSDP and NHP II), provide the necessary information to guide the review of the current Compact (2010/11-2014/15) and the drafting of the new Compact (2015/16-2019/20).

Status of HSDP development

The development of the HSDP started with the development of the health issues paper which formed the health sector contribution to the NDP II. The health issues paper was developed following a broad consultation with all stakeholders and approvals by the Senior and Top Management of MOH. The elaboration of the HSDP involved further work for the TWGs in detailing out the priority strategies, interventions, indicators and targets for the next five years. Additional consultation will be done at local government levels, with universities, professional bodies, private sector and communities. The HSDP was originally expected to be completed by end of May 2015 and approved by Cabinet by June 2015.

The HSDP drafting team is led by Director Planning and Development MoH. During August 2015 the final draft of HSDP was developed.

2. Objective of the JANS

The overall objective is to improve the quality and relevance of the HSDP. The specific objectives are:

- To make a joint assessment of draft HSDP using the JANS Tool and accompanying guidelines as the guiding framework;
- To present and discuss the analysis of strengths and weaknesses of HSDP with senior policy makers and other stakeholders, and possible courses of action on specific issues.

Specifically the JANS will produce an assessment profile of the strengths and weaknesses along five main categories:

1. Situation Analysis and Programming
2. Process (through which the national plans and strategies have been developed)
3. Costs and budget framework for the Strategy
4. Implementation and Management
5. Monitoring, Evaluation and Review

3. Approach to conducting the JANS

JANS Team responsibilities and tasks

1) Prior to the mission, the JANS team will conduct a desk review of the draft HSDP and relevant documents such as Uganda Vision 2040, National Development Plan II, Second National Health Policy, priority programme Strategies; MTR of HSSIP; Annual Health Sector Performance Reports, GFATM and GAVI reports, programme specific reports, report on process of developing the HSDP, Health Financing Strategy, National Health Accounts, Uganda Health Systems Assessment Report 2011, MDG Report 2013, Client Satisfaction Survey Reports, Compact for the HSSIP, Civil Society Shadow report, IHP+ Score Card 2014, Parliamentary Committee Reports, Auditor General's reports, Previous JANS Report, etc.
2) To agree on a preliminary set of key issues to be discussed in greater depth during the in-country mission
3) When in country, to conduct interviews with key informants, including some at district level
4) To produce a profile of the strengths and weaknesses of draft HSDP
5) To discuss findings with stakeholders in Uganda, and subsequent actions

JANS Team reporting arrangements

The team leader of the JANS team in collaboration with the whole team will prepare a report. The report will be presented to stakeholders for validation and consensus. The final report will be shared with the MOH and IHP+ Secretariat.

4. Programme of work for the JANS

1) Meet MoH Top Management
2) Review documents (3 days)
3) Adopt the tools and conducting the assessment (4 days)

4) Stakeholder engagement and possible field visits (4 days)
5) Feedback session (core team and other key stakeholders SMC + HPAC) (1 day)
6) Debrief with Top Management
7) Drafting the report within 5 days from the end of the mission
8) Present the report to the HSDP Task Force
9) Finalizing the JANS report following comments

Annex 2 Schedule of the JANS team

JANS PROGRAM

DATES: 7th – 16th SEPTEMBER, 2015

JANS TEAM WORKSTATION: OFFICE OF THE DIRECTOR HEALTH SERVICES (PLANNING & DEVELOPMENT)

Date	Time	Activity	Location	Participants
Monday 7th Sept, 2015	09:00 – 11:00	Meeting of JANS Team with Top Management Committee and the JANS Steering Committee: • Introduction (CHS-P) • Program and ToRs for the JANS • Purpose, Value of the JANS and Sector benefits from the JANS (JANS Team Leader) • Highlights of the JANS Tool (JANS TL) • Question & Answer Session (Moderated by DHS P&D)	3rd Floor Board-room	Timothy Musila, Head, PPP Henry Mwebesa, DHS P&D Sarah Byakika Comm. Pl. Tom Aliti Ass. Comm. Pl. Peter Okwero, WB Peter Ogwang Ogwal, WB Filippo Curtale, BTC Team
	11:00 – 13:00	JANS Team commences work	Office of the DHS P&D	
	13:00 – 14:00	Lunch		
	14:30 – 15:45	Presentation of HSDP	Office of the DHS P&D	Tom Aliti Timothy Musila Sarah Byakika Team
	16:00 – 17:00	Meeting with WR WHO Uganda Office	WHO	Wondimagegnehu Alemu, WR Grace Kabaniha, WHO MO, SZ, FT, ES
	16:00 – 17:00	Meeting with the World Bank	WB	Peter Okwero MD
Tuesday 8th Sept, 2015	08:30 – 09:00	Presentation of HSDP (continued)	Office of the DHS P&D	Tom Aliti, Timothy Musila, Sarah Byakika Team
	09:00 – 09:45	Meeting with PS	Office of the PS	Dr. Lukwago Asuman Team Timothy Musila, Tom Aliti
	10:00 – 12:00	Meeting with WHO	WHO	Grace Kabaniha Julius Mukobe MD
	10:00 – 10:45	Social Protection Unit, Ministry of Gender	Ministry of Gender	Stephen Kasaija, Head, Social Prot. Secretariat David Lambat Tumwesigye, Pol & Adv. Adviser Lydia Nabingo, Pol. & Adv. Off. Zephania Ogen, M&E/MIS Expeditus Ahimbisibwe, MoH

Date	Time	Activity	Location	Participants
				FT, SZ, MO, ES
	11:00 – 12:20	Chair, Health Services Commission	HSC	Prof. Pius Okongo, Chair Timothy Musila FT, SZ, MO, ES
	12:00 – 13:00	Teamwork	Office of the DHS P&D	Team
	13:00 – 14:00	Lunch		Team
	14:30 – 16:30	Meeting with the medical bureaux	Catholic Medical Bureau	Sam Orach, Exec. Secr. UCMB Tonny Tumwesigye, Exec. Dir., UPMB Henry Kasyaba SZ, FT, MO, ES
Wednesday 9th Sept, 2015	10:00 – 11:00	SIDA	Swedish Embassy, 24 Lumumba Avenue	Anne Lindeberg, First Secretary, Health and Social Protection ES
	11:00 – 12:30	National Planning Authority	Planning House	John B. Ssekamatte-Ssebuliba, Head, Population and Social Sector Planning Sarah Nahalamba, Senior Planner, Population, Gender and Social Development Timothy Musila FT, SZ, MO, MD, ES (partly)
	14:30 – 15:45	CSO and School of Public Health, Makerere University	MoH	Sebastian Olikira Baine, Makerere SPH Joshua Wamboga, Exec. Dir., UNASO Aloysius, Makerere SPH Moses Mukulu, Dep. Executive Director, National Health Consumers Organisation Lena, Reproductive Health Uganda Team
	16:00 – 17:45	Belgian Technical Cooperation	BTC, Lower Kololo Terrace	Sam Vanhuytsel, Embassy of Belgium Filippo Curtale, BTC, Health Sector Adviser Gauthier de Woelmont Wouter Cools Team

Date	Time	Activity	Location	Participants
Thursday 10th Sept, 2015	08:00 – 17:00	Field visit by JANS Team to Jinja District LG and Jinja RRH		JANS Team Expeditus Ahimbisibwe, MoH Dyogo Mamtamu, DHO Sheila, HMIS M&E Sophie Namasopo-Oleja, Hospital Director
Friday 11th Sept, 2015	08:00 – 08:30	Human Resource Department	MoH	FT
	08:30 – 09:30	Meeting on resource allocation	MoH	Tom Aliti, FT (MD)
	08:30 – 09:00	Meet UN Organizations UNFPA, Unicef	WHO	Grace Kabaniha, WHO Juliet Bataringaya, WHO Modibo Kassogue, UNFPA MO, SZ, ES
	08:30 – 09:30	Meeting with WHO on financing		MD
	09:30 – 11:00	Preliminary JANS report to MOH TMC/SMC	3rd Floor Board-room	Timothy Musila Sarah Byakika Alex Opio Ronard Ssegawa Catherine Betty Odeke Winyi Kaboyo Filippo Curtale Team
	11:00 – 12:00	Meeting of the Task Team on the GFF/RMNCAH investment case and proposal drafting. Presentation by Dr. Mikael Ostergren, WHO	3rd Floor Board-room	Timothy Musila Sara Biyakika Jessica Nsungwa Team
	16:30 – 18:00	MOFPED and MoH	MoH	Juliet Kyokuhaire, Principal Economist, Health Sector, MOFPED John Musingusi, Head, Procurement and Disposal, MoH MD
	15:00 – 16:00	Prime Minister's Office	PMO	Maureen Bakunda Team
	16:00 – 17:00	Procurement	MoH	FT, MD
	18:00 – 20:00	Team meeting	Sheraton	Team
Sat. 12th Sept, 2015		Report writing		
Sunday 13th Sept, 2015		Report writing		
Monday 14th Sept, 2015	08:00 – 08:45	Meeting with Dr. Jimmy Opigo (Chair, DHOs)	MOH	Team
	09:00 – 10:00	World Bank	WB	Paul Kamuchwezi, Senior Fin. Mngmt Specialist

Date	Time	Activity	Location	Participants
				MD
	09:00 -	Prepare draft JANS Report	Office of the DHS P&D	Team
Tuesday15th Sept, 2015	10:00 – 11:00	Feedback session by JANS Team to Top Management Committee on the draft JANS report	3rd Floor Board-room	SZ, ES
	11:00 – 13:00	Feedback session by JANS Team to HDPs	WHO Board-room	SZ, ES
	14:00 -	Prepare draft JANS Report		SZ, ES
Wednesday 16th Sept, 2015	09:30 - 12:30	Presentation of draft JANS report and recommendations by the JANS Team to Health Policy Advisory Committee (HPAC)	3rd Floor Board-room	SZ, ES

Abbreviations of the names of the JANS Team Members:
MD: Maxwell Dapaah
MO: Mikael Ostergren
SZ: Saman Zamani
FT: Frank Terwindt
ES: Esben Sonderstrup

Annex 3 Suggestions for reformatting chapter 3 of the HSDP

Suggestions for reformatting chapter 3 of the HSDP

Chapter 3 of the HSDP is provides the main content of the plan. As presented now, it does not convincingly "tell or sell" the case. The overall strategic directions and logical framework are drowned in a mix of interventions, which are somewhat overlapping and include different level concepts from routine activities to capital investments. The chapter uses a lot of expressions liberally, without attaching a well-defined meaning to them: Flagship projects, programs, domain areas, program areas, strategic directions, strategic focus and priority interventions, etc. Without changing the main content of the plan, but to make it flow more logically and keeping it at a strategic level, the following options for re-structuring the chapters may be considered:

3.1: Keep as is

3.2.1: It is hard to see what constitutes innovations in the sub-chapter. Many of the listed approaches seem to be more strategic directions or approaches, i.e. life course approach, quality of care. It is suggested that this section be taken out – if there is content not already mentioned in other places of the strategy it should be placed under appropriate sections. For instance, increased focus on determinants of health is also a "domain area" under 3.3 and so on.

3.2.2 This section is making the economic argument for investing in health rather than being an investment case. Could that be included in the introduction?

3.2.3 It is suggested that the number of flagship projects be reduced – many are repeated in other parts of the document. Further, many are routine activities and not really flagships. It is suggested that this part be annexed and/or a few flagships be mentioned at the end of relevant outcome areas under 3.3.

3.3 Health outcomes and targets: It is suggested that the overall health sector targets from the NDPII section 13.1.2 be included and mentioned in the beginning:

- Increase life expectancy at birth from 54 to 60 years
- Reduce child stunting of U5s from 31 to 25
- Reduce TFR from 6.2 to 4.5
- Reduce IMR from 54 to 44
- Reduce MMR from 438 to 320

The "domain areas" may provide good headings for the subsequent subsections, except "essential clinical, rehabilitative and palliative care", which seems to be a repetition of the priority interventions under 3.4.2 Service delivery systems. It is suggested to replace "Domain Area" with "Thematic Area".

3.3.1-5: the so-called "Strategic directions" seem more to be outcomes – consider changing name to "Outcomes". Consider changing the structure of these subsections as follows (Health Promotion across the life course as an example):

Thematic Area 1: Health promotion across the life course		
Outcome 1: By 2020, the health sector will have reduced preventable mortality and morbidity specifically for mothers, new-borns, children, adolescents, adults and elderly persons.		
Indicators	**Baseline**	**Target**
ANC visits		
Immunization coverage		
Skilled birth attendance		
Etc		

The total list of outcomes will be:

Outcome 1: By 2020, the health sector will have reduced preventable mortality and morbidity specifically for mothers, new-borns, children, adolescents, adults and elderly persons.
Outcome 2: By 2020, the health sector will have reversed the rising burden of NCDs.
Outcome 3: By 2020, the health sector to reduce the burden of communicable disease conditions with the highest impact (morbidity and mortality).
Outcome 4: By 2020, the health sector will have attained universal access to key social determinants of health[2].

This procedure will involve a discussion for each outcome on which performance measures (indicators?) are so important that they should be incorporated in the above matrix. They will subsequently be part of the M&E framework, and therefore there should not be too many.

Many of the priority interventions may be translated coverage indicators and targets as above and will therefore in essence remain in the matrix. The full list of priority interventions may go into an annex.

Section 3.4: This section covers basically the health systems interventions or investments needed to achieve the overall health sector goals and outcomes as listed under 3.3.1-5.This should be mentioned as in introduction. It is suggested to keep the tables. Like in 3.3 it is suggested to replace "Strategic direction" with "Outcome". It may be useful to review and reduce the number of priority investments and keep them at a strategic level. For example, establishment of CHEW program is obviously an investment whereas training of health managers is an activity.

[2] You cannot attain SDHs. Suggest to reformulate: By 2020, the health sector will have effectively addressed key social determinants of health

Health system area 1: Appropriate governance and partnership					
Outcome HSA1: By 2020, the health sector intends to have comprehensive governance and partnerships from community to national levels, ensuring appropriate voice, accountability, rule of law, control of corruption and involvement of stakeholders is effectively practiced and the health sector is globally recognized for excellence					
Programs / service areas	**Priority interventions**	**Measures of success**			
		Milestone	**Baseline**	**Midterm target**	**End term target**

Etc…

Annex 4 List of Documents Consulted

Author & Date	Title of the document
MoH, January 2013	Guidelines for Governance and Management Structures
HSC	The Health Service Commission (pamphlet)
MOH, April 2006	Human Resources for Health Policy
MOH, June 2007	Uganda Human Resources for Health Strategic Plan 2005-2020
J. C. Oonyu, Sep 2007	A Review of the In-Service Training Strategy of the MOH Uganda
MOH, July 2012	Human Resources for Health Training and Development Policy (final editorial draft)
MOH, 2009	The Uganda Human Resources for Health Strategic Plan 2005-2009, supplement
	Human Resources for Health Strategies for 2015-2020 (draft)
MoH June 2007	Uganda Human Resources for Health Strategic Plan 2005-2020: Responding to Health Sector Strategic Plan and Operationalising the HRH Policy
MoH, 2012	Uganda National Health Accounts
2015/16	National Budget Framework Paper
2015/16	Budget Call Circular
2015	Uganda Public Finance Management Act, (revised)
2010	Fiscal Space for Uganda Health, Series No. 10
MoH, July 2015	Health Financing Strategy
GoU	Vision 2040
GoU, March 2015	Second National Development Plan 2015/16 – 2019/20
IEG, April 2015	Joint Evaluation of Budget Support to Uganda
MoH	Annual Health Sector Performance Report for Financial Year 2013/14
MoH	Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda
MoH, Nov. 2013	A Promise Renewed: RMNCH Sharpened Plan for Uganda
WHO and WB	Business Plan for Global Financing Facility
The Lancet 11 July 15	The Global Financing Facility: Country investments for every woman, adolescent and child
MOGLSP July 2015	Draft Social Protection Policy
MoH	Midterm Review Report of the HSDP 2010/11-2014/15, Volume I and II