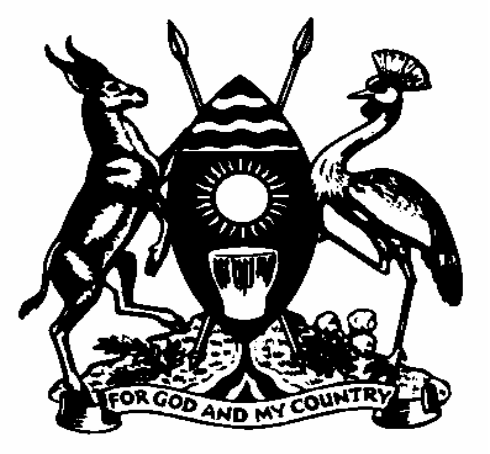

THE REPUBLIC OF UGANDA

Ministry of Health

Health Sector Strategic Plan II
2005/06 – 2009/2010

Volume I

Foreword

Table of Contents

Acronyms

ABC	Abstinence, Be faithful, Condom use
ACT	Artemesinin-based Combination Therapy
AHSPR	Annual Health Sector Performance Report
ANC	Ante Natal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BEmOC	Basic Emergency Obstetric Care
BFP	Budget Framework Paper
CB-DOTS	Community based Directly Observed Treatment, Short Course
CBHI	Community based Health Insurance
CDTI	Community Directed Ivermectin Distribution
CEmOC	Comprehensive Emergency Obstetric Care
CFR	Case Fatality Rate
CME	Continuing Medical Education
CSO	Civil Society Organizations
CYP	Couple Years of Protection
DDHS	District Director of Health Services
DHT	District Health Team
DOTS	Directly Observed Treatment, Short Course
ECN	Enrolled Comprehensive Nurse
EMHS	Essential Medicines and Health Supplies
EmOC	Emergency Obstetric Care
EPI	Expanded Programme for Immunization
FGM	Female Genital Mutilation
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender based Violence
GFATM	Global Fund to fight AIDS, TB and Malaria
GNP	Gross National Product
GoU	Government of Uganda
HC	Health Centre
HDP	Health Development Partners
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRH	Human Resource for Health
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IDP	Internally Displaced Persons
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
IST	In-service Training Strategy
ITN	Insecticide Treated Nets
JLOS	Justice, Law and Order Sector
JRM	Joint Review Mission
KDS	Kampala Declaration on Sanitation
LLU	Lower Level Unit
LTEF	Long Term Expenditure Framework

MAAIF	Ministry of Agriculture, Animal Industries and Fisheries
MAP	Multicountry AIDS Project
MDA	Mass Drug Administration
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNT	Maternal and Neonatal Tetanus
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NCD	Non Communicable Diseases
NCRL	Natural Chemotherapeutics Research Laboratory
NDA	National Drug Authority
NGO	Non Government Organization
NHA	National Health Assembly
NHP	National Health Policy
NHS	National Health System
NIDs	National Immunization Days
NMS	National Medical Stores
OHS	Occupational Health Services
OPD	Outpatient Department
OPV	Oral Polio Vaccine
PEAP	Poverty Eradication Action Plan
PEPFAR	President's (Bush) Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHC-CG	Primary Health Care Conditional Grant
PHP	Private Health Practitioners
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not-For-Profit
PPPH	Public Private Partnership for Health
PWD	People with Disability
QA	Quality Assurance
SHI	Social Health Insurance
SOP	Standard Operating Procedures
SOS	Sustainable Outreach Services
SRH	Sexual and Reproductive Health and Rights
SWAp	Sector-Wide Approach
TCMP	Traditional and Complementary Medicine Practitioners
TFR	Total Fertility Rate
TT	Tetanus Toxoid
U5MR	Under-5 Mortality Rate
UBTS	Uganda Blood Transfusion Services
UDHS	Uganda Demographic and Health Survey
UNHCO	Uganda National Health Consumers Organization
UNHRO	Uganda National Health Research Organization
UNMHCP	Uganda National Minimum Health Care Package
UVRI	Uganda Virus Research Institute
VACS	Vitamin A Capsule Supplementation
VCT	Voluntary Counseling and Testing
VHT	Village Health Team

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Executive Summary

Uganda has been consistent in its pursuit of poverty eradication as the overriding priority for national socioeconomic development. The overall goal of the government is to reduce absolute poverty to less than 10% of the population by 2017. The country has experienced strong economic growth averaging 6.5% per annum since 1991/92, with inflation at an annual average of 4.8%. However, the percentage of the population living below the poverty line has risen slightly to 38% in 2003

The Government of Uganda has reaffirmed its commitment to achieving the Millennium Development Goals (MDGs) which show extensive overlap with National Poverty Eradication Action Plan (PEAP). Successive Participatory Poverty Assessment reports have identified ill-health as a leading cause of poverty in Uganda. Health therefore, continues to be an important element of the Human Development Pillar of the PEAP.

Achievements and Challenges of Health Sector Strategic Plan I 2000/01 – 2004/05

The National Health Policy provided strategic direction for implementation of HSSP I through a Sector Wide Approach (SWAp). Within this period, there was a significant shift towards PHC backed by reallocation of resources in favour of lower levels of care. Health services delivery was decentralized to districts and further to Health Sub-Districts. The health SWAp resulted in a modest growth in the health resource envelope, as well as an important shift in the pattern of financing the sector, with an increasing proportion of external funding being in the form of budget support. Deliberate efforts were made to make available essential health system inputs and in particular drugs, vaccines, human resource, medical equipment and health infrastructure.

Many of the HSSP I output targets were achieved and in some cases surpassed. User-charges were abolished in 2001 in all government health facilities except for private wings in hospitals. The combination of improved physical access, improved quality of care and removal of the major financial barrier for the poor have resulted in a dramatic rise in utilization of public sector and PNFP services. Significant gains were realized in many of the priority programmes notably, the Expanded Programme on Immunization, Coverage for DPT 3 rose to 83% in 2003/04 compared to 55% pre HSSP I. No new case of polio has been reported over the period under review and only 4 deaths from measles were reported in the first half of 2004.

Additional proven and cost-effective interventions for the prevention and control of Malaria were introduced including home based management of fever (HBMF), intermittent preventive treatment in pregnancy (IPT), and vigorous marketing and distribution of insecticide treated bed-nets (ITNs). The HIV/AIDS epidemic continued to be contained effectively, with the national indicator of seroprevalence in pregnant women stabilized around 6.2% against the 2005 national target of 5%. Programmes for the prevention of mother to child transmission (PMTCT), Voluntary Counseling and Testing (VCT) and antiretroviral therapy (ART) were successfully introduced and/or expanded.

Efforts were renewed to address other infectious diseases of public health importance such as Lymphatic Filariasis, Onchocerciasis, Sleeping Sickness, Schistosomiasis and Soil Transmitted Helminths.

The near universal first attendance at antenatal clinic has continued, but this was not matched by improvement in access to Emergency Obstetric Care. Consequently, the maternal and neonatal mortality reduction targets have only shown marginal improvement.

The achievements were made in spite of severe constraints of under-funding, continuing inadequacies in the production, recruitment and deployment of trained personnel, frequent stock outs of essential medicines, and lack of equipment for operationalising the new health centres. The mismatch between the construction of HC IIs countrywide and the speed at which resources were made available for their operationalisation severely limited the planned inequity reduction targets. The establishment of the Village Health Teams has been slow and not well coordinated and the linkage with the formal health system and the community remains weak. Furthermore, continuing insecurity in the North and North East impacted negatively on effective health service delivery in the affected areas.

Health Sector Strategic Plan II 2005/06 – 2009/10

HSSP II represents a consolidation and extension of the achievements of HSSP I. HSSP II has been developed through an intensive and iterative process that involved all key stakeholders in health development in Uganda. The elements of the UNMHCP have been restructured to illustrate more clearly, how the various clusters will contribute to the HSSP II key programme outputs, as well as fostering improved operational coordination and integration.

The overall development and programme goals remain as for HSSP I and are to be attained through universal delivery of the Uganda National Minimum Health Care Package.

The overriding priority of HSSP II will be the fulfillment of the health sector's contribution to the PEAP and MDG goals of reducing fertility; malnutrition; maternal and child mortality; to reducing the burden of HIV/AIDS, Tuberculosis and Malaria; and to reducing disparities in health outcomes among the lowest and highest income quintiles by at least 10% over the HSSP II period.

HSSP II key output targets by 2009/10

- Percentage of children <1yr receiving 3 doses of DPT/Pentavalent vaccine according to schedule from 87% to 93%
- Percentage of households with at least one Insecticide Treated Net (ITN) from the estimated 23.5% (in rural areas) to 72%
- Precentage of households with a pit latrine fom 60.2% to 80%
- Total (GoU and PNFP) per capita OPD utilization from 0.72 to 1.0
- Percentage of deliveries taking place in a health facility (GoU and NGO) from 24.4% to 50%
- Proportion of approved posts (HSSP I norms) that are filled by trained health personnel from 68% to 90%
- Percentage of health facilities without any stockouts of first line antimalarial drugs, Fansidar, measles vaccine, Depo Provera, ORS and cotrimoxazole from 40% to 100%
- Couple Years of Protection from 223,686 to 494,908
- Reduce the Case Fatality Rate among malaria inpatients aged less than 5 years from 4% to 2%
- Proportion of TB cases that are cured from 62% to 85%

Base year 2003/04

Priority will be given to accelerating the operationalisation of the Health Sub-Districts including the Village Health Team component so as to achieve more effective and equitable delivery of the selected sets of cost-effective interventions, and to strengthening management capacity at all levels.

While the PEAP 2004 recognizes that improving health outcomes "will be the achievement of several sectors", the central role of the health sector in this has not been lost sight of. Harnessing the contribution of the health related sectors is an important stewardship function of the MoH and DDHS Offices.

The Uganda National Minimum Health Care Package

The elements of the UNMHCP have been regrouped in 4 clusters so as to foster increased coordination in planning, budgeting and implementation. These are: Cluster 1 - Health Promotion, Disease Prevention and Community Health Initiatives, Cluster 2 - Maternal and Child Health; Cluster 3 - Control of Communicable Diseases and Cluster 4 - Control of Non-Communicable Diseases/Conditions.

The HSSP II building on the approaches and lessons learnt from the HSSP I focuses on health promotion and prevention, including the provision of basic curative services. The HSSP II emphasizes the role of communities/households and individuals ownership for health and health services.

Integrated Support Systems for Delivery of the Minimum Package

HSSP II defines the planned investments for achieving an optimal balance for scaling up the priority interventions within the available resource envelope. Achieving this delicate balance is perhaps the greatest challenge of HSSP II. The areas for special focus for integrated support systems will be Hunan Resources for Health, Health Infrastructure Development and Management, and Essential Medicines and Health Supplies.

Financing the HSSP II

The key constraint for the sector remains under funding - with only 30% of HSSP I funded. Attempts have been made to mobilize additional funds for the sector but these have been constrained by macroeconomic concerns and the rigid sector ceilings. The funding requirements for HSSP II, resources likely to be available, the process of prioritization given limited resources and strategies to close the financial gap are highlighted.

The inputs required for the delivery of health services and hence the Minimum Health Care Package at every level of National Health System that would most likely result in maximum progress towards achievement of the PEAP and MDG targets were identified, quantified and then costed. When the resultant costing is compared to the resources available in the current Medium Term Expenditure Framework (MTEF), there is a big resource gap to finance the requirements of the HSSP II. Based on the current financial projections in the MTEF, a Short – Medium Term costing scenario is therefore proposed. This costing scales down the inputs to be more in line with the MTEF. In scaling down the cost of the HSSP II from what is really required to what is likely to be available, priority focus is on interventions that will ensure maximum impact on maternal and child health, with particular emphasis on scaling up these priority interventions that were initiated in HSSP I.

It is important to note that if no additional resources are found, the health sector will not achieve the targets and goals outlined in the HSSP II. The targets will therefore be reviewed annually in line with the Budget Framework Papers (BFP).

Implementation of Health Sector Strategic Plan II

During the implementation of the HSSP II, emphasis will be put on making sure that the different levels carry out their mandated functions. A major focus of the HSSP II will be to scale up interventions initiated in the HSSP I both in terms of geographical and functional coverage. The poor, children, women, the elderly, orphans, displaced persons (refugees and internally displaced), nomads, and people living in areas with insecurity will be specially targeted. Special programmes will be implemented for the areas affected by insecurity and for Karamoja.

Supervision for the Implementation of the HSSP II

Under HSSP II regular and appropriate supervision of the different entities of the health sector will be provided. The supervision framework includes the following components:

- Supervision and Monitoring to and by local governments;
- Supervision and Monitoring of Hospitals and lower level health units by technical health workers;
- Supervision of central programmes within MoH and other central institutions;

Monitoring Framework for the HSSP II

The HSSP II like the HSSP I will be implemented through the Sector-Wide Approach (SWAps). The same structures used under the HSSP I will continue to be used, namely: the Memorandum of Understanding, the Joint Review Missions (JRM), National Health Assembly (NHA) and the Health Policy Advisory Committee (HPAC). The HSSP II has been developed in the context of the Millennium Development Goals and the Poverty Eradication Plan. As such the indicators in the HSSPII will be closely aligned with the MDGs and PEAP Monitoring Framework. In the same manner the targets set will reflect the global and national targets.

CHAPTER 1 INTRODUCTION

1.1 Background

Uganda has remained consistent in its pursuit of poverty eradication as the overriding priority for national socioeconomic development. The overall goal of Government is to reduce absolute poverty to less than 10% of the population by 2017 (PEAP 2004).

Uganda has registered significant progress in reorganizing and stabilizing its economy, improving economic growth and reducing poverty. Uganda has experienced strong economic growth averaging 6.5% per annum since 1991/92. Inflation fell from 150% per annum in 1985/86 to an annual average of 4.8% over the past decade. However the percentage of the population living below the poverty line, which had been on the decline from 52% in 1992/93 to 44% in 1997/98 and to 35% in 2000, has risen slightly to 38% in 2003[1]. This has been accompanied by a marked increase in inequality, which has been on the rise since 1997. Poverty continues to be higher in the rural areas, with 96% of the poor living in rural areas in 2000[2]. However the recent rise in poverty levels revealed a proportionate rise in poverty higher in urban areas than in rural areas[3] (MoFPED, 2003) Regional disparities still exist with the Northern region lagging behind most of the country followed by the Eastern region[4]. The revised Poverty Eradication Action Plan (PEAP 2004) has therefore been designed to address these challenges and to consolidate and extend the achievements that have been made in human development.

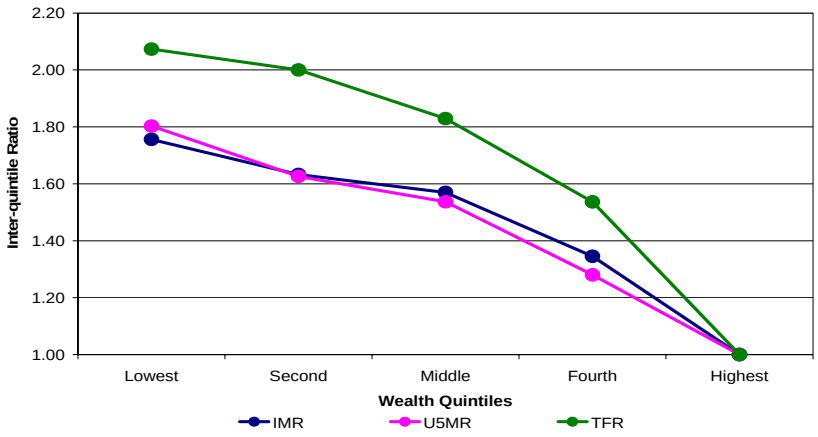
In the PEAP 2004, the Government of Uganda reaffirmed its commitment to achieving the Millennium Development Goals (MDGs). The MDGs show extensive overlap with PEAP, and therefore seen as being "fully consistent with Uganda's national priorities". The PEAP however, recognizes that "the relative speed at which any particular target (of the MDGs) is approached will reflect the particular constraints and trade-offs that the country faces". With successive Participatory Poverty Assessment reports having identified ill-health as the leading cause and consequence of poverty in Uganda, health continues to be an important element of the Human Development Pillar of the PEAP, with "priority on preventive health care and commodities for basic curative care". The presence of good health is necessary not just to improve the quality of life of an individual in terms of his/her general well-being, but is an essential input for raising the ability of people to increase their incomes at a micro level, thereby contributing to poverty alleviation, and to facilitate a productive and growing economy at the macro level. The PEAP also emphasizes the need to enhance deliberate efforts regarding the national development process, to consciously target and benefit both women and men and to focus on the poor and vulnerable groups of the population. Evidence on the link between gender (the socio-economic aspects of being male or female) and poverty and its relevance to health status and access to healthcare, calls for adoption of a gender mainstreaming strategy to address the gender issues in the sector.

The population of Uganda is estimated at 27 million persons with an average inter-censual population growth rate of 3.4% between the 1991 and 2002 censuses[5]. This growth rate is one of the highest in the world. Health outcomes for Uganda are poor. The UDHS 2000 recorded the Infant Mortality Rate at 88 deaths per 1,000 live births, Under-five mortality rate at 152

[1] Poverty Eradication Action Plan 2001-2003 and Uganda National Household Survey 2003.
[2] Poverty Status Report 2000
[3] Poverty Eradication Action Plan 2001-2003
[4] Uganda National Household Surveys 1999/00 and 2002/03.
[5] Uganda Bureau of Statistics 2002

deaths per 1,000 live births, Total Fertility Rate of 6.9 and the Maternal Mortality Ratio at 505 deaths per 100,000 live births[6]. There are socioeconomic differences in the health outcomes with the IMR at 60.2 deaths per 1,000 live births for the highest socioeconomic quintile compared to 105.7 deaths per 1,000 for the lowest socioeconomic quintile with an inter-quintile ratio of 1.76. Similarly, the Under 5 mortality rate for the lowest quintile is twice as high as that for the highest quintile. The TFR for the highest quintile is 4.1 births per woman while that for the lowest quintile is 8.5 births per woman. Figure 1.1 shows the inter-quintile ratios for the health outcomes using UDHS 2000 data. Raising the country averages for the health outcomes without specifically targeting the poor is unlikely to improve the situation for many of the disadvantaged groups in the population because the better off have higher capacity to benefit from social services and thus higher rate of improvement in health outcomes without impacting on the health of the poor.

Figure 1.1: Socioeconomic Differences in Health Outcomes, Uganda 2000[7]



Health outcomes showed little or no progress in the 1990s, while some outcomes actually worsened (Table 1.1). A UDHS is due in 2005 and will hopefully show that the HSSP has reversed these trends. The stagnation of health outcomes in the 1990s is a manifestation of underlying poverty with deprivation not only in nutrition, housing, water/sanitation and education, but also the high burden of communicable and non communication diseases. The HIV/AIDS pandemic that peaked in the early 1990s, has led to far reaching social and economic consequences including a decline in life expectancy

Ccommunicable diseases continue to be the leading cause of morbidity and mortality in Uganda. According to the Uganda Burden of Disease study, over 75% of life years lost due to premature deaths are due to ten preventable diseases[8]. Perinatal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), HIV/AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total disease burden. The common non-communicable diseases include hypertension, diabetes and cancer, mental illness, chronic and degenerative disorders and cardiovascular diseases.

[6] Uganda Demographic and Health Survey 2000/01
[7] World Bank, 2005. Socioeconomic differences in Health, Nutrition and Population. An analysis of Uganda Demographic and Health Survey 2000/01data
[8] National Health Policy 1999

Table 1.1: Trends for the PEAP Health-related Outcomes in the PEAP 1990 - 2000

Indicator	1990	1995	2000	PEAP Target (by 2005)	MDG Target (by 2015)
IMR (deaths/1,000 live births)	122	81	88	68	Reduce IMR by 2/3 i.e. to 41 deaths per 1,000 live births
Under 5 MR (deaths/1,000 live births)	180	147	152	103	Reduce U5MR by 2/3 i.e. to 60 per 1,000 live births
MMR(deaths/100, 000 live births)	527	506	505	354	Reduce by ¾ i.e. to 131 per 100,000 live births
Stunting (Chronic Malnutrition)	38	38	38.5	28	Reduce people suffering from hunger by ½ i.e. to 19%

1.2 Achievements and Challenges of Health Sector Strategic Plan I 2000/01 – 2004/05

i) HSSP I signified the beginning of implementation of major health reforms initiated in the late 1990s. The National Health Policy provided strategic direction for implementation through a Sector Wide Approach (SWAp). There was an articulated shift towards PHC backed by reallocation of resources in favour of lower levels of care. Health services delivery was decentralized to districts and further to Health Sub-Districts. This served to bring services closer to the people and also allowed for their increased involvement in definition of priorities and participation in the management of health services. Sector and programme policies and guidelines were drawn up to support health systems strengthening and extensive capacity building in planning and management at various levels. HSSP I laid the foundation for health development by institutionalizing structures and processes for health systems functionality.

ii) As a result of supply side and demand side reforms, many of the HSSP I output targets were achieved and in some cases surpassed. The health SWAp is maturing and has resulted in a modest growth in the health resource envelope (both Government and external sources), as well as an important shift in the pattern of financing the sector, with an increasing proportion of external funding being in the form of budget support. The trends for the health PEAP indicators during the HSSP I period are shown in Table 1.2.

iii) Deliberate efforts were made to make available essential health system inputs, in particular drugs, vaccines, human resources, medical equipment and health infrastructure. An increased proportion of the non-wage budget was expended on essential medicines and other health supplies at both district and referral hospital levels. Staffing of district level facilities improved, attaining 68% compared to the revised HSSP I target of 52% of established posts filled by trained health personnel. As a consequence, quality of care improved substantially with increased availability of essential medicines and deployment of additional trained staff.

An additional 400 HC IIs were constructed bringing the total to 1,593 including PNFP and PHP facilities; 180 HC IIs were upgraded to HC IIIs; and the new HC IV service tier was introduced to bring life-saving skills nearer to the population. By December 2003, 151 facilities had been built or upgraded to HC IV status, with wards, operating theatres, staff housing and equipment at varying stages of being established. Physical access to primary care services saw significant improvement with 72% of the population being within 5 kilometers

of a health facility, against the end HSSP I (2005) target of 68% and the pre-HSSP baseline of 49%.

Table 1.2: Trends for the Health PEAP Indicators 1999/00 to 2003/04

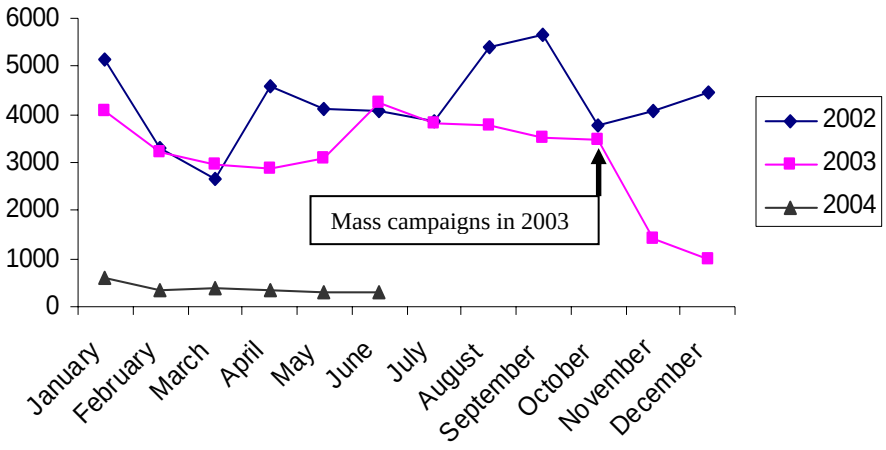
Indicator	Baseline 1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 Target
OPD Utilization	0.40	0.43	0.60	0.72	0.79	0.7
DPT 3/Pentavalent vaccine coverage	41%	48%	63%	84%	83%	85%
Deliveries at Health Facilities – GoU and PNFP	25.2%	22.6%	19%	20.3%	24.4%	35%
Approved Posts filled by Trained Health Workers[9]	33%	40%	42%	66%	68%	52%
National Average HIV Sero–prevalence as captured from ANC Surveillance sites	6.8%	6.1%	6.5%	6.2%	NA	5%

iv) In 2001 user-charges were abolished in all government health facilities except for private wings in hospitals. The combination of improved physical access, improved quality of care and removal of the major financial barrier for the poor have resulted in a dramatic rise in utilization of public sector and PNFP services. New per capita out-patient attendance rate increased from 0.40 (pre-HSSP I) to 0.72 and 0.79 in the 2002/03 and 2003/04 financial years respectively, surpassing the HSSP I 2005 target of 0.7. Several studies carried out by MoH, WHO, World Bank, and analysis on the HMIS and 2003 Household Survey data all give strong indications of higher rate of rise in OPD use by the poorer segments of the population.

v) The Expanded Programme on Immunization (EPI) that had faltered before HSSP I has been fully revitalized. The pentavalent vaccine was successfully introduced, National and sub National Immunization Days were held for polio, measles and tetanus, and the surveillance was strengthened. Coverage for DPT 3 rose to 83% in 2003/04 compared to 55% pre-HSSP I. No new case of polio has been reported over the period under review and total reported cases of measles between January and June 2004 has declined to 1,498 from 11,800 over the same period in 2003. Consequently, only 4 deaths from measles were reported in the first half of 2004 (Figure 1.2).

[9] Excludes Nursing Assistants

Figure 1.2: Reported Measles Cases, Monthly HMIS Reports, Uganda 2002 - 2004



vi) Response to the challenge of malaria has been intensified through active introduction of proven and cost-effective interventions such as home based management of fever (HBMF), intermittent preventive treatment in pregnancy (IPT), and vigorous marketing and distribution of insecticide treated bed-nets (ITNs). Monitoring of the sensitivity of the malaria parasite to first line drugs resulted in the successful introduction of the use of chloroquine and Fansidar as the new first line antimalarial replacing the chloroquine monotherapy.

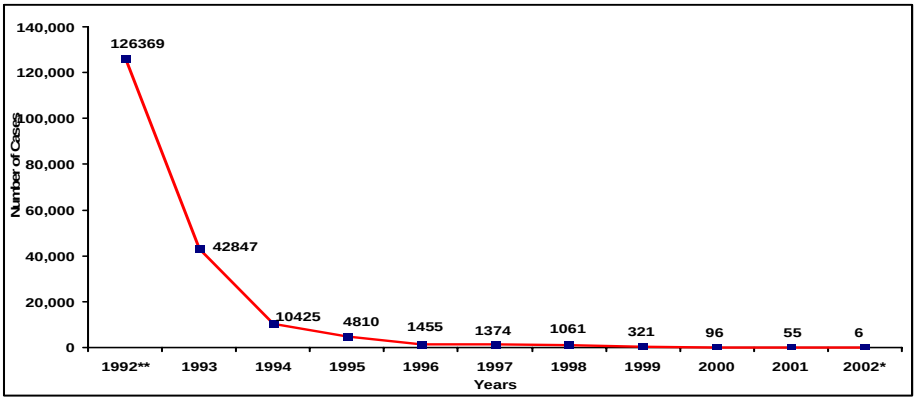
However, lack of consistency in the availability of the current first line drugs including HOMAPAK[10], rapidly emerging resistance to the new first line antimalarials, and low levels of coverage with ITNs continued to hinder achievement of the national level programme indicators. Close drug sensitivity surveillance led to a proposed change in malaria drug treatment policy in 2004 to an Artemesinin-based combination (ACT) as first line treatment regimen.

vii) The HIV/AIDS epidemic continued to be contained effectively, with the national indicator of seroprevalence in pregnant women stabilized around 6.2% over the last four years, against the 2005 national target of 5%. Programmes for the prevention of mother to child transmission (PMTCT), Voluntary Counseling and Testing (VCT) and antiretroviral therapy (ART) were successfully introduced and/or expanded. Challenges include inadequate access to IEC messages and condoms in rural areas, limited coverage of VCT and PMTCT services, and limited access to safe blood, especially in rural areas. There is also limited access to clinical, palliative, and home based care, and voluntary counseling and testing services, as well as inadequate supply of drugs including those for opportunistic infections and ART. In addition, human resource capacity in terms of numbers and skills poses a special challenge.

viii) Significant progress has been made in the diseases targeted for elimination or eradication. The leprosy elimination target of less than one case per 10,000 population was achieved. The Guinea worm eradication programme has had zero indigenous cases since the start of the HSSP I and only one imported case from Sudan was registered in 2003/04. The target for non-polio Acute Flaccid Paralysis rate of 1.0 per 100,000 population has been achieved. Cross border surveillance systems have been established. There are renewed efforts to address other infectious diseases of public health importance such as Lymphatic Filariasis, Onchocerciasis, Sleeping Sickness, Schistosomiasis and Soil Transmitted Helminths among others.

[10] Blister packs of chloroquine (CQ) and sulfadoxine/pyrimethamine (SP) for children

Figure 1.3: Number of Reported Cases of Guinea Worm 1992 - 2002



ix) The near universal first attendance at antenatal clinic has continued, although the proportion of women who reach the national target of 4 attendances per pregnancy and deliveries in health facilities has only marginally improved. The recruitment of doctors and midwives for HC IV and HC III, appropriate staff training, regular supply of contraceptives, provision of equipment and ambulances were all aimed at strengthening RH services. Access to basic emergency obstetric care, the main determining factor for improved maternal and neonatal survival remains extremely low at 5.1% nationally, compared to the UN recommended minimum rate of 15% for a country such as Uganda. Only 14% of the 592 facilities surveyed (February/March 2003, June/July 2004) offer emergency obstetric care services (Status of EmOC in Uganda, October 2004). Particularly worrying are the findings that 33.3% of hospitals and 90.1% of HC IVs did not meet the criteria for adequacy of Emergency Obstetric Care (EmOC). Although adolescent pregnancy rate of 31% is among the highest in the region, there are few services dedicated to adolescents.

x) It must however be noted that the sector has had to contend with the major constraints of severe under-funding which has meant continuing inadequacies in the production, recruitment and deployment of trained personnel; frequent stock outs of essential medicines, lack of equipment for operationalising new health centres. Furthermore there has been continuing insecurity in the North and North East; and the inadequate framework for intersectoral collaboration.

xi) The improved physical access to primary care services reported above does not present the full picture of persisting inequity in access, with coverage rates ranging from 7.1% for Kotido to 100% for Kampala. There has been a mismatch between the construction of HC IIs countrywide and the speed at which resources are made available for their operationalization with new facilities remaining closed for lack of staff, basic equipment and drugs. The construction has also been geographically inequitable. The increase in funding for drugs has not been enough to prevent frequent stockouts in health facilities.

xii) Although the revised HSSP I staffing target was achieved, 56 of the 868 GoU & PNFP HC IIs remained totally un-staffed by end 2003 and the remaining 812 HC IIs, 32% were staffed exclusively by Nursing Assistants. There are a number of challenges related to pre-service training that are affecting the quality of training and need urgent attention. These include; critical shortage of tutors, inadequate infrastructure, excessive enrollment of trainees beyond designed capacity and under funding.

xiii) The establishment of the Village Health Teams has been slow and not well coordinated. There are health workers in the community supported by different programmes and the connection between the multiple community health initiatives and HSSP is not always evident. The linkage with the formal health system and the community remains weak.

Based on the premise that over the medium term, malnutrition, perinatal and maternal conditions, malaria, acute respiratory tract infections, diarrhoea, HIV/AIDS and tuberculosis will together continue to account for the overwhelming proportion of disease and premature death in Uganda, HSSP II represents a consolidation and extension of the achievements of HSSP I. Special effort will be made to improve on areas that have not shown similar progress, particularly in mobilizing communities, service providers and decision makers for improved maternal and child survival and in the control of malnutrition.

A sense of optimism is expressed in the Mid Term Review of HSSP I (2003) and the subsequent Annual Health Sector Performance Reports 2002/03 and 2003/04. The Mid Term Review Report concluded that "we are moving in the right direction" and that "implementing the Uganda Health Sector Strategic Plan through a Sector-wide Approach was succeeding, and that with some qualification, the strategies adopted in the HSSP I remain relevant and appropriate". HSSP II will therefore further refocus the sector's priorities so as to achieve the maximum health outcomes that are possible within existing resource constraints.

1.3 Health Sector Strategic Plan II 2005/06 – 2009/10 Development

The Ugandan Constitution (1995), the Local Authorities Act (1997) and the 2001 Local Government Amendment Act, the National Health Policy (NHP 1999) and the National Poverty Eradication Plan (2004) provide the policy basis for Uganda's second Health Sector Strategic Plan (HSSP II).

HSSP II has been developed to provide a common strategic framework for the new plan period covering 1st July 2005 to 30th June 2010; a framework that will guide ALL interventions by ALL parties at ALL levels of the national health system. The scope of the strategic plan is therefore national. As such, achievement of its targets is the collective responsibility of ALL stakeholders and service providers.

Specifically, HSSP II forms the basis for:

a) Developing the long (LTEF) and medium term expenditure frameworks (MTEF) and the annual budget framework paper (BFP) for the health sector
b) Guiding investment by the health development partners, including project support
c) Developing and implementing the respective strategic and operational plans of the departments, divisions and units of the central Ministry of Health, the District and Health Sub-District, Hospitals (including PNFP and related PHP interventions), and Community health action
d) Guiding participation of all stakeholders in health development in Uganda

Process for Developing HSSP II

HSSP II has been developed through an intensive and iterative process that involved all key stakeholders in health development in Uganda. The process commenced in the last quarter of 2003 and completed in 2005. The process was coordinated by a specially constituted Secretariat based in the Health Planning Department of the Ministry of Health and under the direction of the Director General of Health Services. The preparatory work for HSSP II

entailed an intensive process of SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of the past four years by each of the 9 Working Groups: Health Systems, Basic Package, Human Resources, Public Private Partnerships for Health (PPPH), Drugs, Infrastructure, Finance and Procurement, Health Research and Development, and Support and Supervision (including Surveillance, Quality Assurance, Monitoring and Evaluation).

The reviews included examination of the Annual Health Sector Performance Reports, the report of the Midterm Review (2003) of HSSP I, data from the Health Management Information System, various monitoring and supervision reports, special studies undertaken during HSSP I, and detailed discussions within and between the Working Groups. This preparatory work culminated in a joint retreat of all the Working Groups, representatives of health related sectors of Government, Local Authorities, Development Partners, the Private Health Sector, and the civil and other Non-governmental Organizations. The products of the April 2004 Entebbe Joint Retreat provided the material for the initial draft plan.

Successive drafts went through review by the Annual Meeting of District Directors of Health Services (May 2004), the Annual Meeting of Hospital Managers (June 2004), the Health Policy Advisory Committee (HPAC) in June 2004, Senior Management Committee (SMC) of the MoH, the Technical Review Committee (June 29 to July 1 2004), the October 2004 National Health Assembly and Joint Review Mission. The final document is to be approved by Cabinet in by June 2005.

1.4 Conceptual Framework for the Health Sector Strategic Plan II

Compared to HSSP I, the new strategic plan document has been constructed to reflect more clearly, the maxim that **the primary purpose of the National Health System (NHS) is to achieve improved health of the people** (Figure 1.4). The programme objectives (1-4) are seen as the means to achieving the desired health outputs and outcomes but not as an end in themselves. The programme overview has therefore been amended to show that implementing the Uganda National Minimum Health Care Package (UNMHCP) is the main approach for achieving the sector programme goal and development goal. This will be accompanied by a stronger focus on health promotion and disease prevention.

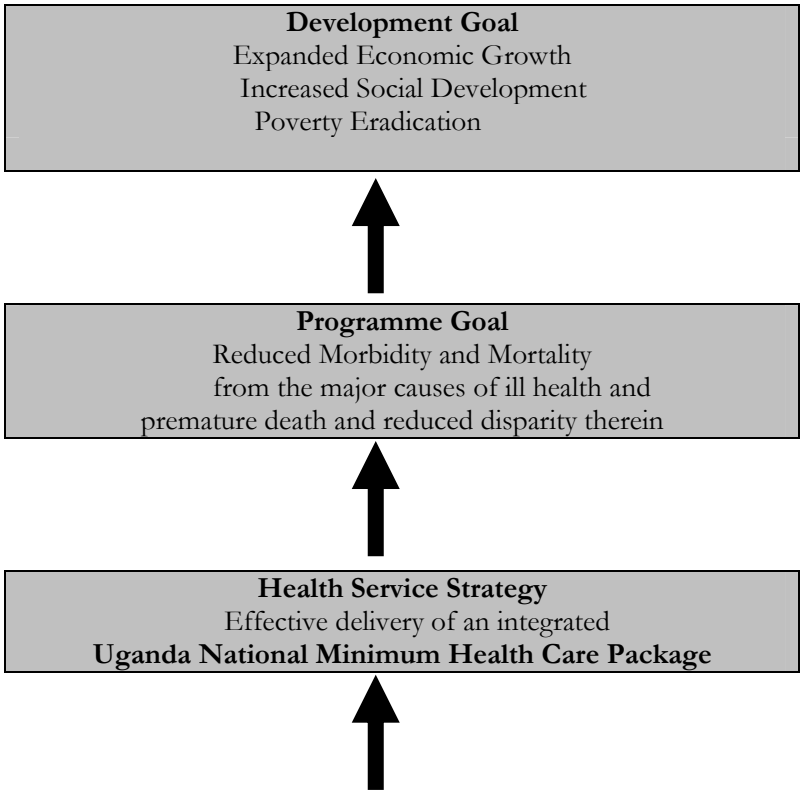
The elements of the UNMHCP have been restructured (see Chapter 3) to illustrate more clearly, how the various clusters will contribute to the HSSP II key programme outputs, as well as fostering improved operational coordination and integration.

1.5 HSSP II Programme and Development Goals

The overall development goal remains *"the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life" (NHP).* The improved human development contributes to increased socioeconomic growth and poverty eradication.

HSSP II also retains the same programme goal as for HSSP I, i.e. "*Reduced morbidity and mortality from the major causes of ill-health and premature death, and reduced disparities therein*" - to be attained through universal delivery of the Uganda National Minimum Health Care Package.

Figure 1.4: Conceptual framework for Health Sector Strategic Plan II



Programme Objective 1	Programme Objective 2	Programme Objective 3	Programme Objective 4
A Health Care Delivery System that is effective, equitable and responsive	To strengthen the Integrated support systems	To reform and enforce the Legal and Regulatory Framework	An Evidence-based Policy, Programme, Planning and Development in place
Components	**Components**	**Components**	**Components**
1. Central level organization and management 2. Decentralized heath care delivery system 3. Public/Private Partnerships in Health 4. Intersectoral action for health 5. Effective Community Participation	1. Human Resources for Health 2. Health Financing 3. Health Infrastructure 4. Essential Medicines and health supplies 5. Diagnostic and Blood transfusion services	1. Health Acts 2. Professional Councils and Associations 3. Private Sector Regulation 4. Traditional and Complementary Medicine Practitioners Regulation	1. Health Policy and Planning 2. Health Management Information System 3. Integrated Disease Surveillance 4. Quality Assurance 5. Support and Supervision 6. Research and Development

1.6 PEAP and HSSP II Health Targets

The overriding priority of HSSP II will be the fulfillment of the health sector's contribution to the PEAP and MDG goals of reducing fertility; malnutrition; maternal and child mortality; and to reducing the burden of HIV/AIDS, Tuberculosis and Malaria, and reduce disparities in health outcomes among the lowest and highest income quintiles by at least 10% over the HSSP II period (Figure 1.1)

Targets for the PEAP (2004) health related outcomes by 2009

The PEAP 2004 presents a development framework for five years up to 2009. The Poverty Monitoring and Evaluation Strategy (PMES) developed in 2001 presents an overarching plan for monitoring and evaluation within the context of the PEAP. The health outcomes presented in Box 1.1 are monitored every five years using the Uganda Demographic and Health Survey. The base year is 2000, with updates expected in 2005 and 2010.

Box 1.1: Targets for the PEAP health related outcomes by 2009

- Reduce Infant Mortality Rate from 88 to 68 per 1,000 live births
- Reduce Under-5 Child Mortality from 152 to 103 per 1,000 live births
- Reduce Maternal Mortality Ratio from 505 to 354 per 100,000 live births
- Reduce Total Fertility Rate from 6.9 to 5.4
- Increase Contraceptive Prevalence Rate from 23% to 40%
- Reduce HIV prevalence at ANC sentinel sites from 6.2% to 5%;
- Reduce stunting in children under 5 years from 38.5% to 28%

Base year 2000

HSSP II key output targets by 2009/10

The HSSP II monitoring framework spans five years 2005/06 – 2009/10. The key indicators relating to disease burden and their targets are highlighted in Box 1.2. These indicators are the health sector contribution to the annual monitoring of the PEAP. The full list of the health sector input, process and output indicators is in Chapter 6 while other indicators relating to monitoring performance at the district level and hospital performance are in Volume II of HSSP II.

Box 1.2: HSSP II key output targets by 2009/10

- Percentage of children <1yr receiving 3 doses of DPT/Pentavalent vaccine according to schedule from 87% to 95%
- Percentage of households with at least one Insecticide Treated Net (ITN) from the estimated 23.5% (in rural areas) to 70%
- Percentage of households with a pit latrine from 60.2% to 80%
- Total (GoU and PNFP) per capita OPD utilization from 0.72 to 1.0
- Percentage of deliveries taking place in a health facility (GoU and NGO) from 24.4% to 50%
- Proportion of approved posts (HSSP I norms) that are filled by trained health personnel from 68% to 90%
- Percentage of health facilities without any stockouts of first line antimalarial drugs, Fansidar, measles vaccine, Depo Provera, ORS and cotrimoxazole from 40% to 100%
- Couple Years of Protection from 223,686 to 494,908
- Reduce the Case Fatality Ratio among malaria inpatients aged less than 5 years from 4% to 2%
- Proportion of TB cases that are cured from 62% to 85%

Base year 2003/04

1.7 HSSP II Strategic Approach

Principles guiding implementation

i) Adopt strategies that would help overcome the key constraints identified in implementing HSSP I, enhance synergies in health interventions and between the various health-related sectors.
ii) Increase the focus on health outcomes in parallel with process and programme outputs
iii) Establish effective affirmative action for the attainment of health equity by giving special attention to the most vulnerable groups (women, children under-5, the poorest quartile of the population, IDPs, Orphans, People with Disability)
iv) Accelerate operationalising the Health Sub-Districts including the Village Health Team component
v) Strengthen management capacity at all levels
vi) Increase spending on essential medicines, vaccines and other health supplies.
vii) Increase efficiency so as to mitigate the effects of the severe resource constraints (financing, human resources, effective physical access, essential medicines, management capacity, etc) that hamper effective performance of the national health system.
viii) Further strengthen the broader health partnerships, especially at the district level, including community participation, intersectoral collaboration and collaboration with the private sector.

ix) Strengthen attention to gender concerns in the Health Sector Strategic Plan (HSSP) to take account of the socio-economic differences between men and women that influence their accessibility and utilization of health services.

1.8 Structure of the Strategic Plan Document

HSSP II is presented in two volumes. Volume I represents the strategic plan and Volume II the detailed annexes. Volume I is structured as follows:

Chapter 1 situates the strategic plan within the context of the overall national development framework, the PEAP, MDGs, the National Health Policy and HSSP I. It recapitulates the policy basis and defines the overriding priorities for the sector over the plan period.

Chapter 2 presents an overview of the National Health System and relates each of the programme outputs to the core functions of the national health system. Only those elements that have not been addressed in other sections of the document are described in Chapter 2.

Chapter 3 details the UNMHCP under operational clusters, with emphasis on the selected strategies and core interventions for HSSP II.

Chapter 4 describes the Integrated Support Systems for delivering the UNMHCP.

Chapter 5 outlines the financing of the plan and related financial management

Chapter 6 depicts the implementation strategy, including monitoring and evaluation of the plan.

CHAPTER 2: THE NATIONAL HEALTH SYSTEM

Background

The National Health System comprises all the institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. The boundaries of Uganda's National Health System encompass the public sector including the health services of the army, police and prisons; the private health delivery system comprising of the private-not-for-profit organizations (PNFP), private health practitioners (PHP), the traditional and complementary medicine practitioners (TCMP); and the communities. The role of government in health service provision will continue to be vital for the foreseeable future, and full integration of the private providers into the NHS will remain an important policy objective. Far reaching restructuring of the National Health System (NHS) was achieved through implementing the National Health Policy (1999) and HSSP I. This chapter describes in detail the functional and organizational setup of the NHS.

2.1 Functions of the National Health System

The core functions of a national health system are:

i) Stewardship of the sector including policy appraisal and development; oversight of health sector activities; assuring quality, health equity and fairness in contribution towards the cost of health care; harnessing the contribution of other health-related sectors; ensuring that the sector is responsive to expectations of the population; and to be accountable for the performance of the wider health sector (in Chapter 2)
ii) Provision of preventive, promotive, curative and rehabilitative services (in Chapter 3)
iii) Policy and Planning, Monitoring and Evaluation (in Chapter 6)
iv) Mobilization of resources including human resources, health infrastructure, medicines and other health supplies, data and information, etc (in Chapter 4 and 5)

The structures and mechanisms established for fulfilling these core functions have been extensively reviewed in the context of the Annual Reports of the Ministry of Health, the formal Midterm Review of HSSP I (2003), the Joint Review Missions and special studies.

Government Stewardship

The Government of Uganda, through the Ministry of Health, has the lead role and responsibility for delivering the outputs of HSSP. Various other partners have defined roles to play and contributions to make. The Ministry of Health initiates policy and coordinates overall sector activities and brings together stakeholders at the central, district and community level. The MoH organizes the annual meeting for District Directors of Health Services, the annual meeting for Hospital Managers and the National Health Assembly, all of which provide fora for detailed consultation with the districts and other major stakeholders. The stewardship function extends to the district level whereby the district leadership is responsible for coordinating all the stakeholders within the district.

The HSSP I Midterm Review recognized the impressive achievements of the MoH in shouldering its leadership and coordinating functions in spite of the heavy workload resulting from the demands of implementing the sector reform programme and the new working arrangements called for by the SWAp partnership. During HSSP II, the separation of its

policy and management functions will be made clearer, and the process of decision-making streamlined further.

2.2 Organisation of the National Health System

The National Health Policy objective for the National Health System is to restructure the organization and management of the Ministry of Health and the District Health System to ensure effective harmony and linkages between the centre and the districts on the one hand and the public and private components on the other. It further calls for the establishment of "a network of functional, efficient and sustainable health infrastructure for effective health care delivery closer to the people". In pursuit of this objective, Government shall:

a) Develop mechanisms to ensure equity in access to basic services for the most life-threatening health problems, particularly to avert pregnancy and birth-related deaths and the childhood killer diseases
b) Build and strengthen the capacity of health facilities to improve health service provision
c) Strengthen and rationally expand the national health infrastructure through a medium term health facility development plan
d) Establish an appropriate and efficiently functioning referral system".

The national standard is to have the following structures in place and functional[11] (Figure 2.1).

i) **Ministry of Health and other National Level Institutions**
ii) **National Referral Hospitals** (27,000,000)
iii) **Regional Referral Hospitals** (2,000,000 population)
iv) **District Health Services** (District level, 500,000 population)
v) **Health Sub-District**
   - Referral Facility — General Hospital (District level - 500,000 pop) or Health Centre IV (County level - 100,000 pop)
   - Health Centre III — (Sub-country level - 20,000 population)
   - Health Centre II — (Parish Level – 5,000 population
   - Health Centre I — (Village Health Team - 1,000 population)

The functions and responsibilities of each level of the delivery system have been defined. Minimum service standards and staffing levels have been set for each tier of service delivery. These will be updated in light of HSSP II orientation.

[11] This is in reference to the public and PNFP health infrastructure.

Figure 2.1: The National Health System

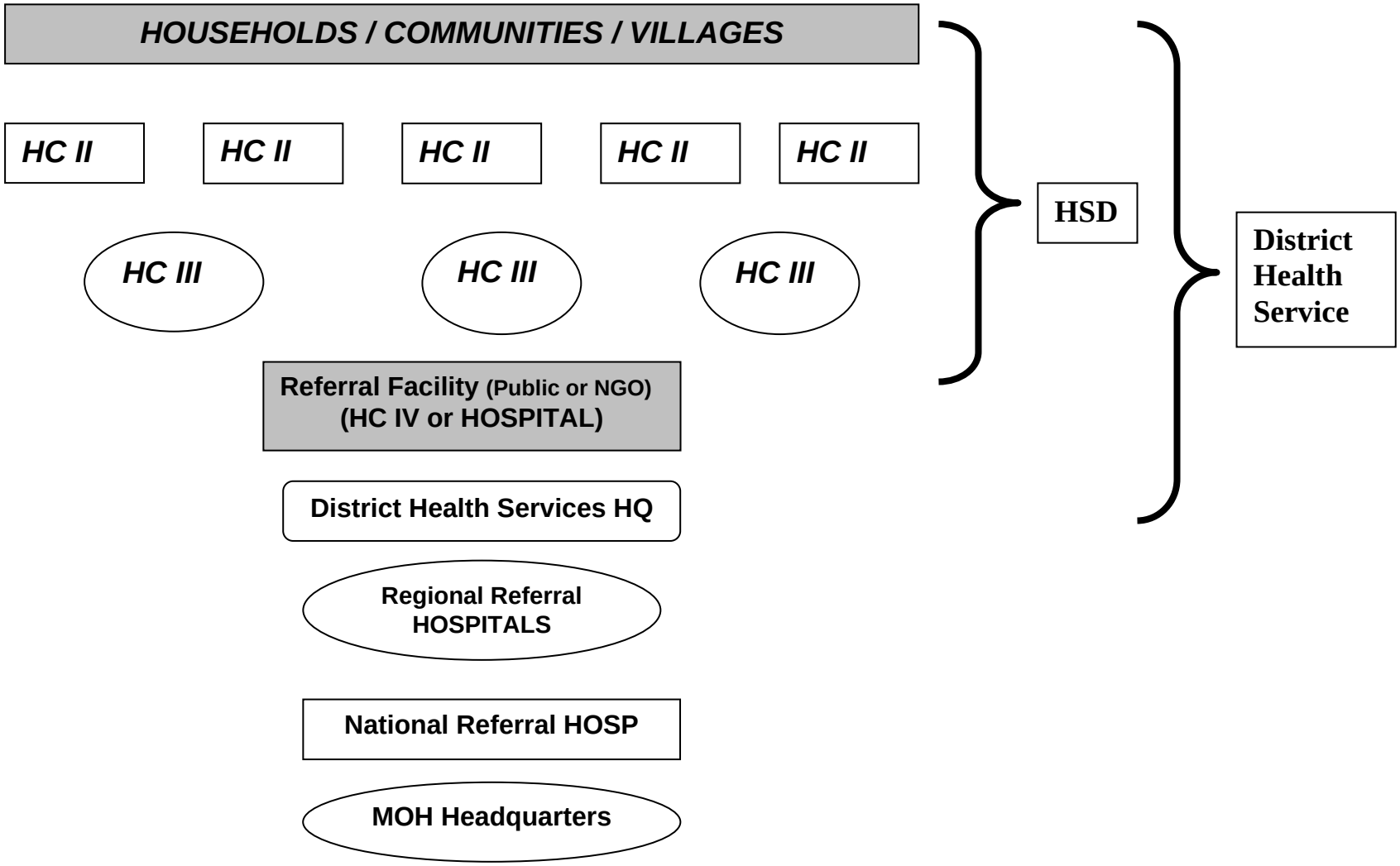
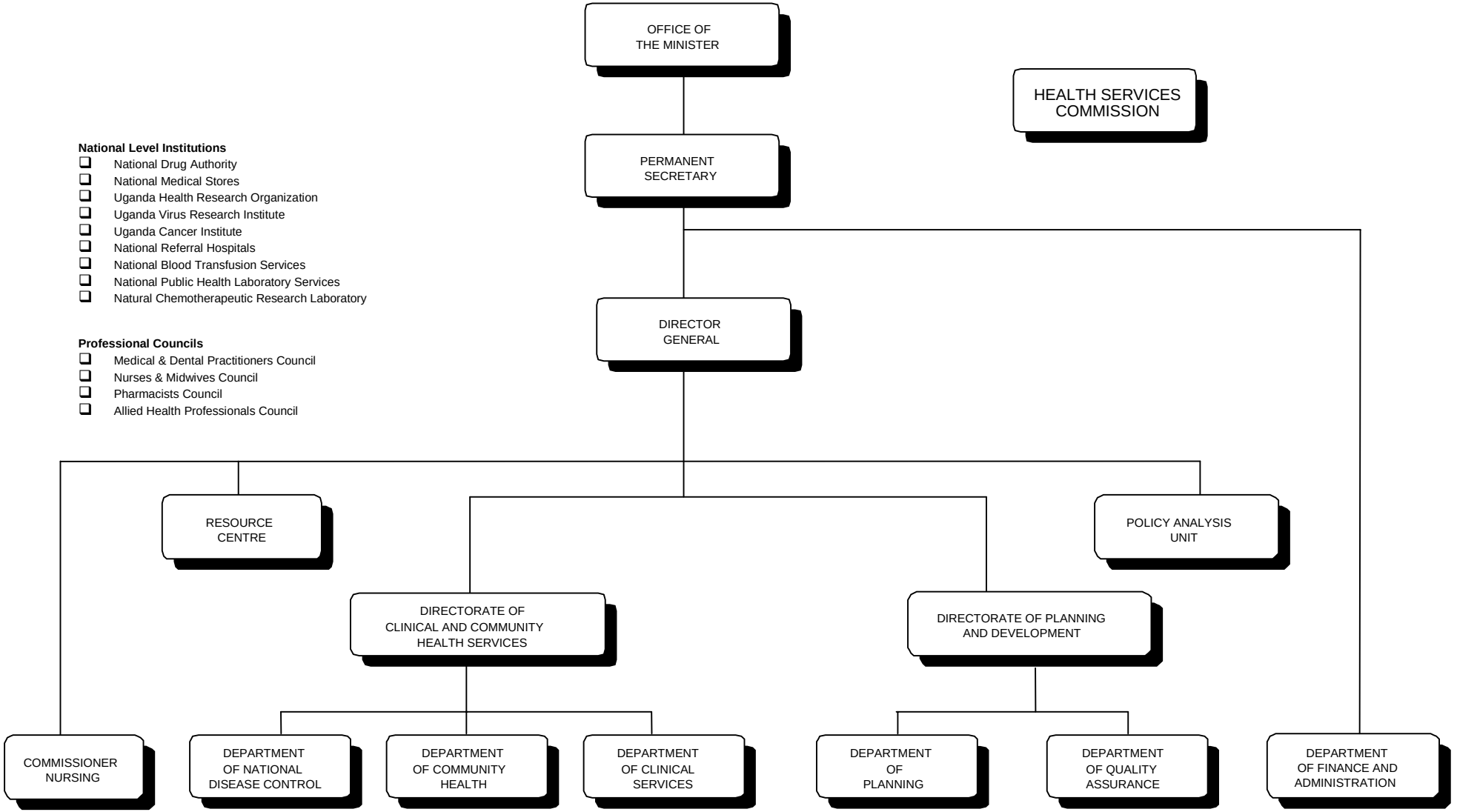


Figure 2.2: Organogram of the Ministry of Health



National Level Institutions

- National Drug Authority
- National Medical Stores
- Uganda Health Research Organization
- Uganda Virus Research Institute
- Uganda Cancer Institute
- National Referral Hospitals
- National Blood Transfusion Services
- National Public Health Laboratory Services
- Natural Chemotherapeutic Research Laboratory

Professional Councils

- Medical & Dental Practitioners Council
- Nurses & Midwives Council
- Pharmacists Council
- Allied Health Professionals Council

2.2.1 Ministry of Health and other National level institutions

Ministry of Health
The Ministry of Health was restructured in line with its mandate and core functions. Figure 2.2 outlines the organogram. The national Heath Policy defines the core functions of the Ministry of Health as:

i) Policy formulation, setting standards, and quality assurance
ii) Resource mobilization
iii) Capacity development, training and technical support
iv) Provision of nationally coordinated services, e.g. Epidemic control
v) Coordination of health research
vi) Monitoring and evaluation of the overall sector performance.

The MoH retains responsibility for such central services as health emergency preparedness and response, epidemic prevention and control. Other nationally delivered services are by specialized institutions under the stewardship of the Ministry of Health.

National Level Institutions
The autonomous National level institutions include the National Referral Hospitals, National Medical Stores, National Drug Authority, Uganda Virus Research Centre, Uganda Cancer Institute, National Blood Transfusion Service, National Public Health Laboratories and the Uganda Natural Chemotherapeutic Research Laboratory. The Regional Referral Hospitals and the National Blood Transfusion Services have been accorded self accounting status and shall become fully autonomous in the course of HSSP II. The National Health Research Organization is responsible for coordination of health research.

Health Services Commission
The Health Service Commission is a statutory body established in the 1995 Constitution. It is responsible for reviewing the terms and conditions of service of health workers. It reports directly to Parliament from which it gets its budget. The Health Services Act, governs the operational aspects of the Commission and establishes the code of conduct of all health workers.

2.2.2 Hospitals

Hospitals represent the top end of a continuum of care providing referral services for both clinical and public health conditions to the District Health Services. They play an important complementary role to primary care and constitute an important and integral part of the National Health System.

A National Hospital Policy has been formulated to streamline the role and functions of hospitals within the National Health System. Given the present challenges and health sector reforms of recent years, well-defined role and functions of hospitals in Uganda is essential. The objective of the policy is to improve the performance and accountability of the hospitals in order to contribute to the overall economic growth of the country by ensuring a healthy and productive population. The guiding principles of the policy are:

i. Ensuring equity of access to hospital services.
ii. Creating an enabling environment for the delivery of hospital services through effective management, an improved referral system and resource mobilization.

iii. Guaranteeing that hospitals provide quality and affordable services consistent with the National Minimum Health Care Package.
iv. Creating a conducive environment for the development of private hospitals in the country.

The policy is expected among other things, to define the role and functions of the hospital sub-sector by tier, clarify its linkage with the overall sector plan in line with new partnership arrangements, and define mechanisms for assuring its resources and accountability. The operationalisation of the new hospital policy will be an integral part of HSSP II.

Hospital structure
In Uganda, hospital services are provided by public, private not-for-profit and private health institutions. The degree of specialisation varies between hospitals. The public hospitals are divided into three groups according to the level of services available and their responsibilities: general hospitals, regional referral hospitals and national referral hospitals. The private hospitals are designated as general hospitals but the services they provide vary, with some providing specialist services usually found only in referral hospitals.

Of the 102 hospitals in the country, two are the national public referral hospitals, 11 are regional, and 43 are general – giving a total of 56 public hospitals. 42 are private not-for-profit hospitals and four are private health practitioner hospitals. The private for profit hospitals are not designated as referral institutions although they offer secondary and tertiary specialized services. Lack of adequate resources is limiting hospitals in their effort to provide the services expected from them. In many instances basic emergency infrastructure, supplies and equipment for support services are inadequate.

General Hospitals: These provide preventive, promotive, outpatient curative, maternity, inpatient health services, emergency surgery, blood transfusion, laboratory and other general services. They also provide in-service training, consultation and research in support of the community-based health care programmes.

Regional Referral Hospitals: In addition to the services offered at the general hospital, these hospitals offer specialist services such as psychiatry, ear, nose and throat (ENT), radiology, pathology, ophthalmology, higher level surgical and medical services, including teaching and research.

National Referral Hospitals: In addition to the services offered at the regional referral hospital, they provide comprehensive specialist services and are involved in teaching and health research.

All hospitals are also expected to provide support/supervision to the level below i.e. general hospital to lower level health units in the districts; Regional Referral to General Hospital and HC IV; and National Referral to Regional Referral through specialists programme. All hospitals maintain linkages with the communities through their Community Health Departments. The level of effectiveness in fulfilling the related functions varies widely, with many not in regular contact with the lower units and communities they are supposed to serve.

Hospital Governance and Management
The public general hospitals are under the respective local governments. The hospitals are managed by the district local governments in collaboration with guidelines from the Ministry

of Health. These hospitals have Management Committees appointed by the respective district councils.

The regional referral hospitals have been granted self-accounting status by the Ministry of Finance, Planning and Economic Development. Some of the hospitals have Management Boards appointed by the Minister of Health on the recommendation of the district councils within the catchment area. In future these will be prepared for autonomy on a case-by-case basis. The two national referral hospitals, Mulago and Butabika, have interim boards and preparations for full autonomy are ongoing. All the PNFP hospitals have self accounting status granted by the legal owners (trustees) and they are governed by Boards appointed by the Trustees. The Board in turn appoints a team of managers.

2.2.3 District Health System

In line with the 1995 Constitution and the 1997 Local Governments Act, the new roles of the Local Authorities (in the context of the health sector) are:

- Health service delivery
- Recruitment and management of personnel for District Health Services
- Passing by-laws related to health, and
- Planning, budgeting, additional resource mobilisation and allocation for health services.

The District Health System is a more or less self-contained segment of the National Health System. It consists of various tiers under the overall direction of the District Director of Health Services. The District Health System comprises a well-defined population living within a clearly delineated administrative and geographic boundary and includes all actors in the recognized spheres of health within the district. It is expected that the activities of the diverse partners in health are reflected in the District Health Sector Strategic Plan, which in turn is an integral part of the rolling District Development Plan. The NHP established the Health Sub-District as a functional subdivision or service zone of the district health system to bring quality essential care closer to the people, allow for identification of local priorities, involve communities in the planning and management of health services and increase the responsiveness to local need.

District Health Teams

Under decentralization, the roles and responsibilities of the centre and the districts were redefined. The transfer of responsibility for service delivery to the HSD necessitated redefining the roles and responsibilities of the DDHS Office. The District Health Teams (DHTs) retain the functions of planning, budgeting, coordination resource mobilization, and monitoring of overall district performance. Poor logistics, inadequate staffing, weak management capacity and poor working conditions have been cited as the main factors that have dictated the pace and general effectiveness of this policy change.

HSSP II will give priority to capacity development of DHTs based on needs assessment in areas of human resource development and management, logistics and working environment. In order to strengthen the public-private-partnership in health care delivery, the expanded District Health Team will include district representatives of PNFP and other Civil Society service providers that are active in each district. A new structure of local government will be implemented during the course of HSSP II.

Health Sub-District

The National Health Policy devolved operational responsibility for delivery of the minimum package to the HSD. Each HSD management team is expected to provide overall day to day management oversight of the health units and community level health activities under its jurisdiction. Its specific functions include:

a) Leadership in the planning and management of health services within the HSD, including supervision and quality assurance
b) Provision of technical, logistical and capacity development support to the lower health units and communities including procurement and supply of drugs.

Although significant progress has been made, many of the 214 HSDs have encountered difficulty in meeting the policy expectations. Constraints related to inadequate funding; recruitment, deployment and housing of personnel; high rates of turnover of recruited staff; heavy workload resulting from combining clinical and health management functions of senior HSD personnel; low rates of completion and operationalisation of infrastructure have all contributed to the lower than expected performance of the HSDs observed during HSSP I.

Conscious of the central role of the HSD in the delivery of the UNMHCP, during HSSP II high priority will be given to making the HSDs fully functional. This will be achieved through preferential allocation of necessary personnel and elements of health infrastructure for making the HSDs effective. The proposed Local Government staffing norms of providing 2 medical officers per HSD will be implemented in a phased manner depending on availability of funds and suitable candidates.

Referral Facility (General Hospital or Health Centre IV)
The leadership of the HSD is located in an existing hospital or a HC IV (Public or PNFP) located within the HSD. Its functions are primarily the:

a) Provision of basic preventive, curative and rehabilitative care in the immediate catchments
b) Provision of second level referral services for the HSD including life-saving medical, surgical and obstetrical emergency care such as blood transfusion, caesarean section, and other medical and surgical emergency interventions
c) Provision of the physical base of the HSD Management Team. In 29 out of 214 HSDs, the function of HSD management has been delegated to the PNFP referral facility.

Health Centre III
The HC III offers continuous basic preventive, promotive and curative care and provides support supervision of the community and HC IIs facilities under its jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county.

Health Centre II
The HC II represents the first level of interface between the formal health sector and the communities. HC IIs provide only ambulatory services, except in strategic locations (e.g. poor access to HC III or HCIV) where as interim strategy maternity services are being provided. An Enrolled Comprehensive Nurse is key to the provision of comprehensive services and linkages with the Village Health Team.

Village Health Team (Health Centre I)
The NHP calls for the establishment of a network of functional Village Health Teams (VHTs) to facilitate the process of community mobilization and empowerment for health

action. Each village would have a VHT comprised of 9-10 people to be selected by the village (LCI). Women's participation in the VHT is promoted through an affirmative action measure of requiring at least $^{1}/_{3}$ of the team members to be women, thus ensuring their active participation in health activities at this level. The VHT is responsible for:

- Identifying the community's health needs and taking appropriate measures;
- Mobilization of additional resources and monitoring of utilization of all resources for their health programs including the performance of health centres;
- Mobilization of communities using gender specific strategies for health programs such as immunization, malaria control, sanitation and construction, and promoting health seeking behaviour and lifestyle
- Selection of Community Health Workers while maintaining a gender balance;
- Overseeing the activities of Community Health Workers;
- Maintaining a register of members of households and their health status and
- Serving as the first link between the community and the formal health providers.

2.3 The Health Partnership

The National Health Policy and the Health Sector Strategic Plan are implemented through partnerships described under the broad framework of the Health Sector Wide Approach or SWAp. Under this framework, the Government of Uganda, through the Ministry of Health, has the lead role and responsibility for delivering the outputs of HSSP. Various other partners have defined roles to play and contributions to make. A series of memoranda of understanding or other formal arrangements such as government regulations, policy documents and contracts, are in place or are under development to govern these relationships.

2.3.1 Government of Uganda / Development Partners partnership

The Sector wide Approach (SWAp) was developed as a mechanism to "addresses the health sector as a whole in planning, management and in resource mobilization and allocation". The SWAp supports Government in mobilizing and managing resources for the sector. Although support to the government's budget (either general or sector specific) is the preferred financing mechanism, where partners cannot follow this approach, project support can be provided. The revised Memorandum of Understanding between the Government of Uganda and the health development partners (HDPs) spells out the obligations of the main parties and describes the structures and procedures established to facilitate the functioning of the partnership. The following are key structures and processes:

- The Health Policy Advisory Committee (HPAC) has proved beneficial in providing overall policy guidance to the sector. The HPAC Working Groups continue to carry out functions assigned by HPAC

- The annual GoU/DP Joint Review Missions enable the joint monitoring of the sector performance. The JRM receives the Annual Health Sector Performance Report and determines whether overall performance has been satisfactory. JRM also sets the priorities for the following year at the strategic level, through the identification of priority technical programmes, agreeing undertakings (or key process outputs) and determining broad allocations for the budget cycle. The HPAC Secretariat ensures that

the participants receive in a timely manner, electronic copies of the relevant documents for each Joint Review Mission.

- The Health Sector Working Group (SWG), established under the auspices of the Ministry of Finance, Planning and Economic Development, is the structure focused on the budget cycle and managing the approval and alignment of project inputs to the sector. New projects should follow GoU standards, guidelines and systems, be fully aligned with HSSP II priorities and minimize overheads as project resources are now counted as part of the total allocation to the sector and can displace budget resources. The budget process for FY 2005/06 – 2007/08 includes guidelines to SWGs on gender and equity budgeting.

- The National Health Assembly (NHA) was created to provide an annual forum for the broader health partnership (central and local governments, civil society, and development partners) to review sector policy, plans and performance. It provides an effective medium for wider consultation, political mobilization for health, and for consensus development among the stakeholders. The NHA first convened in 2003. As part of HSSP II the scope and mandate of the NHA will be clearly defined and its organization improved so as to derive maximum benefit from the effort. The Assembly is consultative and advisory. The NHA convenes once a year, with the MoH providing the secretariat.

- The health development partners (HDP) are responsible for their own co-ordination through the HDP group, which provides a forum for information sharing, consensus building and collating and coordinating responses to government. It is intended to reduce transaction costs for all parties, but especially government partners. The lead agency role is rotated on an annual basis.

The rapidly evolving nature of SWAps and the high turn-over rate of officers at all levels of the partnership demand that there is periodic information sharing and capacity building during the HSSP II period. The main purpose is to reorient and update on a periodic basis all major stakeholders, including the Local Authorities, on the principles and practice of SWAps in the health sector in Uganda.

2.3.2 Public Private Partnership for Health

The National Health Policy objective of making the private sector a major partner in national health development has to a large extent been achieved for the Private-Not-for-Profit sub-sector. A central PPPH coordinating office has been established within the MoH and a focal person for PPPH designated. The National Policy on Public Private Partnership in Health has been drafted and contains components addressing partnership with the PNFP and PHP. The component addressing partnership with the Traditional and Complementary Medicine Practitioners in not yet drafted. The related implementation guidelines for the PNFP and the PHP sub-sectors once approved, will be applied during HSSP II.

During HSSP II, effort will be directed to strengthening and broadening the partnership through more active engagement with other health related sectors, professional associations, private health care providers and TCMP, civil society and representatives of the principal consumers. In particular:

- The finalization of the National policy on Public Private Partnership in Health

- Implementing the guidelines for the PNFP and PHP sub-sector to promote the partnership at Local Government level.
- Generation of evidence to promote and support the Public Private Partnership
- Strengthening the regulation of the private sector through the professional Councils and Associations
- Creating an enabling environment for investment in health
- Establishing appropriate institutional structures for implementing the PPPH; and
- mainstreaming PPPH in MoH activities, other line ministries and districts, including instituting a process for joint operational planning for a single District Work Plan.

A similar policy framework will be developed for other private service providers such as private laboratories, pharmacies, drug shops and civil society non-facility-based service providers. The objective is to update and harmonize regulatory provisions governing the various components of the private health sector.

The important role of traditional and complementary medicine cannot be overstated. During HSSP II, the PPPH Office will expedite the process of facilitating the TCMP groups to come together and develop an appropriate policy and draft regulatory bill.

2.4 Intersectoral Collaboration

While the PEAP 2004 recognizes that improving health outcomes *"will be the achievement of several sectors*", the central role of the health sector cannot be lost sight of. Harnessing the contribution of the health related sectors is an important aspect of the stewardship functions of the MoH and DDHS Offices. Figure shows the summary of the roles and responsibilities of health related sectors in promoting good health. In collaboration with the Office of the Prime Minister, MoH will support central and district level health managers in developing capacity in fostering effective intersectoral partnerships.

During the last plan period some promising collaborative initiatives were forged between health and agriculture, education, water, gender, etc. HSSP II will progressively consolidate and expand these partnerships by applying proven partnership principles. The principles to be followed include development of a joint plan of action for achieving concrete outcomes specifying resource needs and their sources, defining and accepting assigned roles and responsibilities, respecting the mandates of each partner, recognizing the comparative advantages of partners and agreeing on common working arrangements including joint monitoring of partnership outputs and outcomes.

Ongoing collaboration in areas such as maternal and child health, HIV/AIDS prevention and control, information and education for health, water and sanitation, school health and human resource development, malaria control, and accident prevention will be strengthened. Similar effort will be given to building partnerships for improving nutrition, gender sensitivity, and in humanitarian assistance to internally displaced persons (IDPs) and refugees. Improved coordination in health infrastructure development with sectors such as roads and communications, water and electricity could make significant contribution to improving both physical access and the quality of health services in the rural areas. Imaginative use of existing local government structures (District Sectoral Committees, District Technical Planning Committees, District Planning Meetings, Meeting of Heads of Departments, etc) could yield significant gains in intersectoral collaboration.

Table 2.1: Summary of the roles and responsibilities of health related sector in promoting good health.

No.	Health related sector	Role of health related sector
1.	Ministry of Finance, Planning and Economic Development	- Mobilisation of resources
		- Rational allocation of resource to different sectors according to government priorities
2	Minister of Lands, Water and Environment	- Development of water sources (drilling bore holes, provision of piped water in urban areas, protection of springs, water for production – valley dams, rain water harvesting)
		- Provision of sanitation services in rural growth centres & urban areas and communal toilets.
		- Control of and/or sustainable use of the environment (avoid pollution, ensure sustainability use of wetlands)
		- Support communities to plan trees (aforestation)
3.	Ministry of Agriculture, Animal Industry and Fisheries	- Production of food – (both plant and animal sources of food)
		- Preservation and storage of food items (food security)
4.	Ministry of Gender, Labour and Social Development	- Community mobilization through
		- Develop policies for social protection of the vulnerable groups
5.	Ministry of Works, Housing and Communication	- Advise on standards for building structures
		- Construction and maintenance of roads for accessing to health facilities to facilitate patient flow and referral of patients
		- Establishment of communication network to facilitate communication (for e-governance, telemedicine, telephone, radio call)
5.	Ministry of Education and Sports	- Education of the population to have a literate population which can read and write and interpret information for healthy life styles. E.g education of the women very critical for improving the maternal and child health.
		- Training of health workers
		- Research and Development
6.	Ministry of Public Service	- Maintenance of payroll of civil servants (health workers inclusive)
		- Ensure entry on to the payroll of new recruits
7.	Ministry of Local Government	- Recruitment and deployment of health workers (PHC and general hospital)
		- Delivery of health services
		- Supervision and monitoring of health service delivery

CHAPTER 3: THE UGANDA NATIONAL MINIMUM HEALTH CARE PACKAGE

Introduction

Communicable diseases particularly malaria, acute respiratory tract infections, diarrhoea diseases, malnutrition, perinatal and maternal conditions, HIV/AIDS and tuberculosis together continue to account for the overwhelming proportion of disease and premature death in Uganda. There are proven cost effective intervention which were applied during HSSP I and constituted the Uganda National Minimum Health Care Package (UNMHCP). The UNMHCP is still appropriate for HSSP II. HSSP II therefore represents a consolidation and extension of the achievements of HSSP I.

During HSSP I, many bottlenecks in implementation of the UNMHCP were identified. These include: inadequate level of prioritization, inadequate investment in critical inputs, piecemeal implementation and poor coordination of technical interventions resulting in hindrance to faster achievement of national service coverage and health outcome targets. In light of this, the emphasis of HSSP II is to concentrate effort and resources on a limited set of evidence-based, cost effective interventions under each of the elements of the UNMHCP. These will receive priority in the allocation of available resources for scaling up to full national coverage.

The elements of the UNMHCP have been regrouped in 4 clusters. This grouping is meant to demonstrate more clearly the integrated approach and to foster increased coordination in planning, budgeting and implementation at the various levels.

The clusters of the UNMHCP are as follow:

Cluster 1 comprises of the crosscutting areas of health promotion, disease prevention and community health initiatives, environmental health, and school health, as well as gender and health

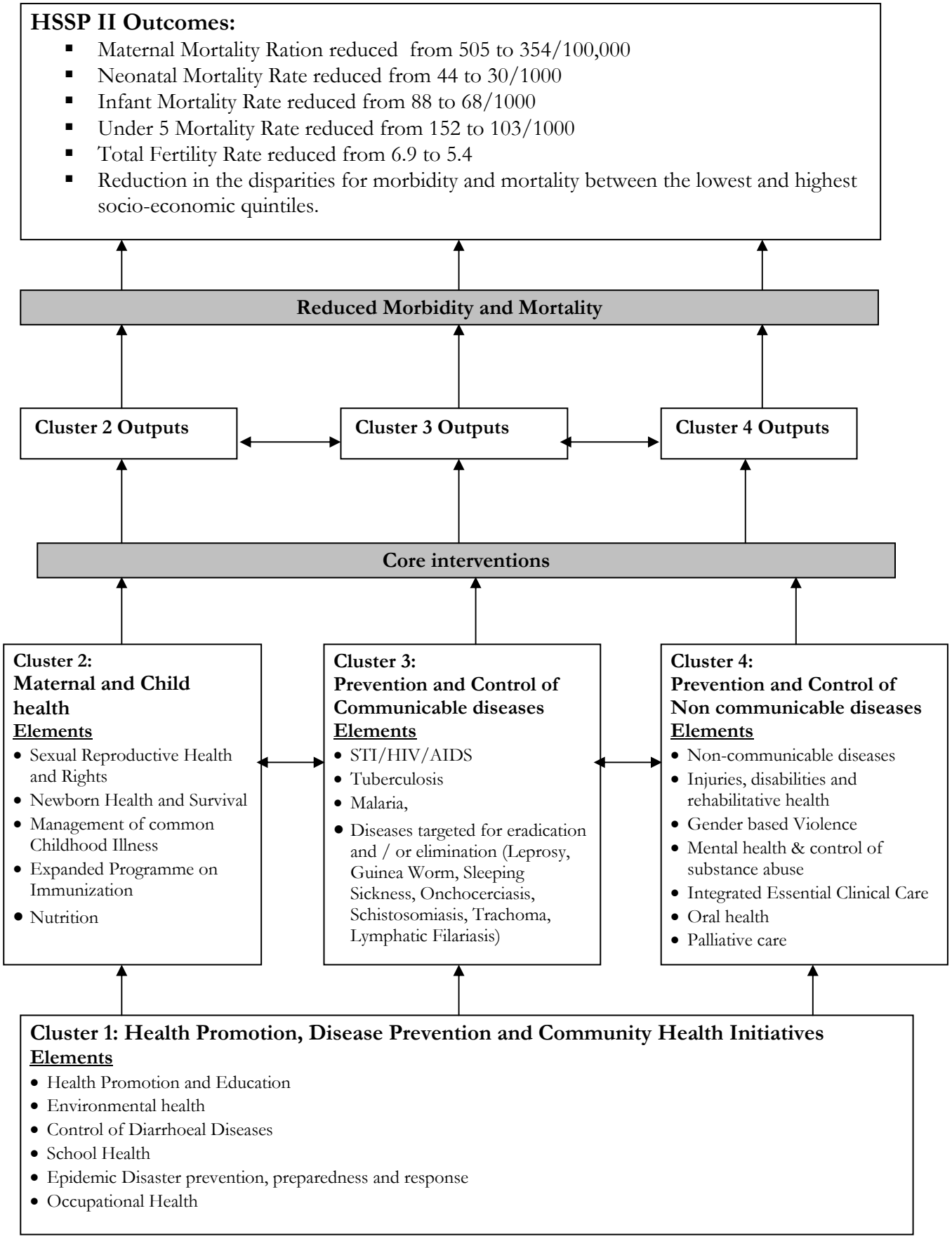
Cluster 2 represents integrated maternal and child health that emphasizes safe motherhood, newborn care and child survival.

Cluster 3 groups together the prevention and control of communicable diseases with accent on HIV/AIDS, Tuberculosis, Malaria and diseases targeted for elimination or eradication.

Cluster 4 addresses non-communicable diseases with emphasis on healthy lifestyles for prevention of NCD and control of poverty producing conditions such as mental health, deafness and blindness, age and disability.

The framework in Figure 3.1 illustrates the vertical and horizontal linkages between clusters and contribution towards the outputs and outcomes. The programme components of the HSSP II (Chapters 4 – 6) are in support of the delivery of the UNMHCP.

Figure 3.1: Framework for the Delivery of the Minimum Health Care Package



3.1 Cluster 1 - Health Promotion, Disease Prevention and Community Health Initiatives

Introduction

Over 75% of Uganda's disease burden is considered to be preventable as it is primarily caused by poor personal and domestic hygiene and inadequate sanitation practices (failure to break the faecal-oral disease transmission routes). Other preventable diseases include malaria, acute respiratory infections (ARI), diarrhoeal diseases (DD), HIV/AIDS and vaccine preventable diseases. This massive burden of preventable disease results in diminished productivity and increased poverty. This vicious cycle that affects most Ugandans can be reversed, as has already been proven in several other countries, through a well-integrated and coordinated deployment of existing resources. In particular, through the active engagement of the district extension staff, including Health Assistants, Village Health Teams, Community Development Workers and Education Officers together with Faith Based Organisations (FBOs), NGOs and CBOs, in focusing their co-ordinated activities down at household, community and parish levels.

Greater inter-sectoral collaboration and integration of resources, particularly at district and sub-district levels, will be employed to synergistically address the six elements of this crosscutting Cluster (see Figure 3.1). Considerable improvements in the health, quality of life and ultimately the national economy will result from this cost-effective initiative that promotes health and prevents disease at individual, household and community levels. The Cluster will contribute to the attainment of all of the HSSP II outputs through supporting the strategies of the other three clusters.

Health Promotion, Disease Prevention and Community Health Initiatives cluster objective

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3.1.1 Health Promotion and Education

Health Promotion and Education supports all other elements to achieve their objectives. Its major aim is to create health awareness, promote public participation and involvement in health care delivery, and increase demand and utilization of the services provided by the sector. This should result in adoption of appropriate healthy lifestyles and health-seeking behaviour.

The sector strategy for reaching the communities and households is the establishment of Village Health Teams (VHT) in all villages in Uganda. Community participation and empowerment is the strategy for enabling communities to take responsibility for their own health and well-being and to participate actively in the management of their local health services. During HSSP I, the VHT strategy and guidelines were finalized and establishment of VHT commenced. In collaboration with partners, the establishment of VHTs has expanded to cover several districts, although the process is constrained by lack of resources for operationalization of VHTs. During HSSP II, the establishment of VHT shall be extended to cover the whole country.

Specific Targets

i) To increase to 100% the proportion of villages with trained VHTs by 2010

ii) To increase by 40% the proportion of health facilities and community institutions with health promotion materials (IEC
iii) To increase by 50% the proportion of political and religious and cultural institutions promoting health
iv) To increase by 30% the proportion of population seeking health services according to national standards
v) 80% of media institutions having own health promoting programmes

Core interventions

- Intensify health awareness and behaviour change for health promotion
- Strengthen community capacity for health promotion and improved health service delivery with emphasis on the roles of women and men.
- Advocate for participation of political, religious and cultural institutions in promoting health programmes
- Strengthen interface between service providers and consumers
- Monitor and evaluate health promotion interventions.

3.1.2 Environmental Health

The improvement of environmental health aims to contribute to the reduction of morbidity, mortality and disability among the people of Uganda through improvements in housing, use of safe water, food hygiene promotion, waste management and control of vectors/vermin. During HSSP I, the challenge of determining sectoral responsibilities and mandates was overcome with improved intersectoral collaboration. Considerable progress was made in the development of strategies, guidelines and legislation (notably on sanitation and food hygiene), and steps were taken to improve national and district-level monitoring of progress in environmental health, with proformas developed for monitoring household hygiene and sanitation practices. In addition, various categories of district staff were trained in water quality surveillance techniques and in information management. The implementation of the Kampala Declaration on Sanitation (KDS) is ongoing with increase in latrine coverage from 49% in 1997 to 57% in 2003/04. During HSSP II, emphasis shall be placed on capacity building support for environmental health and sanitation and the promotion of KDS

Specific Targets

i) Improvement in safe waste disposal using latrine coverage as proxy from 57% to 70% in 2010
ii) To increase from 18% to 100% of districts implementing Water quality surveillance and promotion of safe water consumption;

Core Interventions

- Promotion of the Kampala Declaration on Sanitation in all districts
- Formulation of appropriate by-laws and regulation for improved environmental health
- Training extension workers engaged in hygiene promotion;
- Water quality surveillance

3.1.3 Control of Diarrhoeal Diseases

During HSSP I diarrhoeal disease (cholera and dysentery) outbreaks were controlled in most parts of the country. Cholera Case Fatality Rate (CFR) fell from 6% in 2000 to 2.5% in 2003

(WHO recommends CFR of less than 1%). The outbreaks were due mainly to poor sanitation, low safe water coverage, poor domestic and personal hygiene practices and constant mass movement of populations - refugees and internally displaced persons, with over 1,600,000 persons displaced in Northern Uganda alone. There is a continuing need for strengthening national capacity at all levels to prevent and effectively control epidemics of diarrhoea. During HSSP II, emphasis shall be placed on integration of interventions for IMCI, environmental health and community based health activities.

Specific Targets

i) To reduce the incidence of annual cases of epidemic diarrhoeal disease from 3/1000 to 1.5/1000
ii) To reduce the cholera specific case fatality rate from 2.5% to 1.0%
iii) To increase the proportion of patients with epidemic diarrhoea receiving appropriate treatment within 12 hours of onset of symptoms

Core Interventions

- Diarrhoeal diseases surveillance, epidemic preparedness and response
- Prompt and appropriate case management
- Community education and mobilization
- Re-activation of the Protocol of Cooperation of Countries in Great Lakes Region

3.1.4 School Health

During the HSSP I, the school health programme was introduced to create an enabling environment for delivering quality education, for inculcating healthy habits and practices in children in their formative years when they are most receptive. During HSSP II, the school health programme will integrated within the district activities

Specific Targets

i) 75% of primary and 50% of secondary schools implementing the main components of the Health Promoting School Initiative (HPSI), including sex education, counseling and life skills;
ii) 75% of all primary and secondary schools have healthy physical environment with latrine and safe water facilities that meet the national guidelines - pupil per latrine stance ratio 40:1 or better; hand washing facilities; safe water (piped, borehole, protected well or protected spring) within 0.5km radius of institution;
iii) 75% of schools providing basic school health services;
iv) Sickness related absenteeism among pupils/students reduced from the current 60% to below 30%.

Core Interventions

- Implementation of the Health Promoting Schools Initiative
- Advocacy for and provide support to provision of safe water supply and latrines in primary and secondary schools
- Screening of children in schools
- Support introduction of the basic health care package in each school.

- In collaboration with the Ministry of Education and Sports, and the Department for Water Development, build the capacity of teachers for implementation of the Health Promoting Schools Initiative

3.1.5 Epidemic and Disaster Prevention, Preparedness and Response

The element aims to improve emergency preparedness and response both at national and district levels in order to promote health, prevent disease and reduce death among the affected population. During HSSP I, surveillance for potential epidemics was actively pursued. The outbreak of EBOLA in Gulu district in 2000 was successfully contained with a relatively low Case Fatality Rate (**24%**?). There was an increase in the number of Internally Displaced Persons (IDPs) in 12 districts in North and North-Eastern Uganda, which left over 1,600,000 persons internally displaced. Several incidents of road traffic accidents and natural disasters due to heavy rains were reported and given appropriate response. During HSSP II, the planning for emergencies with health implications shall be included within the national and district workplans. The strategies dealing with health and Internally Displaced Persons are addressed in Chapter 6.

Specific Targets

i) To achieve a reaction/response period for confirmed epidemics of less than 48 hours
ii) Case fatality ratio for epidemics of less than xxx%

Core Interventions

- Appropriate health services in conflict and post conflict situations (see Chapter 6)
- To establish early warning system for outbreaks and disasters
- To ensure adequate timely response through disaster preparedness
- Improved coordination of efforts during emergency situations
- Provisions within the national an district workplans for management of emergencies and disasters

3.1.6 Occupational Health

Due to the current increased industrial, agricultural (especially horticulture) development in Uganda, threats from emerging and re-emerging diseases, there is need to scale up interventions in Occupational Health. There is a need to promote Occupational Health services and practices in workplaces with special emphasis on the high risk Sectors.

Specific Targets

i) 50% of all health workers in the formal sector accessing Occupational Health services
ii) 30% of all health workers in the informal sector accessing Occupational Health services
iii) All Trade Unions are made aware and educated about Occupational Health

Core Interventions

- All health facilities delivering occupational health services by 2010
- Awareness building for occupational health services

3.2 Cluster 2 - Maternal and Child Health

Introduction

During the decade of the 1990s, health outcomes related to maternal and child health did not show improvement. While acknowledging that improving maternal and child survival transcends the health sector, the health sector carries a major responsibility in the provision of life saving interventions that contribute to the improvement of health outcomes. Several reports including the Infant and Maternal Mortality reduction report, the Child Survival Lancet papers, multi-country evaluation of IMCI and Cochrane reviews on maternal and perinatal mortality indicate that cost effective interventions are already known. The need for systematic scale up of sets of proven, cost effective interventions and ensuring adequate national coverage while reducing inequality between the least and most poor has been identified. The utilization of maternal and child health services is inadequate. The low level of education of women and cultural practices, which include power dynamics at household and community levels contribute to the low utilization of health services and the disparities in health services utilization.

Maternal and neonatal conditions contribute the highest (20.4%) to Uganda's total burden of ill health and avoidable death. During HSSP I, maternal and child health was accorded priority, particularly the Reproductive Health programme and the Expanded Programme on Immunization. HSSP II being outcome oriented will focus on reducing the Infant mortality rate and Maternal Mortality ratio. During HSSP II, the maternal and child health will be delivered under a single cluster consisting of five elements: Sexual and Reproductive Health (SRH), Newborn care, Common childhood illnesses, Immunization and Nutrition. This process emphasizes the link between maternal and child health mortality and the cumulative nature of health problems through the entire lifecycle.

Maternal and Child Health Cluster Objective

To contribute towards the achievement of a level of reduction in maternal, neonatal and young child mortality that is commensurate with the timely achievement of the PEAP targets and related Millennium Development Goals.

3.2.1 Sexual Reproductive Health and Rights (SRH)

During HSSP I, emphasis has been put on operationalising the health sub districts to be able to handle obstetric emergencies. The management of family planning commodities improved and increasing the uptake of family planning services. Despite the achievements, the unmet need for family planning stands at 35% while the unmet need for EmOC is 86%. Only 24.4% of births take place in a health facility, and 38% of deliveries occur under the supervision of trained health workers. The percentage of adolescent pregnancies has reduced from 43% to 32% but this is still unacceptably high. The Total Fertility Rate remains high at 6.9.

Specific targets for SRH

i) Increase the proportion of deliveries by skilled attendants from 38 to 50%
ii) Reduce the unmet need for emergency obstetric care from 86% to 40%
iii) Increase the attendance for 4 visits per pregnancy from 42 to 50%
iv) Increase the Contraceptive Prevalence Rate from 23% to 40% (increase CYPs from 223,686 per annum to 500,000 per annum)
v) Reduce the percentage of teenage pregnancy rates from 37 to 20%

Core interventions for Sexual Reproductive Health and Rights

- Operationalize EmOC services at HC III, HC IV and hospital level including establishment of maternal death reviews
- Community mobilization and capacity building for reproductive health care including capacity to identify and refer high risk pregnancies and complicated deliveries and also male involvement in SRH.
- Scale up goal oriented ANC including provision of IPT and PMTCT
- SRH to be part of integrated sustainable outreach services (SOS)
- Provision of a range of Family Planning services, with special emphasis on improving logistics and making available to adolescents
- Advocacy and IEC stating the importance and availability of RH services
- Improve capacity at district level to deliver RH services through support supervision.

3.2.2 Newborn Health and Survival

Half of deaths in infants occur in the neonatal period (first 28 days after birth). Of these nearly 2/3 die in the first week of life, and 2/3 of those deaths occur within the first 24 hours after birth. During HSSP 1, newborn health care was not given due attention. The majority of deaths during the new born period result from infections, asphyxia and birth injuries, and complications of premature births. Low birth weight underlies 40 - 80% of newborn deaths, and low birth weight babies who survive have an increased risk of developing diseases and learning disabilities. During HSSP II, the care of the newborn is given attention and a set of core interventions are highlighted.

Specific targets for newborn care

i) Reduce the proportion of children with low birth weight by 30%
ii) Reduce the proportion of neonates seen in health facilities with septicemia/severe disease by 30%

Core interventions for care of the newborn

- Provision of essential care during pregnancy including Tetanus toxoid immunization, proper nutrition including iron/folate supplements and prevention and treatment of maternal infections such as malaria, STDs
- Infection control during & after delivery including the distribution of Maama Kits
- Improving new born resuscitation
- Provision of essential care during the postnatal period including promotion of immediate and exclusive breast-feeding, thermal control, clean cord practices and Vitamin A supplementation
- Counseling and education on new born care practices especially careful management of low birth weight babies and timely recognition and antibiotic treatment of pneumonia, sepsis and meningitis
- Sensitization and education on danger signs for the newborn
- Promote appropriate care seeking and home care practices for newborn health including encouraging fathers to assume more responsibility for child care
- Strengthen Post Natal Care follow up of the mothers and infants for both ordinary and PMTCT mother/baby pairs.

Integrated Child Survival

During HSSP I, a number of interventions to improve child survival were established including revitalization of EPI, Vitamin A supplementation, IMCI, Home based management of fever and Child days. The overall effectiveness of all these interventions was however limited due to low coverage, piecemeal implementation and sometimes lack of logical synchronization. During HSSP II, the focus will be to scale up evidence based interventions with a focus on reaching households with known interventions and strengthening health systems supports for child health.

3.2.3: Management of Common Childhood Illness

Integrated Management of Childhood Illness (IMCI) is a key strategy for delivery of integrated child health services through improvement of health worker skills in regard to integrated assessment and management of malaria, acute respiratory infections, diarrhoea, and malnutrition, which contribute to over 70% of overall child mortality. The strategy also focuses on improving health system issues that affect care for children in health facilities as well as working to improve key family care practices that have the highest potential for child survival, growth and development. During HSSP II, emphasis shall be placed on the decentralized level for integrated scale up of services.

Specific Targets

i) Increase the proportion of sick children under five years seen by a health worker using IMCI guidelines from 45 to 75%.
ii) Increase the proportion of children under five with fever, diarrhea and pneumonia seeking care within 24 hours of illness from 30 to 60%.
iii) Increase the proportion of children under five with acute diarrhea receiving Oral Rehydration Therapy RT from 37 to 80%.
iv) Increase the proportion of children under five with pneumonia receiving appropriate antibiotic treatment from 30 to 80%.
v) Reduce by 75% missed opportunities for immunization among sick children under five.

Core interventions for common childhood illnesses

- Improve Health worker skills in managing childhood illness using IMCI guidelines.
- Community treatment of fever/malaria, diarrhea and pneumonia.
- Family Care Practices message dissemination (care seeking, disease prevention, home treatment and compliance).
- Integrated sustained outreach services and bi annual Child Days
- Provision of comprehensive management of pediatric HIV and support

3.2.4 Expanded Programme for Immunization (EPI)

The Expanded Programme for Immunization programme covers the Tuberculosis, Diphtheria, Whooping Cough, Tetanus, Hepatitis B, *Heamophilus influenzae* b, Poliomyelitis and Measles antigens. The EPI services were revitalized during HSSP I, which saw the levels of full immunization increase from 44% to 71%[12] and DPT3 coverage increase from 41% pre HSSP to 83% for FY 2003/04. The scope of the programme services was successfully

[12] Coverage survey done in 11 districts from different regions of Uganda

expanded by the introduction of hepatitis B and *Heamophilus influenzae* b antigens using the pentavalent vaccine. Immunization campaigns against neonatal tetanus, polio and measles were carried out countrywide or in high-risk districts, which resulted in drastic reductions of cases and deaths. No new case of polio was reported during HSSP I. The injection safety program was also introduced. Despite the improvements, problems with DPT1-3 drop out remain and vaccine management skills at district and lower levels are still a major challenge.

Specific Targets

i) Increase the proportion of fully immunized children from 71 to 80%
ii) Increase DPT-Hib+Hep3 /OPV3coverage from 87 to 93%
iii) Reduce DPT-Hib+Hep1-3 drop out rate from 16 to 10%
iv) Increase measles coverage from 91 to 97%
v) Eliminate maternal and neonatal tetanus
vi) Maintain zero cases of AFP due to wild polio virus

Core interventions for the Expanded Programme on Immunization

- Ensuring an efficient cold chain system
- Forecasting, procurement and distribution of adequate vaccines and supplies within the Vaccine Independency Initiative framework
- Social mobilization for immunization including campaigns
- Injection safety promotion
- Surveillance of measles and polio cases
- Implementation of Reach Every District (RED) strategy

3.2.5 Nutrition

Malnutrition is identified as a key determinant of infant mortality, with 54% of all childhood deaths globally being related to malnutrition. In Uganda 40% of children are chronically undernourished with many more deficient in several micronutrients. The Ministry of Health is pursuing a multisectoral approach to improve the nutritional status. During HSSP 1 Vitamin A capsule supplementation was introduced and food fortification program launched as partnership between government and the private sector. Infant and young child feeding was strengthened including community based growth monitoring promotion which was initiated in 6 districts. Therapeutic centers were put in place in IDP camps and efforts were made to address the nutrition challenges of the elderly.

Specific Targets

i) Increase the prevalence of Exclusive Breastfeeding from 70 to 80%
ii) Reduce the prevalence of under weight among under fives from 23 to 17%
iii) Increase Vitamin A supplementation uptake for 6-59 months from 60 to 80%
iv) Attain 100% household salt iodization

Core interventions for Nutrition

- Growth monitoring and promotion activities
- Routine supplementation with vitamin A, iron, zinc and de-worming
- Food fortification with vitamins and minerals, and regular de-worming

- Improve Infant and Young Child feeding: Breastfeeding promotion and Code for marketing breast milk substitutes
- Increase Micronutrient supplementation during the bi annual Child Days
- Increase routine iron, folic acid and Vitamin A supplementation to both ANC and Post Natal mothers.

Mechanism for scaling up interventions for the Maternal and Child Health Cluster

1. Social marketing of maternal and child health services
2. Focus on districts with low coverage and high mortality for core interventions
3. Application of more efficient integrated services or strategies
4. Innovative strategies for delivering services to the most poor and in war torn areas
5. Involvement of the private sector in delivery of interventions
6. Emphasis & focus on reaching households with interventions and documenting best practices
7. Involving all partners at community level through dialogue approach
8. Vital registration of births and deaths

3.3 Cluster 3 - Control of Communicable Diseases

Introduction

This cluster covers the major communicable diseases of global and national importance or of epidemic potential in Uganda. These include HIV/AIDS, Malaria, Tuberculosis, diseases targeted for control, eradication or elimination (i.e. Guinea Worm, Onchocerciasis, Leprosy, Lymphatic Filariasis, and Trachoma), Rabies, Plague, Human African Trypanosomiasis, Schistosomiasis and intestinal worms.

In general**, c**ommunicable diseases account for 54% of the total burden of disease in Uganda. Malaria, HIV/AIDS and TB remain the leading causes of ill health and mortality. The major part of this disease burden is borne by children under five years of age. Control of vaccine preventable diseases in this age group is highly dependant on increased vaccine coverage. Furthermore, these are diseases of poverty which constitute a major underlying cause of socio- economic underdevelopment in the country by sustaining an unfavourable environment for families and communities to fight poverty effectively.

Despite significant progress made during the HSSP I period (such as with the prevention and control of HIV/AIDS, TB, Malaria, Guinea worm, Onchocerciasis, Leprosy), communicable diseases continue to dominate Uganda's disease profile. Therefore the prevention and control of communicable diseases remain a priority agenda for attention in HSSP II.

Under HSSP II, effort will be intensified to strengthen the provision and coordination of related programmes and control activities, such as HIV/AIDS and TB, and integrated control of vector borne diseases.

Control of Communicable Diseases cluster objective

To reduce the prevalence and incidence of communicable diseases by at least 50% and thus contribute towards achieving the health related MDGs and the overall goal of the Poverty Eradication Plan in Uganda.

3.3.1 Prevention and control of STI/HIV/AIDS

Since the onset of the HIV epidemic a cumulative total of over two million Ugandans have been infected with HIV and there are currently about 120,000-150,000 adults with AIDS disease. It is also estimated that there have been about 900,000 HIV/AIDS related deaths since the beginning of the epidemic. The weighted national average prevalence based on antenatal figures has stabilized at around 6%. Over the years disparities in HIV prevalence between sexes have been noted and these could be attributed to biological, economic and socio-cultural factors.

During HSSP I, government focused on mainstreaming HIV/AIDS into all sectors and decentralization of the implementation plan. A comprehensive patient care package was developed which included the management of opportunistic infections including TB, palliative care, home based care and the provision of antiretroviral drugs for post-exposure prophylaxis. Regional blood banks were established to ensure safe blood for transfusion. Epidemiological surveillance for STI/HIV/AIDS to support programme monitoring and evaluation was strengthened. A number of challenges still remain; these include sustaining the momentum to scale up the core interventions, avoiding complacency, promoting condom use, improving access to effective IEC/BCC messages, shortage of human resource, stronger involvement of men in VCT and PMCT services and the inclusion of children and older people in the prevention and control. The HIV serosurvey shall provide more information for strategic direction.

Specific Targets

i) Increase the proportion of population knowledge of at least 2 correct methods of HIV prevention from 90 to 95%.
ii) Reduce from 6.2 to 5% the prevalence of HIV among women attending ANC.
iii) Reduce from 7 to 4% the prevalence of HIV among the general population
iv) Scale up VCT services to all HC III by 2010
v) Scale up PMTCT services to 50% of HC III by 2010
vi) 75% of HC IV offering comprehensive HIV/AIDS care with ART by 2010
vii) 100% accessibility to information and services, and improving access and availability of condoms

Core Interventions

- IEC and community mobilization with emphasis on the Abstinence Be faithful and Condom use (ABC) principle
- Condom promotion and use
- Provide VCT services up to Health Centre III level
- Provision of PMTCT services up to Health Centre IV level including strengthening of Post Natal Care
- Comprehensive HIV/AIDS care for both adults and children including access to ART at Health Centre IV
- Ensuring nationwide availability of safe blood for transfusion
- Consolidating management of STI, surveillance and infection control.
- Home based care management

3.3.2 Tuberculosis

Notifications of tuberculosis continue to rise and in 2003 a total of 42,901 cases of TB of whom 20,320 were new smear positive were notified. During HSSP I community participation and ownership of the TB program increased. Community based Direct Observed Therapy (CB-DOTS) was expanded to 49 districts improving the treatment outcome. Uniform diagnosis through sputum smear microscopy was adopted as the national strategy for case finding and integrated in the national laboratory network and adopted countrywide. Short course chemotherapy using 4 Fixed Dose Combination Drugs was implemented countrywide. A logistics management system with computerized tracking system was piloted in a few districts and monitoring system was implemented at health sub-district and community level.

Several strategies including expansion of DOTS through Public Private Mix (PPM-DOTS), Intensified Support and Action in Countries (ISAC) and the Practical Approach to Lung Health (PAL Initiative) were initiated. The Uganda STOP TB Partnership was also established to strengthen interagency coordination and harness partner efforts towards the speedy attainment of the 2005 targets and the MDG

The major challenges for the HSSP II period are achieving global targets for case detection, contending with the increasing case load of TB cases, implementing the IEC strategy that was developed in the latter half of HSSP I and establishing a system for surveillance and policy for treatment of multi-drug resistant TB.

Specific targets

i) To have raised from 60.1 to 70% the TB case detection rate
ii) To increase from 62 to 85% the TB cure rate
iii) To reduce from 6.2 to 3.1% the TB associated death rate
iv) To achieve 100% national coverage for TB DOTS
v) To achieve 80% level of concordance quality assurance and control of sputum smear microscopy in all districts.

Core Interventions

- Community based TB Care with DOTS to cover all HSD and sub- counties, including private sector involvement
- Community Mobilization and Participation in the TB control at all levels
- Training microscopists in peripheral laboratories and ensure one laboratory per HSD to be able to undertake sputum smear microscopy
- Partnerships for TB/HIV and STOP TB.

3.3.3 Malaria

Malaria is one of the leading causes of morbidity and mortality in Uganda. During HSSP I, prevention, promotive and case management interventions were employed in combination within the updated national malaria control strategy. The first line treatment of chloroquine and sulfadoxine/pyrimethamine was adopted, replacing chloroquine monotherapy. In the year 2002 a new strategy for home based management of fevers (HBMF) was launched. There has been a significant improvement in the supply of anti-malarial drugs and overall strengthening of the health system. Intermittent preventive treatment in pregnancy (IPT) and Insecticide

Treated Nets (ITNs) were scaled up through a number of partnerships. The coordination of stakeholders was strengthened through the functioning of the Inter-Agency Coordination Committee for Malaria (ICCM). Close drug sensitivity surveillance led to a proposed change in malaria drug treatment policy in 2004 of an Artemesinin-based combination (ACT) as first line treatment regimen. The main challenge in HSSP II, is scaling up the core programme interventions and implementation of the proposed anti-malarial treatment regimen using ACTs.

Specific Targets

i) Increase the proportion of pregnant women who have completed IPT2 from 24 to 80%.
ii) Increase the proportion of households having at least one insecticide-treated net (ITN) from 15 to 70%
iii) Increase the proportion of targeted structures for indoor residual spraying (IRS) in epidemic areas from 0 to 80%.
iv) Increase the proportion of children under five getting correct treatment within 24 hours of onset of symptoms from 25 to 80%.
v) Reduced the case fatality rate among malaria in-patients under five from 4 to 2%

Core Interventions

- Effective case management of malaria
- Selective vector control including indoor residual insecticide spraying (IRS), ITNs, and environmental management
- IPT to pregnant women
- Malaria epidemic preparedness and response
- IEC/BCC for malaria prevention and control.

Disease targeted for elimination and/or eradication

The Government of Uganda is a signatory to international resolutions committed to the elimination and eradication of particular diseases. The diseases targeted for elimination include Leprosy, Guinea Worm, Onchocerciasis, micronutrient disorders (addressed under Nutrition), and Poliomyelitis and Neonatal tetanus (addressed under EPI). In collaboration with various global and regional partnerships, Uganda registered creditable progress towards the elimination targets during HSSP I. HSSP II will continue to target these diseases and support acceleration of their elimination.

Sleeping sickness, Lymphatic filariasis, schistosomiasis and trachoma are diseases of public health potential covering certain geographical areas in Uganda. During HSSP I, the programmes to address the above diseases remained vertical and as a result, registered poor ownership at the district level. During HSSP II this approach will be reviewed with the objective of integrating implementation activities where these are shown to be rational, practicable and more cost-effective. Appropriate guidelines shall be formulated for integrated vector management, as well as integration of other control measures such as IEC, community managed drug distribution and mass treatment.

3.3.4 Leprosy

Uganda achieved the WHO global target for elimination of leprosy as a public health problem in 1994. The challenge in HSSP II is to maintain the required level of interest, skills, commitment and investment in resources to sustain the elimination status.

Specific Targets

i) To reduce the prevalence of leprosy to less than 1 case per 10,000 population
ii) To reduce the rate of grade II disability in newly diagnosed cases to less than 5%

Core Interventions

- Leprosy Elimination Campaigns
- Active case finding in the high burden areas
- Periodic examination of school children
- Systematic contact surveillance for new leprosy cases
- Health worker training in diagnosis, treatment & referral of cases
- Awareness building for self care among Persons Affected with leprosy.

3.3.5 Guinea worm

During HSSP I, guinea worm was virtually eliminated with only one village in Kotido reporting 13 cases in 2003. The program however still faces the challenges of cross border cases imported from Sudan. The persistent insecurity that prevails in most of the previously endemic districts results into movement of people across the border increasing the risk of importation of disease.

Specific Targets

i) To achieve 100% case containment

Core interventions

- Advocating for increased access to safe water supply in endemic districts
- Re-training village volunteers and sub-county supervisors on all interventions
- Case- management and containment of reported Guinea Worm cases.
- Vector control through Abate application to ponds and filtering unsafe water
- Active surveillance system and information gathering
- Reward scheme for the improvement of sensitivity of surveillance

3.3.6 Onchocerciasis

During HSSP I, all (100%) communities affected by onchorcerciais were reached for mass treatment with Ivermectin and vector control measures using Community Directed Ivermectin Distribution model (CDTI). The mass treatment covered 100% of all eligible clients in FY 2003/04. CDTI was to cover new areas such as Soroti, Kumi & Kaberamaido districts. The interruption in funding of the programme in 2004 poses the risk of reversing the gains made so far. During HSSP II, the focus will be on advocacy for CDTI support by local governments and integrating CDTI within the mainstream PHC structure.

Specific targets

i) Eliminate Onchocerciasis as a disease of public health importance in all districts
ii) Achieve at least 70% therapeutic coverage in all affected communities.
iii) 90% of endemic districts integrate CDTI activities within their district health plans

Core Interventions

- Advocacy for CDTI support
- Integration of community mobilization and sensitization activities
- Capacity building at district and community levels and in schools for prevention and management of onchocerciasis

3.3.7 Trachoma

During HSSP I, Uganda became a signatory of the World Health Organisation Alliance for the Global Elimination of Trachoma (GET). The mapping of trachoma within districts was done in 2003 which indicated that the 15 most endemic districts are located mainly in Eastern and North Eastern regions of Uganda.

Specific targets

i) All endemic districts integrate prevention and control measures within the district workplans
ii) Reach 100% of the communities with mass distribution of tetracycline and Azithromycin
iii) Increase by 30% access to, and provision of surgical services to patients with trichiasis

Core interventions

- Mass community distribution of Tetracycline and Azithromycin
- Training of lid rotation surgeons and provision of equipment
- Promotion of school facial hygiene practices, family sanitation and improved water supply through the school health programme.
- Capacity building in the communities and schools to address the prevention and control of Trachoma

3.3.8 Lymphatic Filariasis

During HSSP I a mapping exercise for Lymphatic Filariasis in 20 affected districts was completed and a national plan of action developed. Uganda became eligible for the Alliance's drug donation programme for Albendazole and Ivermectin for Mass Drug Administration (MDA) and mass administration campaign were initiated in selected districts. During HSSP II the remaining endemic districts will be systematically introduced into the programme.

Specific targets

i) To achieve 90% therapeutic coverage for the affected people with a single annual dose of Ivermectin and Albendazole
ii) Reduce by 25% morbidity and disability associated with Lymphatic Filariasis

Core interventions

- Mass drug administration in all the endemic areas
- Intensive public education and social mobilization

3.3.9 Trypanosomiasis (Sleeping sickness)

During HSSP I, the transmission was nearly interrupted in the two major endemic foci for sleeping sickness in Uganda (West Nile and Eastern Regions) However a re-emergence of active transmission occurred and has now reached epidemic proportions in both foci. The disease has also spread to new areas within Soroti, Kumi & Kaberamaido districts. In 2000, the Pan African Tsetse and Trypanosomiasis Eradication Campaign was established and launched on 5/10/2001, calling for mobilization of the international community and African countries in particular, to combat sleeping sickness. During HSSP II, the focus is on scaling up efforts to interrupt transmission through integrated vector management and active case detection and management.

Specific Targets

i) Improved by 80% access to and quality of diagnostic and treatment facilities
ii) Community empowerment for sleeping sickness control for 100% of the communities in the endemic districts.

Core Interventions

- Social mobilization
- Case detection & management including regular screening of communities
- Drug distribution
- Integrated Vector Management
- Sleeping sickness surveillance and monitoring.

3.3.10 Schistosomiasis and soil transmitted helminths

During HSSP I, a national plan for the control of Schistosomiasis and soil transmitted worms was developed and resources mobilized through the Gates Foundation funded Schistosomiasis Control Initiative. A pilot phase involving treatment of 500,000 individuals in 18 districts was completed. In October 2003, in collaboration with the measles campaign, 9 million school age children were de-wormed. During HSSP II, the focus shall be on scaling up the intervention to reach the new populations at risk in addition to re-treatment of previously treated populations both in the communities and schools.

Specific targets

i) To achieve 100% coverage of all the endemic districts with mass chemotherapy
ii) 100% of the endemic districts integrate prevention and control measures within the district workplans

Core Interventions

- Social mobilization

- Periodic mass chemotherapy
- Systematic regular treatment in school-age children at risk of morbidity
- Selective vector (snail) control
- Advocacy for improved water supply and sanitation.
- Capacity building in the communities and schools to address the prevention and control of schistosomiasis

Mechanisms for scaling up interventions for the Control of Communicable Diseases cluster

1. Providing of targeted capacity and technical support to districts to take ownership and management of communicable diseases.
2. Ensuring availability of drugs for disease management and increase on the efficiency of community distribution through community drug distributors
3. Integrating control measures for communicable diseases including integrated vector management
4. Involvement of the private sector in case detection and strengthen in-country partnerships for disease control e.g. TB
5. Institute regular Drug Resistance Surveys and integrated disease surveillance

3.4 Cluster 4 - Control of Non-Communicable Diseases/Conditions

The National Health Policy calls for the assurance of basic essential clinical care, including emergency care, and care of common illnesses and injuries. It recognizes that while infectious diseases must be given priority, selective attention will be given to all the key determinants of ill health in Uganda, including unhealthy lifestyles, non communicable diseases and the rising toll of accidents. Under HSSP II, greater attention will be devoted to meeting the basic clinical needs and addressing non communicable diseases.

Non-communicable disease cluster objective

To decrease the mortality and morbidity due to non-communicable diseases, injuries and common emergencies.

3.4.1 Prevention and Control of Non-Communicable Diseases

Non-communicable diseases (NCD) include the chronic illnesses that are prolonged, do not resolve spontaneously, and are rarely cured completely. They include hypertension, diabetes mellitus, bronchial asthma, stroke, cardiovascular diseases, sickle cell disease, cancer and arthritis. Although both the NHP and HSSP I recognized the emerging importance of non-communicable diseases, the latter contained no specific section that provided guidance on how to address non-communicable diseases. HSSP II shall address the lack of information on the magnitude of the problem and therefore will initially focus on quantification of the disease burden and sensitization of the population.

Specific Targets

i) Establish the Burden of Disease and main risk factors for Non-communicable disease conditions in Uganda by end 2005
ii) Increase community awareness on NCDs/conditions to 80 %

iii) 100% of districts implementing social mobilisation for the prevention and control of NCD/conditions
iv) Integration of NCD prevention and management in the functions of 100% of HC IVs

Core interventions

- Formulation of the national policy and medium term strategic plan for NCD (end of 2006)
- Build community awareness on prevention and control of NCDs using a multisectoral approach
- Development and implementation of an information and advocacy strategy on the public health importance of NCD
- Capacity strengthening at all HC IVs to correctly manage NCDs so as to prevent avoidable complications.

3.4.2 Injuries, disabilities and Rehabilitative Health

This element of Non-Communicable diseases encompasses conditions that result in deprivation or loss of the needed competency. This may be due to damage or harm done to or suffered by a person before or after birth. The conditions include deafness, blindness, physical disability, and learning disability.

In Uganda, 10% of the population have hearing impairment, while 250,000 are blind, the causes of which are largely preventable. The population of 60years and above has increased from 4% to 6% between 1991 and 2002. Despite increasing demand, geriatrics services are non-existent. Currently, only 2% to 25% of People with Disability (PWDs) have access to rehabilitation services. Uganda has adopted community-based rehabilitation (CBR) as the main strategy to reach PWDs with services. Death from road traffic crashes has more than doubled over the past 10 years from 992 in 1993 to 1,996 in 2003. In 1998 Uganda lost 151.7 billion shillings through road traffic crashes accumulated from costs of fatalities, injuries, and vehicle damage. The cost for 2003 is estimated at over 300 billion shillings. Globally, the cost of accidents lies between 1-2% of the world's Gross National Product.

During HSSP I, disability, prevention and rehabilitation section in the MoH was established. In addition an Injury Control Unit was set up in Mulago National Referral Hospital, which works closely with the MoH. Several new partnerships have also been built including civil society organizations. During HSSP II further consolidation of injuries and disabilities will be made with a focus on integrating these programmes with other sectors and activities.

Specific Targets

i) To reduce hearing impairment from 10% to 8%
ii) To reduce visual impairment from the estimated 1% to 0.8%
iii) To increase provision of assistive devices to PWDs who need them
iv) To reach 80% of the population with messages on Disability Prevention and Rehabilitation.

Core interventions

- Put in place preventive, promotive and rehabilitative interventions to reduce mortality morbidity or disability caused by injuries

- Strengthened orthopaedic workshops for production of assistive devices
- Dissemination of guidelines on the handling of trauma, disabilities and rehabilitation
- Intensive mobilization of communities for early detection and proper treatment of disorders of sight and hearing in order to minimize complications.
- Enhanced collaboration with the Social Development Sector with respect to the Community Based Rehabilitation initiative.
- Improve documentation and data of the scope of burden of disability.

3.4.3 Gender-Based Violence (GBV)

Gender based violence arises from discrimination and oppression particularly against women and children but also experienced by some men. It includes physical and psychological injury due to domestic violence, assault, rape and defilement, conflict situations as well as cultural practices including Female Genital Mutilation (FGM).

Specific Targets

i) Integrated strategy to address GBV in the health sector developed and disseminated

Core Interventions

- Compile and analyse information available to establish the prevalence of GBV in Uganda and formulate strategic interventions for the Health Sector
- Initiate a campaign to raise awareness about GBV amongst healthcare workers.
- Support agencies and organizations that work to address GBV and violence against women
- Enhance partnership with other sectors (Social Development Sector and Justice, Law and Order Sector) and Civil Society Organizations.

3.4.4 Mental Health and Control of Substance Abuse

Mental Health and Control of Substance Abuse is not merely the absence of mental disorder or illness but also includes a positive state of mental well being. It describes the capacity of an individual for social adaptation, to fulfil their social roles and responsibilities. It also describes the capacity to handle frustrations and enjoy life and the capacity to cope with most of life's daily challenges.

Mental Health problems account for 12.5% of the global burden of disease. They include mental health disorders/conditions such as depression, schizophrenia, psychosocial disorders and substance abuse related disorders. The Mental Health Programme also coordinates management of neurological disorders such as epilepsy which affects about 3% of the general population.

Specific Targets

i) 100% of the Regional Referral Hospitals with functional Mental Health Units
ii) To increase community access to mental health services by 50%
iii) To establish a community strategy for prevention of mental health problems.

Core interventions

- Promote the integration of mental health services into Primary Health Care
- Development and dissemination of appropriate messages for improving community mental health
- To promote the rights of the mentally ill
- Monitor and provide technical support supervision at all levels
- Provision of care for neurological disorders at primary care level
- Provide services for demand reduction for alcohol and drug abuse,
- Address effects of trauma and violence in conflict situation.

3.4.5 Integrated Essential Clinical Care

The National Health Policy calls for the assurance of basic essential clinical care, including emergency care, and care of common illnesses and injuries. The essential clinical care involves the management of communicable and non communicable disease conditions to achieve the best possible outcome. The Integrated Essential Clinical care component cuts across Clusters 1 and 2. During HSSP I, basic essential clinical care focused on improving provision of basic medical services. During HSSP II greater effort will be put on improving emergency care in addition to consolidating the essential clinical services. This shall be achieved through more systematic training of service providers and provision of essential medicines and supplies.

Specific Targets

i) All health units providing basic and life saving measures to the victims
ii) Establishing a functional ambulance system
iii) Establish functional Accident and Emergency Units in 100% of Regional Referral Hospitals
iv) Establish casualty units in 80% general hospitals
v) Train key health workers in emergency response in all hospitals.

Core interventions

- Improved case management of common illnesses and injuries
- Public education on prevention and control of common illnesses and injuries.

3.4.6 Oral Health

Oral health encompasses the positive aspects of good oral health, all oral conditions including dental caries, periodontal disease, derangement of oral-facial tissues and other oral pathology including oral cancer.

Specific Targets

i) National policy and guidelines on oral health in place and being implemented
ii) 80% of HC IV with well equipped and functional dental units
iii) Awareness of the population on the risk factors and prevention of oral diseases/conditions increased to 80%
iv) 80% of the population has access to primary oral health care.

Core Interventions

- Public information and education
- Capacity development for delivery and management of oral/dental health conditions
- Assuring fully operational oral health infrastructure.

3.4.7 Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with diseases not responsive to cure, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other symptoms, physical, psychosocial and spiritual. Currently, very limited services are available.

Specific Targets

i) All hospitals and HC IVs providing palliative care
ii) Assurance of adequate stocks of appropriate medication and supplies at palliative care centres.

Core Interventions

- Building capacity for palliative care in collaboration with other stakeholders
- Strengthened partnerships with community based palliative care providers
- Strengthened referral systems and linkages with health services and home care
- Intensified public education on palliative care
- Community based rehabilitation of the terminally ill.
- Outreaches established and strengthened
- Palliative care integrated into the curricular of health training institutions.

CHAPTER 4: INTEGRATED HEALTH SUPPORT SYSTEMS

Introduction
Effective delivery of the integrated UNMHCP requires strengthened supportive systems, services and inputs. This chapter outlines the strategies and actions adopted in HSSP II to achieve coordinated support for delivery of the minimum package.

The main components of the health support systems are:
i) Health system inputs
    a. Human Resources for Health
    b. Health Infrastructure and
    c. Essential medicines and health supplies
ii) Diagnostic and blood transfusion services
    a. Laboratory services
    b. Imaging services
    c. Blood transfusion services
iii) Information for decision making
    a. The Health Management Information System
    b. Information and Communication Technology
    c. Integrated Disease Surveillance
    d. Research and Development
iv) Legal and regulatory framework.

In this chapter, planned investments for achieving an optimal balance for scaling up the priority interventions within the available resource envelope are defined. Achieving this delicate balance is perhaps the greatest challenge of HSSP II. The need for reliable, timely, evidence-based information for rational decision-making in policy and programme implementation will be of paramount importance. The legal and regulatory framework under which the plan will be implemented is also addressed in this chapter.

4.1 Health System Inputs

Among the lessons learnt from implementing HSSP I is the need for coherent and balanced planning and sequencing of the inputs of operating budgets, infrastructure, human resources, and essential medicines and other health supplies. This lesson has been taken as the underlying principle for implementing the strategic plan. Judicious flexibility will be applied in the allocation of resources so as to achieve an optimum balance in the mix of inputs.

Overall objective

To achieve the appropriate quantities and mix of inputs; human resource, infrastructure and essential medicines and health supplies in order to enable delivery of UNMHCP in an efficient and equitable manner.

4.1.1 Human Resource for Health

HSSP I recognized that reforms in the health sector present major challenges for human resource training, deployment and management. Availability of trained health workers is

perhaps the most critical limiting factor for the delivery of the minimum package. In addition to the Ministry of Health, other stakeholders include the Ministry of Education and Sports, Ministry of Local Government (District Service Commissions), Ministry of Public Service, Health Service Commission and Private not for Profit sector. A human resource policy and strategic plan is essential to guide the various stakeholders. The partnership implementation strategies on human resource development and management emphasize harmonisation between the government and PNFP sector. HSSP II will ensure strengthened coordination between the stakeholders, availability of trained human resources for health, appropriately deployed, and managed.

Human Resource Staffing

Availability of appropriately trained human resources is an important pre-requisite for the delivery of the Minimum Health Care Package. HSSP I defined the minimum staffing norms for each level of service delivery and aimed at attaining at least 75 % of the minimum staffing norms at each level of the district health system. This target was revised to 52% of all approved posts to be filled by appropriately trained staff. Approximately 2,900 health workers were recruited during HSSP I. This increased the proportion of approved posts filled with trained health workers from 33% to 68% (when Nursing Assistants are included this comes to 86%).

The total number of staff in the public health sector, including the PNFP, is approximately 30,000 (Table 4.1 below). Of these, 53% are in government Health Centres IIs – IVs and General Hospitals (total health workers at the district level), 30% at PNFP Health Centres IIs – IVs and hospitals, while the rest (17%) are in Regional and National Referral Hospitals and the Ministry of Health headquarters.

Table 4.1: Current numbers of Human Resource for Health – GoU/PNFP

	Districts	DDHS	Total Districts	RH	Mulago	Butab.	Total GoU	PNFP	Total
Clinical	1 319	53	1 372	168	91	7	1 638	436	2 074
Medical	308	50	358	164	111	15	648	305	953
Midwifes	1 635	18	1 653	312	147	35	2 147	914	3 061
Nursing	2 542	34	2 576	758	1 114	86	4 534	1 915	6 449
Total Medical/clinical	5 804	155	5 959	1 402	1 463	143	8 967	3 570	12 537
Nursing Assistants	4 165	21	4 186	175	123		4 484	2 005	6 489
Diagnostic	356	4	360	79	75	3	517	358	875
Pharmacy	76	22	98	29	25	6	158	43	201
Other Medical related	988	161	1 149	63	144	5	1 361	126	1 487
Other staff	1 627	245	1 872	462	433	79	2 846	3 052	5 898
Total	13 016	608	13 624	2 210	2 263	236	18 333	9 154	27 487
Payroll Nov03			**16 070**	**2 284**	**2 092**	**283**	**21 254**	9 154	**30 408**
Difference/adjustment			2 446	74	-171	47	2 921		

Source: Human Resource Inventory, MoH Aug- 04; GoU Payroll Nov 03

Although the numbers of qualified health workers improved it is still inadequate for effective delivery of the minimum health care package (see Table 4.2 below on staffing levels) and the workforce is constrained by the unequal distribution and inappropriate skills-mix.

As shown in Table 4.2, the overall gap between the HSSP I norms and the actual staffing for all districts (GoU and PNFP) and regional referral hospitals is 4,909. The overall staff gap specifically for district HC II -IV and General Hospital (GoU) is 1,082. This takes into

consideration that surplus staff from one district cannot be re-distributed to another district with staff deficiencies. Certain cadres of health workers especially diagnostic, dental and pharmacy staff which have few numbers on the markets have posed extra difficulty to fill their positions across all districts. Nursing Assistants continue to constitute the bulk of the staff at all levels of health care. 255 out of 870 HC IIs, close to 30%, are staffed by Nursing Assistants only. These have been trained through an in-service training programme to upgrade their skills. So far a total of 4,656 Nursing Aides have been trained to become Nursing Assistants.

The capacity to recruit qualified health workers varies from district to district. Some districts are more able to attract and recruit qualified health workers than others. Whereas the overall national coverage is 68 %, the coverage of the individual districts ranges from 26 – 263 %. In addition, there are substantial variations in coverage between facilities within individual districts. The HRH Inventory shows that 65 GoU HC IIs are not staffed at all

Table 4.2: Analysis of Actual Number of Staff and Minimum Staffing Norms - All GoU and PNFP Health Facilities.

	GoU: HC2-GH			PNFP: HC2-GH *			RH No. 10			Total Districts (GoU/PNFP) & RH		
	Act	norm	Gap	Act	norm	Gap	Act	Norm	Gap	Act	Norm	Gap
Clinical	1,319	1,474	-155	436	762	-326	168	347	-179	1,923	2,583	-660
Medical	308	304	4	305	334	-29	164	346	-182	777	984	-207
Midwifes	1,635	798	837	914	1,540	-626	312	369	-57	2,861	2,707	154
Nursing	2,542	5,254	-2,712	1,915	2,908	-993	758	922	-164	5,215	9,084	-3,869
Total Medical/clinical	5,804	7,830	-2,026	3,570	5,544	-1,974	1,402	1,984	-582	10,776	15,358	-4,582
Nursing Assistants	4,165	2,606	1,559	2,005	2,190	-185	175	203	-28	6,345	4,999	1,346
Diagnostic	356	1,208	-852	358	529	-171	79	145	-66	793	1,882	-1,089
Pharmacy	76	266	-190	43	126	-83	29	67	-38	148	459	-311
Other Medical related	988	1,322	-334	126	203	-77	63	138	-75	1,177	1,663	-486
Other staff	1,627	866	761	3,052	3,193	-141	462	869	-407	5,141	4,928	213
	13,016	14,098	-1,082	9,154	11,785	-2,631	2,210	3,406	-1,196	24,380	29,289	-4,909

*Table 4.2 includes all 40 PNFP hospitals, some of which are more comparable with Regional Referral Hospitals rather than General (district) hospitals.

While the health policy is in favour of workload based staffing norms, the practice in HSSP I was application of fixed facility based norms. The staffing norms were in some cases exceeded depending on resource availability in particular districts and there are significant workload variations between facilities at the same level within the individual districts. HSSP I staffing norms are the absolute minimum required to deliver the Minimum Health Care Package. During HSSP II, the norms will be revised to reflect the actual workloads expected at each level of health care delivery. Table 4.3 shows the HSSP I staffing norms and the proposed staffing levels as proposed by the Restructuring of the Local Governments. The new proposed staffing norms will be implemented in a phased manner during HSSP II. The priority shall be given to increase from one to two Medical Officer at HC IVs and from one to two Enrolled Comprehensive Nurses at HC II.

Human Resource for Health Training

The capacities for training remain insufficient to meet the human resource needs for the health sector. The responsibility of the pre-service training of health workers lies with the Ministry of Education and Sports (MoES). Ministry of Health retains a role in defining the standards and to guide the MoES in the cadres and number to be trained.

Table 4.3: HSSP I Staffing norms and Local Governments Staffing levels for District Health Services

Cadre of staff	Number per level							
	HC II		**HC III**		**HC IV**		**General Hospital**	
	HSSP I norms	LG Staffing norme.	HSSP I norms	LG Staffing norms	HSSP I norms	LG Staffing norms	HSSP I norms (not indicated)	LG Staffing norms
Medical Officers								
Principal Medical Officer								1
Medical Officers, special grade(community)								1
Senior Medical Officer						1		1
Medical Officer					1	1		4
Dental								
Dental Surgeon								1
Public Health Dental Officer					1	1		2
Dental Attendant								1
Pharmacy								
Pharmacist								1
Dispensers					1	1		2
Nursing								
Principal Nursing Officer								1
Senior Nursing Officer						1		5
Nursing Officer (Nursing)			1	1	1	1		17
Nursing Officer (Midwifery)					1	1		3
Nursing Officer (Psychiatry)						1		1
Public Health Nurse						1		1
Enrolled Psychiatric Nurse						1		2
Enrolled Nurse	1	2	2	3	2	3		46
Enrolled Midwives				2		3		25
Nursing Assistant	2	2	1	3	1	5		15
Allied Health Professional								
Senior Clinical Officer				1				1
Clinical Officer			1	1	2	2		5
Psychiatric Clinical Officer								1
Ophthalmic Clinical officer						1		1
Health Inspector					1	1		1
Health Assistant			1	1		1		
Medical Entomology Officer					0.5	1		1
Radiographers								2
Physiotherapist								1
Occupation Therapist								1
Orthopedic Officer								2
Health Educationist/Educator								1
Assistant Health Educator					1	1		1
Aneasthetic Officer					1	1		2
Aneasthetic Attendant /(Theater Attendant?)								2
Senior Laboratory Technologist								1
Laboratory Technologist								1
Laboratory Technician				1	1	1		2
Laboratory Assistant			1	1	1	1		1
Administrative and other staff								
Senior Hospital Administrator								1
Hospital Administrator								1
Personal Officer								1
Medical Social Worker								1

Nutritionist								1
Supplies Officer								1
Steno-Secretary								1
Office Typist						1		1
Stores Assistant						1		2
Health Information Assistant (Records Assistant)				1	1	1		2
Senior Accounts Assistant								1
Accounts Assistant								2
Support staff								
Cold Chain Assistant						1		
Darkroom Attendant								1
Mortuary Attendant								1
Drivers						1		2
Cooks								3
Guards/Askari		2		2		3		2
Artisan								3
Support		2		2		3		

Source: HSSP I and Final Report a Report of Review and Restructuring of the Local Governments and staffing levels. (Revised copy 2005), Ministry of Public Service February 2005
Comments:
1. There will be customization of the staffing level for each district
2. The table have a few missing cadres e.g. Theater assistant which is still under debate.

The training institutions are based at public or PNFP hospitals. The largest capacity for nurse training is in the PNFP sector. HSSP I stipulated that training o Enrolled Nurse/Enrolled Midwife would be gradually phased out in favour of training of Enrolled Comprehensive Nurse (ECN), with a curriculum for eventual converting of the existing single trained cadres.

By end of 2004, ten training schools had initiated the ECN training programme and the number of schools is set to increase over the HSSP II period. The training of other crucial Primary Health Care workers such as Theatre Assistants, Anaesthetic Assistants, Clinical Officers, Health Inspectors and the registered Nursing cadres progressed. However, training of laboratory and pharmaceutical staff has remained low and urgent measures are required to scale-up their training.

An In Service Training Strategy was developed in 2002 to address the challenges observed. During the HSSP II, measures will be taken to ensure the implementation of the IST strategy. Health professionals in clinical disciplines (such as Anaesthesia, Pathology, Physiology, Microbiology, ENT, Community Practice and Ophthalmology), super-specialities (such as Urology, Plastic Surgery, Neurology Palliative Care, Theatre Nursing, Professional Counseling, Clinical Psychology and Cardiology), and Public Health, Policy, Planning and Management skills are required. In the HSSP II, this area should be focused on to enable the sector realize adequate numbers for delivery of the above name specialized skills, to support the delivery of the NMHCP

Overall Objective

To increase availability of trained and motivated staff (public and PNFP staff) that are equitably distributed throughout the country who will contribute to the effective delivery of the Uganda National Minimum Health Care Package.

Specific Objectives and Targets

Objective 1: Provide and maintain a policy and strategic framework to guide the HR process

i) By year 2006 have a comprehensive HRH policy in place that is in harmony with national and the major HRH stakeholders policies,
ii) By year 2006 have a long-term (15-20 year) HRH strategic plan in place that is based on flexible and sustainable HRH projection models,

Objective 2: Avail in an equitable and balanced way the human resource capacity to deliver the UNMHCP with the available envelope.

i) The proportion of approved posts filled by health professionals increased from 68% to 90 % by year 2009. (HSSP I staffing norm)
ii) By year 2009 have leveled out the variation in staffing level between the different districts and health units (GoU and PNFP) so no district/unit is having a staffing level below 80 % of the HSSP I staffing norms.

Objective 3: Strengthen institutional capacity for HR policy, planning and management (HR PPM)

iii) By December 2005 an integrated HRH information system as part of the HMIS in place whereby health managers at appropriate levels keep the HR inventory up-dated and maintained.

Objective 4: Enhance capacity and relevance for training of health workers in partnership with other stakeholders

i) 80% of health worker training programmes having an accredited performance based modular training curriculum with related assessment system geared toward UMHCP by December 2008
ii) Strengthened training management capacity at national and institutional level within the GoU and PNFP organization structures through consistent and strong participation in collaboration mechanisms throughout the HSSP-2 period

Objective 5: Upgrade and enhance competencies and performance of health workers.

i) 90% of trained HW exposed to high quality integrated IST for at least 2 but not more than 4 weeks biannually from July 2007 onward

4.1.2 Health Infrastructure Development and Management

During the HSSP I, effort was made to establish a clear hierarchy of health service delivery. The key objective was to establish a network of functional, efficient and sustainable health infrastructure for effective health services delivery closer to the population. Construction, rehabilitation and equipping of health centres were undertaken. Geographical accessibility of households to health facilities increased from 49% pre HSSP to 72% in 2004 as a result of construction of new HC IIs. The upgrading of HC IIs to HC IIIs and HC IIIs to HC IVs respectively led to improved health service delivery. In order to improve emergency obstetric care, theatres and medical officers' houses were constructed at HC IVs. By 2004, 151 Health

Centres had been designated HC type IV by the Ministry of Health (Volume II). Tables 4.4 and 4.5 show the progress registered. Approximately 18 HC IVs operating theatres were functional as of end June 2004.

Table 4.4: Theatres and Doctors' house construction (Dec. 2003)

Completion status	Number of Theatres	Number of Doctors' houses
Complete	110	128
Ongoing	34	5
No work yet	7	18
Total	151	151

Source: Health Facilities Supervision Report (Dec. 2003)

Table 4.5: Upgrading and construction of health facilities

Activity	Number completed	HSSP target
Upgrading HCII to HCIII	180	No specific target
HCII construction	400	868

Source: Health Facilities Supervision Report (Dec. 2003)

Approximately 400 HC IIs were constructed by end of 2003. Although HSSP I recognized that construction of HC IIs was going to be limited to only identified underserved areas, there was incomplete data on new health units constructed. There was a mismatch between construction of new health facilities and the capacity to make these facilities functional in terms of human resources, medical equipment and operational budgets. There is still wide variation of accessibility to basic health services across districts. Table 4.6 shows the variation in accessibility across some selected districts.

Table 4.6: Variations in accessibility across selected districts

No.	District	Pop. within 5 km radius ('000)	% pop. within 5 km radius
1.	Kotido	13.2	7.1
2.	Kitgum/Pader	51.3	13.1
3.	Gulu	168.2	32.6
4.	Bushenyi	437.1	55.5
5.	Katakwi	98.3	56.6
6.	Kiboga	99.3	68.8
7.	Jinja	414.9	99.7
8.	Tororo	486.1	99.8
9.	Kampala	1,358	100

Source: The Health Infrastructure Maps 2002

Although accessibility to basic health services has improved, quality of health services has not improved correspondingly mainly because many of the new health units have remained non operational due to lack of staff and equipment. The turn-over of staff has been very high at some health units because of lack of decent accommodation for staff, and incentives that would keep the staff in the hard-to reach areas.

A few hospitals under went partial rehabilitation/renovation while the majority remained in a state of disrepair.

Maintenance of health infrastructure and medical equipment remained a major challenge in HSSP I. The budgets for maintenance were inadequate. The contribution for maintenance of

medical equipment from the hospitals and HSDs serviced at the Regional Maintenance Workshops is inadequate. In addition, infrastructural maintenance is not prioritized during the budgeting process. Limited funds are allocated for maintenance of equipment and buildings despite the guidelines which state that 5% of the non wage funds allocated to the health facility should be used to carry out maintenance work. During HSSP I there was inadequate capacity in the districts to manage Infrastructure Development projects (i.e. both the construction companies and the Engineering Departments at the districts. In addition there was inadequate supervision and monitoring of construction of health facilities from all levels (central governments and local governments) which resulted in poor quality workmanship at most facilities constructed.

Overall objective

To consolidate the existing health facilities to enhance their functionality and to increase accessibility to health services and quality of health care delivery within the available resource envelope.

Specific objectives and Targets

Objective 1: To consolidate functionality of existing lower level health facilities

i) All HCIII & HCIV with OPD, maternity and general wards where they are lacking.
- HCIV
  - Maternity – from 92% to 100%
  - G/Ward – from 79% 100%
  - Mortuary – 29% to 100%
  - Blood Bank 100%
- HCIII
  - OPD Block – from 96% to 100%
  - Maternity – from 69% to 100%
  - G/Ward – from 36% to 100%

ii) 100% of HCIII & HCIV with basic accommodation for core staff and 85% for core staff at HCII.

iii) Provide reliable Water Supply, Sanitation and Health Care Waste Management facilities to achieve the targets below:
- 80% of HCII & III having a water source,
- 75% of HCIV having running water in maternity, laboratory and theatre,
- 100% of HCs with at least 1 pit latrine and
- 50% of the HCIV with an incinerator

iv) Improve access to energy for all levels of health care to the following levels:
- 65% of HCII having access to modern lighting.
- 70% of HCIII having access to modern energy lighting for maternity and laboratory.
- 100% of HCIV having access to modern energy for lighting and operation of basic medical equipment.
- 60% of the staff houses having access to modern lighting and
- 100% of HCIII and IV having adequate vaccine refrigeration
- 100% HC II – HC IV having improved energy efficient stoves for sterlisation and cooking.

Objective 2: To strengthen the referral system

i) Provide communication facilities to achieve the following levels:
   - 100% of hospitals with at least one form of communication facility and e-mail service,
   - 100% of the HCIV with at least one form of communication facility and email service,
   - 80% of HCIII with at least one form of communication facility

ii) Provide transport and ambulatory services to achieve the following levels:
   - 100% of hospitals and HCIVs with a adequate transport services,
   - 70% of HCIIIs with at least a motor cycle,
   - 100% of HCIIs with at least a bicycle,
   - 100% of hospitals with ambulances,
   - 85% of HCIVs with ambulances and
   - Provide motorboats for difficult areas (islands)

iii) Upgrade up to 7 HC IV to provide specialized diagnostics services (provision of medical diagnostics and imaging is further elaborated under Section 4.2)

Objective 3: To rehabilitate/consolidate/remodel existing secondary and tertiary health facilities

i) 70% of the General hospitals rehabilitated and equipped.
ii) 80% of the referral hospitals rehabilitated and equipped.
iii) 100% of the referral hospitals with mental health services
iv) 100% of the hospitals with an incinerator
v) Construction of a national incinerator.

Objective 4: To strengthen management of health infrastructure and establish a sustainable maintenance programme

i) At least 5% of the annual non wage recurrent budget allocated and used for maintenance of infrastructure at health facility.
ii) Appropriate maintenance structure put in place.
iii) All infrastructure procured should be approved/cleared by the Health Infrastructure division.
iv) 95% the hospitals having required number of technicians and Artisans.
v) At least 2 Engineers/Technicians trained in Biomedical Engineering annually.

Objective 5: To increase accessibility to within 5Km walking distance especially in hard-to-reach areas in order to reduce disparity in access between districts

i) National accessibility increased from 72% to 85%.

4.1.3 Procurement and Management of Essential Medicines, Vaccines and Health Supplies (EMHS)

HSSP I aimed at assuring constant availability of safe and efficacious essential medicines and health supplies (EMHS) and associated logistics required for the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP) nationwide. It also aimed at developing a harmonized, sustainable and efficient procurement and supplies management system. A comprehensive approach to medicines and health supplies that included drug policy development, coordinated selection and quantification of needs, procurement, storage and distribution, rational use, cost recovery, quality control and regulation was to be adopted.

During the HSSP I period, funding for EMHS increased from a baseline of <$0.80/capita to > $1.50/capita by FY 03/04. However, this amount is still far below the estimated minimum of US $3.5 per capita required for the delivery of EMHS for the UNMHCP. Moreover, the EMHS budget requirement would be expected to grow by $2.00 - $2.50 as new technologies such as ACT, long-lasting ITNs, ARVs and pentavalent vaccines are incorporated into the UNMHCP during the HSSP II period.

The Ministry of Health changed the drug ordering system from a push to a pull (order-based) system. A dedicated Essential Drugs Account (EDA) was established at the MoH to service credit lines at National Medical Stores and Joint Medical Stores as a mechanism to channel and therefore integrate all funds for public sector EMHS procurement. This change has significantly improved efficiency in medicines management and availability of EMHS at facility levels. These improvements have been greatly assisted by the establishment within the Pharmaceuticals section of MoH of a district-focused District Medicines Management Programme (DMMP) which is guiding the process of harmonization of procurement and strengthening of EMHS management.

Planning and implementation of parallel EMHS procurement effected through donor-supported programmes and projects remains a critical problem. New initiatives like the GFATM and PEPFAR are creating an increasingly complex environment for the efficient and effective planning, contracting and management of EMHS procurement.

The drug policy was reviewed, a detailed comprehensive National Drug Policy (NDP 2002) developed and a five year National Pharmaceutical Sector Strategic Plan (NPSSP) to implement it prepared, costed and is now being implemented.

Despite the above progress, there remains an urgent need to establish an effective and appropriate structure at central MoH to coordinate, support, supervise and monitor implementation of the NDP and national pharmaceutical sector development initiatives. There is need to radically improve pharmaceutical management at local government levels by filling the many vacant pharmaceutical posts and through appropriate training of other health workers. There are severe and chronic human resource constraints throughout the pharmaceutical sub-sector resulting from low capacity and output of training institutions and non-harmonization of training

The process of gaining consensus on review and development of essential pharmaceutical sector legislation remains unnecessarily long and bureaucratic. Implementation of the NDP/A Act 1993 and the NMS 1993 statutes have been adversely affected by conflicting or inadequate legislation provisions, limited institutional capacities, management problems,

changes in the regulatory environment (eg. decentralization) and (particularly in the case of NDA) chronic severe under-funding.

The NMS statute will also require review to harmonize it with existing procurement legislations. In particular the special nature of, and requirements for, pharmaceutical procurement will need to be explicitly addressed in such legislation.

Overall objective

To ensure the availability of adequate quantities of good quality essential medicines and health supplies required for delivery of the UNMHCP at all levels of the health care delivery system.

Specific objectives and targets

Objective 1: To ensure implementation of the National Drug Policy[13] through an effective pharmaceutical management structure in the MoH headquarters and within the districts

i) Doubled annual out put of pharmacists and pharmacy technicians by training institutions through new integrated training programme and appropriate review and revision of training curricula to meet health sector technical and skills needs
ii) Department of Pharmaceutical Services and Health Supplies established at MoH and the vacant posts in district hospitals and lower level facilities filled to facilitate optimal management of EMHS

Objective 2: To ensure the constant availability and accessibility of key items required for the provision of priority core UNMHCP interventions at each level of the health system through a comprehensive, integrated and harmonized EMHS procurement, financing and logistics system (including any third party contributions)

i) An overall national EMHS budget of at least US$ [2.40] per capita achieved, excluding 'additive' funding from global initiatives
ii) Zero stock-out of HSSP indicator items [to be redefined], <10% stock out of other core EMHS in the Credit Line and <20% stock out of other items required for delivery of the Uganda National Minimum Health Care Package (UNMHCP) achieved
iii) All third party contributions (including new initiatives such as GFATM) executed according to an agreed national procurement plan. Third party procurement for all centrally procured items for nationwide distribution stopped and contributions channeled through the credit line facility.

Objective 3: To ensure the required quality and safety of EMHS (including herbal medicines) and standards of pharmaceutical practice by strengthening the national pharmaceutical regulatory system

i) The new Pharmacy Profession and Practice Bill and Uganda Medicines Control Authority Bill completed and promulgated

[13] The National Drug Policy (NDP) aims to contribute to the attainment of a good standard of health by the population of Uganda, through ensuring the availability, accessibility and affordability at all times of essential drugs of appropriate quality, safety and efficacy, and by promoting their rational use.

ii) NMS statute updated to meet the demands of the current national regulatory settings as well as the special nature of pharmaceutical procurement.
iii) Public Procurement and Disposal of Assets Act (PPDA) to recognize the specialized nature of EMHS procurement to ensure maximum flexibility and responsiveness to meet public sector needs.

Objective 4: To promote the appropriate use of EMHS by health professionals, patients and the general public through the implementation of effective interventions including provision of appropriate information on medicines to the community.

i) Functional Medicines & Therapeutics Committees (MTCs) in place at all Districts, Health sub-districts, and Regional, District/general hospitals.
ii) A Medicines Information System (MIS) as part of HMIS developed and functioning
iii) Essential Medicines List of Uganda (EMLU) updated every three years
iv) Uganda Clinical Guidelines (UCG) and Uganda National Formulary (UNF) reviewed and revised at least once every five years or more frequently as appropriate

4.2 Diagnostic and Blood Transfusion Services

Diagnostic, Medical Imaging and Blood Transfusion services are an integral part of integrated service delivery and impact on quality of health services and health outcome. They substantially increase the human resources capacity to solve health problems and thereby improve the performance of the health system. With the scaling up of core interventions such as EmOC, TB, malaria, ARVs, these services take on increasing importance. This section outlines the proposed action for HSSP II.

Overall objective

To contribute to the improvement of the health status of the people of Uganda by providing safe, efficient and sustainable diagnostic and blood transfusion services able to meet the needs of Uganda's health care system.

4.2.1 Laboratory Services

The HSSP I aimed at strengthening laboratory services to support delivery of the UNMHCP. During the HSSP I period, the main thrust of the activities involved the development of capacity of the Central Public Health Laboratories and the Regional Laboratories to confirm diseases of epidemic potential; development of a network of laboratories for referral of specimens and exchange of information; and putting in place a National Laboratory Quality Assurance Scheme. As a consequence of these efforts, most of the outbreaks that have occurred in the country in the last 3 years have been timely confirmed by public health laboratories.

Laboratory technician training has been strengthened through development of a course curriculum, refurbishing of old laboratories and new construction an annual output of 70 Laboratory Technicians is realised. A Laboratory technical committee was established at national level with membership from public, private, NGOs and other partners. Standard operating procedures (SOPs) for the laboratories were developed and disseminated. A

National Health Laboratory Quality Assurance Scheme has been initiated in 3 districts (Kumi, Nebbi, Ntungamo).

During HSSP II, a special focus shall be directed to development of the health laboratory services. Efforts shall be made to address the challenges related to availability of laboratory infrastructure, equipment and appropriately trained human resource.

Specific objectives and Targets

Objective 1: To develop a comprehensive National Health Laboratory Services policy

i) Finalize the development and production of the National Laboratory Services Policy Guidelines.

Objective 2: To build capacity in laboratory services delivery at national, regional, district, health sub district and primary health care levels

i) Significantly increased annual output of Laboratory Technicians Training Schools to 100 by end of HSSP II
ii) In-service training of relevant staff at all levels to improve laboratory services (new technologies and scaling up interventions – PMTCT, VCT etc)

Objective 3: To establish a sustainable laboratory supplies system as part of the Essential Medicines and Health supplies management, that will ensure steady availability of laboratory equipment, reagents and supplies at all levels.

i) Conduct a needs assessment and develop a consolidated plan for laboratory infrastructure and equipment to allow for the necessary testing at each level
ii) National Medical Stores stocking of laboratory reagents initiated by end 2004 as part of the procurement and management of essential medicines and other health supplies
iii) Building capacity for laboratory reagents and supplies quantification, procurement (through PHC and Credit Lines) and management at all levels

Objective 4: To consolidate and strengthen the National Laboratory Quality Assurance Scheme and establish laboratory linkages with countries in the region so as to ensure an effective sustainable laboratory referral system.

i) Expansion in a phased manner of the National Laboratory Quality Assurance Scheme from 3 regional laboratories (Kumi, Nebbi and Ntungamo) to 10 Regional Laboratories by 2010

Objective 5: To establish an effective management structure in the MoH to provide stewardship, coordination and management of laboratory services

i) Establishment of an appropriate coordination and management within MoH, at the regional level and in districts to assure effective coordination and supervision of laboratory services at all levels

4.2.2 Medical Imaging and Diagnostic Services

The Medical Imaging services, mainly found at the hospital level are important in the provision of emergency and non-emergency care. They contribute to efficient and quality care and leads to less stay in hospitals. During the HSSP I period, the resources allocated to hospitals was inadequate to cater for optimal investment in X-Rays, Ultrasound scans, CT scans and other equipment for imaging and diagnosis. The equipment is often lacking or broken down as a result of years of use/lack of maintenance. The HSSP II proposes phased technological upgrade through procurement and maintenance of necessary equipment for the different levels of care.

Specific objectives and targets

Objective 1: To generate information and build a database on the status of medical equipment in the health facilities

i) A Needs Assessment and database for medical imaging equipment finalized by 2006

Objective 2: To procure, install and utilize appropriate medical and diagnostic equipment within the health facilities

i) Procure install new equipment as described in Table 4.7
ii) Ensure availability of consumables for the medical equipment as part of the procurement for essential medicines and health supplies

Objective 3: Recruit and train appropriate staff (technical and maintenance) at the Regional Medical Equipment Maintenance Workshops

i) Recruitment and CME training for both technical and maintenance staff as elaborated in the section on HRH.

Table 4.7: Targets for equipping Health Facilities

Targets by the end of HSSP II	**Equipment**
77/151 HC IV	- Ultrasound Scan Machine
General Hospital 18/42	- X-Ray (non-invasive) - Ultrasound Scan
Regional Referral Hospital 6/11	- X-ray, (Invasive) - Ultrasound Scan - Radiotherapy in selected centres Mulago National Referral Hospital, Lacor Hospital, Mbale and Mbarara Regional Referral Hospitals
National Referral Hospital	- X-Ray - Ultrasound Scan - CT Scan - MRI - Radiotherapy

4.2.3 Blood Transfusion Services

The Uganda Blood Transfusion Service (UBTS) was established as an autonomous institution and a Board of Directors commissioned in January 2003. The National Blood Transfusion Service is fully operational with efficient central coordination but sufficiently decentralized to render service to all regions of the country. The main centre at Nakasero acts as a reference centre for the regional blood banks and other public/NGO hospitals. The blood collection depends on healthy volunteer donors with least risk for transfusion transmissible infection (TTIs). UBTS is also able to make/supply blood components for management of patients.

The numbers of units collected increased from 78,000 units per year in 2000 to 97,000 units by the end of 2002 and the percentage of collections from voluntary donors gradually increased from 85% in 1999 to 95% in 2002. Each regional blood bank has the capability and capacity to test all donated blood for transfusion transmissible infections including HIV, Hepatitis B and Syphilis. In almost all groups of blood donors, sero-prevalence has decreased ten-fold. During HSSP II, UBTS shall operate as a nationally coordinated, autonomous/semi-autonomous institution with sufficient capacity to meet the blood transfusion needs of the country. The National Blood Transfusion Policy shall be enacted within the framework of the Health Sector Policy and supported by appropriate legislation.

Specific Objectives and targets

Objective 1: To expand the Blood Transfusion Infrastructure to operate adequately within a decentralized health care delivery system.

i) From 5 existing large RBB to 12 RBB by 2010 through upgrading and construction where necessary. With expansion of the services, the Regional Blood Banks will require adequate laboratory, blood donation and administrative space
ii) Blood Transfusion Services at all HC IVs by 2010

Objective 2: To increase the annual blood collection necessary to meet the blood requirements of all patients in the hospitals throughout the whole country

i) Advocacy for increased blood donation, mobilisation of stakeholders
ii) To improve strategies for blood donor selection, education, counselling, care and retention of safe donors for repeated donations
iii) Adequate supplies for blood collection and storage

Objective 3: To test all blood for Transfusion Transmissible Infections (TTIs) and operate an effective, nation-wide Quality Assurance programme that ensures security of the entire blood transfusion process.

i) Laboratory competence maintained
ii) Strengthen QA programme by recruiting appropriate staff, reviewing standards and developing the standards towards accreditation of UBTS and ensuring continuous audit of the blood transfusion activities

Objective 4: To ensure continuous education and training in blood safety

i) Continuous education and training in the use of blood and blood products for medical staff
ii) Prospective donors and community educated on blood safety

4.3. Information for Decision Making

The National Health System needs information in order to ensure that the needs of the population particularly the vulnerable groups are catered for, measure the effects of the interventions, and assess and improve health sector performance. Substantial progress was made in HSSP I, with increasing data being available on health services utilisation and system performance. The MoH, Research Institutions, Universities, other government ministries and departments, NGOs and partners are involved in generation and utilisation of health information. This chapter outlines the following 'medical intelligence' systems, as an integral part of the National Health System

- Health Management Information System
- Information and Communication Technology
- Integrated Disease Surveillance and Response
- Research and Development

Overall objective

To strengthen the health information system to enable timely and quality data collection, analysis, dissemination and utilisation at the local, district, centre, regional and global levels and assist in the measurement of progress towards achieving HSSP II, PEAP and MDGs goals.

4.3.1 Health Management Information System

Health information is important for monitoring the performance of the health sector. During HSSP I, guidelines and generic data analysis formats for all levels were developed and distributed in order to improve the analysis and interpretation of HMIS data. New quarterly performance assessment formats for the HSSP and programme indicators for all levels were developed and distributed to all districts. This was an effort to improve utilisation of HMIS data. Timeliness and completeness of HMIS reporting (a key process indicator for the implementation of the HSSP I and whose 5-year target was set at 80%) improved during the HSSP I. HMIS reporting improved from a national average of 21% in 2000, 53% in 2001, 63% in 2002 and 79% in the first quarter of 2003. The graph below shows the trend in timeliness of HMIS reporting.

HMIS forms however are not adequately distributed to data collection facilities. They are not properly filled, nor analysed and utilised by the health facilities in the planning and decision making process. HMIS is thus not yet recognized as a management tool at all levels. It is used neither in the quarterly nor annual reporting procedures. The inpatient data from both hospitals and admitting health centres is not regularly submitted in the HMIS monthly reporting. Feedback from the centre to the district has continued to be carried out on monthly (from HMIS 123 district reports) and annual (statistical abstracts) basis. However feedback and follow up at the district level remain a big challenge.

HMIS still experiences shortage of health information personnel at all levels which hampers technical support. There is shortage of IT support systems staff. The national Resource Centre at Ministry of Health Headquarters lacks basic computers soft ware system to facilitate the analysis of the HMIS.

Specific objectives and Targets

Objective 1: HMIS made functional and operational

i) Improve the data generation and collection including accuracy, consistency, timeliness and completeness of reporting at facility, HSD, district and national level by end of second year of HSSP II
ii) Install the computer soft ware for analysing the HMIS at Resource Centre by end of first year of HSSP II

Objective 2: HMIS data analysed and utilised for planning and decision making at all levels

i) All HSDs and Districts use the HMIS data in the planning, monitoring and decision making process
ii) Ministry of Health use HMIS data in the planning, supervision & monitoring (league table) and decision making process
iii) All health facilities start analysing the HMIS data collected and use it for planning, monitoring and management
iv) HMIS to generate gender disaggregated data where possible
v) All levels receiving the HMIS data reports provide feedback to the reporting centre
vi) Complete development of a unified computerised HMIS system to capture district data (HSD data) and tested in a number of districts.

4.3.2 Information and Communication Technology for Health Care Delivery

Information and Communication Technology (ICT) is the creation, organization, processing, storage, and transfer of information between different locations using communication infrastructure. The information can be in form of data, voice, text, graphics, and video. In the health sector, ICT has been recognized internationally and by the Government to be of strategic importance as it facilitates the sharing of health data, information, knowledge and resources between the different stakeholders and the delivery of appropriate health services to the populace.

The MoH, Research Institutions, Hospitals, Health Centres, other government ministries and departments, NGOs, and development partners involved in generation and utilization of health information will all benefit from the use of ICT in health care delivery.

ICT mainstreaming/integration in healthcare delivery will facilitate the implementation of the National Health Policy and help in co-ordination of health information for planning and decision making, as well as effective sharing of the scarce resources for optimal health care delivery for all Ugandans.

Specific objectives and targets

Objective 1: To provide a policy and strategic framework for the use of ICT to facilitate the implementation of the various programs.

i) Have a Health Sector ICT Policy and Strategic Plan developed in line with the national ICT, Health Sector and other relevant policies.

Objective 2: To build and sustain appropriate ICT capacity in the sector and mainstream the use of ICT in all aspects of health care delivery.

i) To introduce ICT curriculum in all health training tertiary institutions, including universities and research institutions by 2010
ii) To develop and /or strengthen institutional capacity to enhance and streamline the use of ICT to improve the efficiency and effectiveness of healthcare delivery by 2010
iii) To institute affirmative action provisions to increase access and utilisation of ICT among Health Sector staff so as to bridge the gender digital divide and rural/urban divide.

Objective 3: To expand Telemedicine/ Tele-health for the delivery of health services and tele-consultation in the country.

i) Develop policies for sharing of medical information through the use of ICT while taking into consideration issues of confidentiality and security of patient information by 2006.
ii) To increase centres utilizing telemedicine to 20% of hospitals by 2010

4.3.3 Integrated Disease Surveillance and Response

The national surveillance system, which is essential for prediction and early detection of epidemics, has been strengthened. An Integrated Disease Surveillance and Response (IDSR) which involves innovative approaches such as providing feedback to the districts and other stakeholders, problem based training of health workers and formative support supervision is being implemented. Support for IDSR has been streamlined and is oriented to the district and health sub-district levels. The scope of IDSR, which was limited to strengthening the national surveillance system for communicable disease prevention and control, has been widened to include non-communicable diseases (NCDs) due to its increasing disease burden.

IDSR is coordinated through the IDSR/HMIS committee composed of Ministry of Health (MoH) technical programmes; the Institute of Public Health; the Christian and Islamic Medical Bureaus; and the Laboratory Technical Committee. District surveillance focal persons and laboratory coordinators were appointed. Standard case definitions and action thresholds for the priority diseases have been developed and disseminated to all public health facilities in order to improve case detection. Reporting formats (weekly, monthly, quarterly and annual) were revised and harmonised. Newsletters and surveillance bulleting are published and disseminated to stakeholders. Feedback reports about timeliness and completeness of HMIS reporting are disseminated to districts.

A Laboratory technical committee was established at national level with membership from public, private, NGOs and other partners. Standard operating procedures (SOPs) for the laboratory have been developed and disseminated. The centre maintains weekly radio contact with all the 56 districts through the E-warn system used for early detection and response to epidemics.

There is still irregular data analysis and inadequate feedback especially at lower levels. Many partners and GoU are currently providing technical and financial support for IDSR. Sustaining the gains made and continuing to invest in building capacity for IDSR at all levels is a challenge.

Specific objectives and targets

Objective 1: Strengthening communication so as to improve completeness and timeliness of reporting of priority diseases.

i) Timeliness of weekly reporting of priority diseases improved and sustained maintained at 80 %
ii) Timeliness of monthly reporting of priority diseases improved and sustained at 80 %

Objective 2: Strengthening outbreak/epidemic detection, investigation and response.

i) Proportion of epidemics with case based reports increased from 50 % - 100%
ii) Proportion of epidemics reported to higher level within 2 days of surpassing the action threshold increased from 30 % -80 %
iii) Reduce the case fatality rates for epidemic prone diseases to a level below the recommended WHO standard
iv) To reduce the incidence rate of epidemic prone diseases by 50 %

Objective 3: Improving sharing of surveillance information through regular dissemination and feedback

i) Proportion of weekly newsletters disseminated to districts maintained at 100%
ii) Proportion of weekly newsletters disseminated from district to HSD increased to 80 %
iii) Proportion of quarterly IDSR bulletins produced increased from 66.7 % to 100 %

Objective 4: Strengthening the capacity of health workers through training and support supervision

i) 100 % of health units with at least one person trained in IDSR

Objective 5: Strengthening laboratory networks in all regions and initiate a system of accreditation.

i) Functional Network of laboratories in all regions
ii) Proportion of epidemics with Lab -confirmed diagnosis increased to 100 %

Objective 6: Improving data management, data validity /quality and utilization at all levels.

i) Proportion of health units with current trend lines for one priority disease
ii) Proportion of health units with current demographic and coverage data

Objective 7: Establishing a system for capturing preventive indicators and risk factor surveillance for non communicable diseases

i) At least one national health survey conducted every two years.

4.3.4 Health Research and Development

Research is a critical tool for evidence based policy and decision-making. It provides an informed basis for guiding and rationalizing implementation of the health sector strategic plan. Health research is a vital element for evolving rational approaches for solving specific health problems many of which have multi-factorial causes embracing social, behavioural and economic determinants. Evidence based management of health sector reforms is essential to the improvement of healthcare delivery.

Health research activities in the country are currently fragmented and not properly focused. The Uganda National Health Research Organization (UNHRO), which is the secretariat for health research in the country, has not yet been granted legal state. The bill for legalizing the institution of this health research coordination body is presently with Cabinet and will in the near future be approved and passed on to Parliament for debate and final approval.

A National Health Research Policy document is in an advanced stage of development and a Health Ethics Committee and guidelines for conducting research on humans are in place.

Specific objectives and targets

Objective 1: Improve coordination, dissemination and utilization of operational health research results

i) A mechanism for coordination and dissemination of research findings established by 2010

Objective 2: Mobilize and establish a funding mechanism for operational health research

i) Grant Application procedures finalized by 2005

Objective 3: Develop capacity for operational health research at the district level

i) Proportion of research institutions doing research and reporting their research.
ii) To increase the number of district operational research carried out.

4.4. Legal and Regulatory System

The legal and regulatory system encompasses all health actions and actors in the health system for both the public and private sectors. It covers the framing of all the laws, regulations and policies governing the health sector and ensuring compliance with them. The HSSP II outlines strengthening of public sector oversight while promoting private initiatives for and on behalf of the population.

The aspirations of the National Health Policy cannot be attained without the support of an effective legal and regulatory framework. In the HSSP I period, the process of identification, amendment, repealing and applying the relevant laws was carried out. The procedures for requesting for legislation from the Solicitor General were circulated to all departments,

divisions and units of the ministry. The MoH constituted a Legislation Task Force to deal with matters concerning policies and proposed Bills awaiting legislation. The major constraint was the inadequate facilitation (human, financial and material resources) of the regulatory bodies (Commissions, Authorities, Professional Councils and the Health Inspectorate) making the fulfilment of their respective mandates including enforcement of the laws and regulations a challenge.

The following professional councils were established by statute to regulate the practice of health professionals. They are responsible for enforcing standards of performance, ethical practice and professional qualifications

- Medical and Dental Practitioners Council
- Nurses and Midwives Council
- Pharmacists Council
- Allied Health Professionals Council

Overall Objective

Appropriate laws and regulations governing the behaviour of all actors in the health system in place and enforced in the interest of the population of Uganda

Specific objective

The objective of HSSP II is to review and develop the relevant legal instruments that will govern and regulate health and health-related activities in the country, in order to ensure that the principles and objectives of the National Health Policy are attained.

Targets

1. To develop and gain approval of the relevant laws
2. To publish and disseminate the laws
3. To enforce the laws in collaboration with the other law enforcement bodies
4. To support the Professional Councils (Uganda Medical and Dental Practitioners' Council, the Uganda Nurses and Midwives' Council, Pharmacy Council and the Allied Health Professionals' Council) to fulfill their mandate

Pending Policies and Bills

- Food and Nutrition Bill
- Mental Health Bill
- Environmental Health Bill
- Health Services Bill
- Uganda National Health Research Bill
- Uganda Medicines Control Authority Bill
- Pharmacy Practice and Profession Bill
- Public Private Partnership Policy
- Traditional and Complementary Medicine Policy
- Adolescent Health Policy
- School Health Policy
- Human Resource Policy

Responsibility

Central level:
Ministry of Health, Professional Councils, Health Service Commission, National Drug Authority, Ministry of Justice, Ministry of Internal Affairs, IGG

District level
District Authorities, Local Councils

CHAPTER 5: COSTING AND FINANCING OF HSSP II

Introduction

Inadequate financing remains the primary constraint inhibiting the development of the health sector in Uganda. The different health financing options for the sector and their potential to raise funds for health services were elaborated in the Health Financing Strategy (HFS; 2002/03 – 2012/2013). The financing gap facing the health sector was estimated and the strategy to close the gap by 2019/20 was dependent on the health sector achieving 15 % of a GoU budget growing at approximately 6% per year. Funding a basic package of services in developing countries has been estimated at US$30 – $40 per capita[14]. On the other hand, the Health Financing Strategy (HFS) made an estimate of US$28 per capita, excluding ARVs and the pentavalent vaccine. The current level of funding of US$9 per capita falls far below the estimated requirements, in effect only 30% of HSSP I was funded. Attempts have been made to mobilize additional funds for the sector but these have been constrained by macroeconomic concerns and the rigid sector ceilings.

This section gives the goal and objectives of health financing, funding requirements for HSSP II, resources likely to be available, the process of prioritisation given limited resources and strategies to mobilize additional resources for the health sector. Factors external to the health sector such as performance of the national economy, macroeconomic policies, size of the resource envelope, price of drugs and medical equipment, the international labour market for health workers, and investment opportunities in the private sector dictate the pace at which progress will be realized.

Goal

The goal of health financing for the HSSP is to raise sufficient financial resources to fund the plan whilst ensuring equity and efficiency in resource mobilisation, allocation and utilisation during the plan period.

Medium term objectives

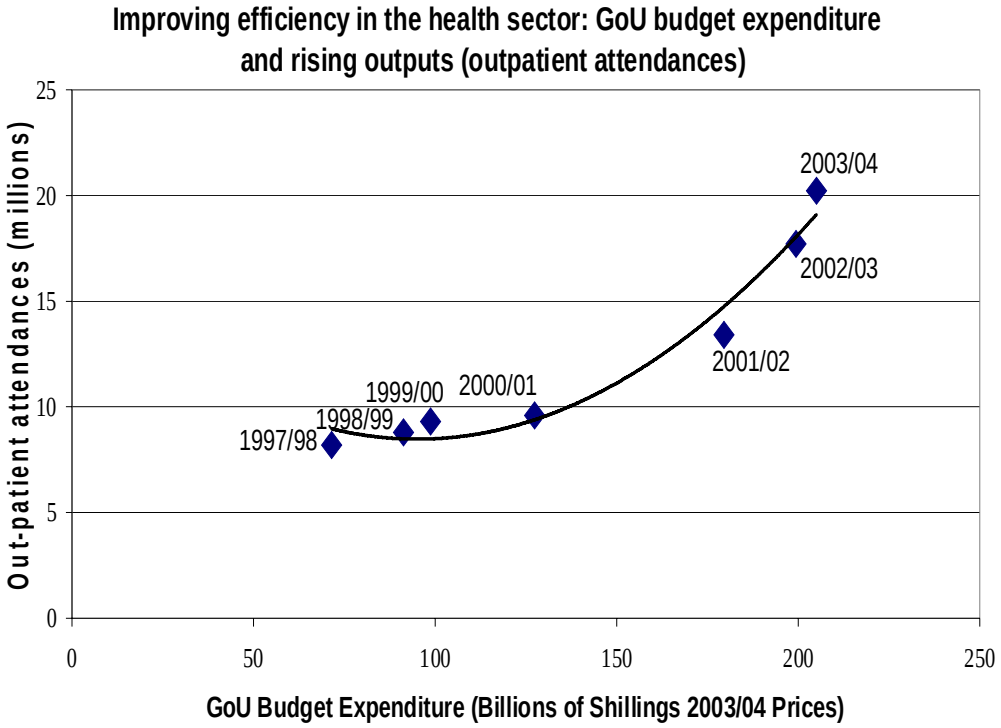
- To mobilize additional resources to fund the HSSP II.
- To ensure effectiveness, efficiency and equity in resource allocation and utilization.
- To ensure transparency and accountability in resource utilization.
-

5.1 Financing mechanisms for HSSP II

The Ministry of Health completed National Health Accounts studies for Uganda covering the years 1997/98 to 2000/01. The sources of financing for the health sector include the central Government budget (including donor budget support and project funding), local government and parastatal contributions, private not for profit agencies, private firms and households through insurance and out of pocket contributions. Financing the Uganda National Minimum Package for HSSP II necessitates identification of financing mechanisms that are able to bring forth significant and sustainable amounts of funds in the medium to long term whilst upholding equity principles. The following financing mechanisms are envisaged during HSSP II.

[14] Commission for Macroeconomics and Health

Government budget and donor budget Support: This includes both government funds and donor budget support. As in the HSSP I the mode of funding preferred by the sector is the government budget. This is a flexible funding source where the government has control to allocate resources to agreed priorities. During the period of HSSP 1 it became apparent that the GoU budget was by far the most efficient financing mechanism at turning financial resources into health care outputs:



Allocations to the health sector increased over the period of HSSP I from 7.6% of the government budget in 2000/01 to 10.3 in 2004/05. These figures exclude the contributions from donor projects increases are envisaged over the period of Long Term Expenditure Framework (LTEF) to reach 15% in 2012/13. However it is of great concern to all stakeholders that more recent MTEFs have showed a slower rate of growth in the MoH budget and that health's share in 2005/06 will be less than in 2004/05. The current MTEF policy is that project funding will displace GoU funding, although project funding may not necessarily address HSSP priorities. The Health Sector Working group will continue to review, approve and align project funding to sector priorities.

i)

Donor Project Funding A systematic and comprehensive analysis of the donor projects with respect to funding composition, flow of funds, compatibility towards HSSP and others will continue to be done. This is particularly crucial given MOFPED position on including donor project funding within sector ceilings, and the knowledge that in the past donor project funds have not always been well aligned with sector priorities, efficiency and equity. Caution will be exercised to ensure that donor project funding and global funding initiatives do not displace GoU budget money for crucial services and do not suppress overarching objectives of the sector. It is prudent for government to consider accepting donor contributions that address the HSSP priorities under the MTEF. For district level projects, the role of the District Director of Health Services as a coordinator will be emphasized.

ii) **Global funding initiatives**: The sector will continue to mobilize resources from global funding initiatives like PEPFAR, GFATM, GAVI, schistosomiasis and filariasis control initiatives. At present funds from these initiatives tend to be e channelled through the donor project funding mode but in the future it is envisaged that more of these resources will pass

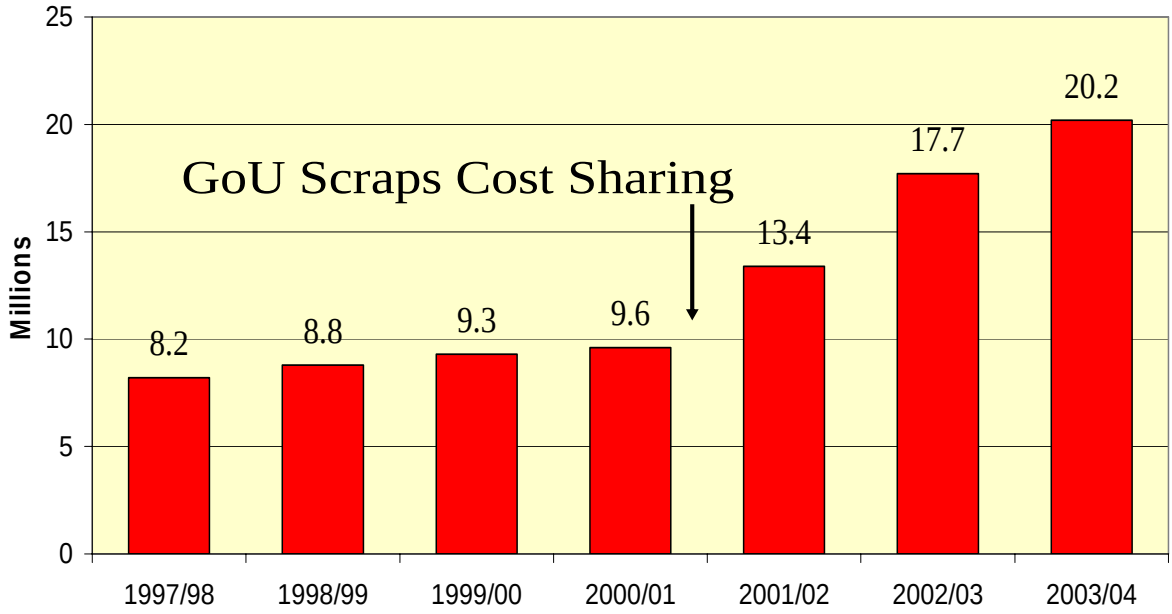
iii) through the Government budget. In order to improve overall efficiency in the sector it is planned that funding from global initiatives will be better integrated with HSSP activities and more predictable in the future.

iv) **Social Health Insurance (SHI):** A feasibility study undertaken in 2001 recommended that SHI be phased in cautiously over the medium to long term starting with people employed in the formal sector. Currently, the Ministry is in the process of drafting the law to govern the scheme. The scheme is envisioned to be fully operational over the medium to long term. During the period of HSSP II SHI activities are likely to concentrate on setting up institutions and management systems. When well established with all formal sector employees (public and private) country-wide subscribing to SHI at a rate of 10% of salary per month the scheme is expected to raise up to Ug. Shs.60 billion in a year To put this in context this sum is less than a quarter of the health sector budget The scheme shall be designed to work in harmony with other social security benefits under development in other government sectors.

v) **Community Based Health Insurance Schemes (CBHI):**
Currently, there are 11 schemes in the whole country. Current analysis shows that the schemes have been beset by a number of challenges including: low recruitment and retention rates, high management costs and low uptake by poor people. More work will be undertaken in future to guide the future actions of these schemes in line with the overall health sector financing goal of efficiency and equity.

vi) **User fees in private wings of public hospitals:**
The government's policy of scrapping cost sharing (user fees) for minimum package services in GoU health units (except private wings in hospitals) has been very successful. Countrywide data has shown that scrapping fees dramatically increased the consumption of UNMHCP services, especially by poor people (see AHSPTs). Information from the HMIS (below) show the increase in demand for services following the abolition of fees and recent research by Ministry of Health and WHO and World Bank among others has proved that the poor benefited disproportionately.

New Outpatient Attendances in Government of Uganda and Private Not for Profit Health Units

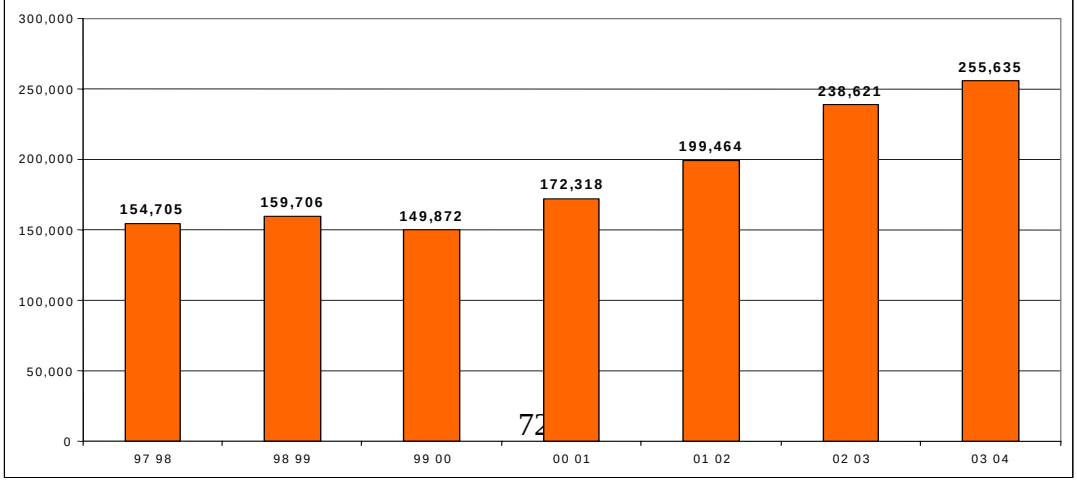


However in recognising that, especially in urban areas, there are sections of society with a greater ability to pay for health services the MoH will maintain a system of patient charges in private wings of hospitals During HSSP II this mechanism will be strengthened with caution being exercised to ensure that services in the general wing are not displaced. Options of partial autonomy and privatisation will be undertaken so as to increase efficiency and expand the scope of services

vii) **User fees in PNFP units**.

Whereas the abolition of cost sharing in GoU health units does not extend directly to PNFP units it is envisaged that these facilities will minimise their charges in order to benefit the poor. During the latter stages of HSSP I a number of PNFP units chose to use their rising GoU grants to reduce and flatten their fee structures and these units also witnessed large increases in the consumption of their services (see below). As it is one of the main principles of the HSSP that there be an equitable access to services GoU and PNFP will work together in order to maintain the downward pressure on patient charges in all units covered by the plan.

Cumulative admissions in a sample of 65% of PNFP Hospitals



5.2 Budget process, Resource Allocation and Financial Management

Budget process

The guiding principles for the sector budgeting process and resource allocation at all levels of service delivery are contained in the Annual Health Sector Budget Framework Paper (BFP). The BFP takes into account the National Health Policy (NHP) and the Health Sector Strategic Plan and the Annual Sector Priorities as agreed by stakeholders at the National Health Assembly and Joint Review Mission. The BFP is aligned to the Government of Uganda Medium Term Expenditure Framework (MTEF). The MTEF sets expenditure ceilings as spelt out by the Ministry of Finance, Planning and Economic Development (MoFPED). The MTEF is the overall mechanism by which resources, expected from Government, including donor budget support are allocated to and within sectors. It sets sector and local government spending ceilings within a three-year rolling framework.

Health Sector Working Group

The Health Sector Working Group (HSWG) oversees the management of the annual health sector budget process, maintains internal mechanisms that would determine and ensure operationalization of the budget and also ensures timely production of the Budget Framework Paper for the sector. It offers opportunity for key stakeholders to review new health sector projects to ensure that all new investment in the sector is within the framework of the HSSP and that new projects represent good value for money.

Fiscal Decentralization Strategy

The purpose of the Fiscal Decentralization Strategy (FDS) is to decentralize decision-making in respect to budget allocation, with the district political and technical leadership taking more responsibility for apportioning centrally allocated funds. The implementation of the FDS has now achieved national coverage. The increased autonomy of Local Governments, resulting from this policy change, demands stronger and more proactive buy-in by the district authorities to the nationally defined health sector priorities. The lesson learnt during the HSSP I period is that sensitization of the political and technical decision-makers at all levels on the impact and use of the FDS modalities needs greater attention. During HSSP II, this will be promoted through the active participation of the district leadership (political, administrative and technical) in all policy development and planning exercises, right from the outset.

During the HSSP II period, the Central MoH in collaboration with MoLG, will take all necessary steps to sensitize Local Governments and the District Health Teams in particular, on the process of implementation. The two central ministries will provide the necessary support to ensure that Local Government Budget Framework Papers and District Development Plans are fully consistent with national priorities for the sector and in line with the principles of FDS. Central support for strengthening the capacity of DDHS Offices to prioritize and negotiate for resources based on sound evidence will receive greater attention during HSSP II. This will be extremely important given the history of unconditional grants where it appeared that many Districts gave a low priority to allocating funds to health.

Resource allocation

Allocation of resources in the health sector shall continue to be guided by the principles of efficiency and equity. In improving allocative efficiency, it is clear that the sector needs to increase the consumption of services (to reach more people) and concentrate resources on cost effective activities which tackle the greatest burden of disease. This translates into increasing the proportion of resources allocated to the district health services where the majority of population lives. The allocation of the Funds to the different levels and entities of health care is done with the guidance of the Budget Framework Paper. Funds are allocated to the central MoH, other central entities, National and Regional Referral Hospitals and districts (including general hospitals, LLUs, public and PNFP services) according to sector priorities and the mandate at the different levels and entities. Efforts shall continue to be made to target health care inputs with a large impact on quality of services especially drugs and other health supplies.

The PHC conditional grant to districts, lower levels and NGOs is determined by taking into consideration the size of the population, poverty levels, health status of the district, special health needs, and access to other funding sources. It will be important to maintain this needs based approach if/when the health sector budget is allocated using a standardized methodology in common with other sectors. At the district level, sector guidelines have been aligned with FDS guidelines and these will guide allocation of funds between the different levels of care and inputs.

There will continue to be affirmative action for health services delivery to disadvantaged populations as laid in Chapter 6: the Implementation Plan. Caution will be exercised not to discriminate against the poor and other vulnerable groups. The government will continue to extend financial support to the Private Not for Profit (PNFP) sub sector in order to strengthen the health care delivery system and also to ensure that user fees are kept low so as not to inhibit utilisation of services.

Financial Management

The timely flow of funds is essential in the continuity of delivery of health services. The rate of timely disbursement has greatly improved during HSSP I. The management, accounting and logistical capacity at district and Health sub-district levels needs further strengthening during HSSP II. The accountability for resources follows the Local Government Finance and Accounting Regulations (LGFAR) and the Poverty Action Fund (PAF) guidelines.

5.3 Costing of the Health Sector Strategic Plan II

This section provides background to the costing of the strategic plan for the next five years. It is an aggregate estimate of the entire sector spending requirements for the next five years. It involves costing of the interventions and inputs that would result in reasonable progress towards achievement of the PEAP and MDG targets (Table 5.1) and is therefore the basis for determining the goals and targets of HSSP II. The costing is based on the assumption that the financing conditions shall improve but considering the practical rather than abstract environment of delivering a minimum health care package During the costing, of HSSP II, prioritization was built in and in particular focus was on interventions that will ensure maximum impact on maternal and child health, with particular emphasis on scaling up these priority interventions that were initiated in HSSP I.

Costing methodology

Building on the cost estimates that had been compiled in the Health Financing strategy and adjusting for new initiatives and scaling up of key interventions, the cost of implementing the HSSP II was estimated. Costing was done by level, considering the cost of delivering a package of services to a given population in an integrated manner, as opposed to costing out individual programmes. Health facilities at different levels of care, operating at higher activity levels were used as models and were therefore purposively selected and costed.

The overall cost of the UNMHCP was determined by summing the products of the average cost of a facility level and the number of units at that level. Data on total number of units for the different levels was obtained from the Health Facilities Inventory 2005. Costs at the National level (MoH HQ) were estimated in line with their roles and responsibilities. Stakeholders at the different levels were interviewed to verify the cost estimates. The costs are classified as recurrent and non- recurrent and cover all GoU and PNFP Services. Whilst acknowledging the important role of the private for profit sector in delivering health services, in line with the rest of the HSSP, their costs were not included in the requirements for the plan;

- **Recurrent Costs**
  a) Human Resources;
  b) Drugs, vaccines, & medical supplies,
  c) Supplemental Immunization Activities,
  d) PHC special services, like IEC, Blood transfusion, Reproductive Health etc,
  e) Operations & Maintenance

1. Human Resource (personnel costs)

Personnel costs include salaries and all consolidated allowances to the sector staff. To cost total annual earnings the following were taken into consideration: salary scales by all cadres, staff in post using the revised Local Government staffing norms as approved by Ministry of Public Service 2005. Based on the revised staffing norms and using information from the Inventory of Human Resources for Health, the proportion of approved posts filled with qualified health workers was found to be 45%. Using expert knowledge of the sector and taking into consideration the output of training schools, the capacity of recruitment agencies, the availability of funds, the targets for the proportion of approved post filled with qualified health workers was estimated at 50% in Year One, raising to 90% in Year Five of HSSP II.

Personnel costs of the HSSP II were therefore calculated using the estimated staffing levels at different levels of health care in each year of the HSSP II, the 10% salary increments every year as recommended by Ministry of Public Service and applying an inflation rate of 5% very year.

2. Drugs, Vaccines and medical supplies

An empirical cost estimate of the essential requirements for delivery of the Minimum Health Care Package was obtained, based on studies of actual prescribing patterns and medicines utilization in a sample of health facilities at the lower levels of care, together with service utilisation figures from registers and HMIS reports. The unit costs per outpatient, antenatal case, obstetric cases (maternity), and inpatient were established for an average facility at each level, assuming a full supply of essential requirements in the baseline study period (2003).

The breakdown of service utilisation by level (HC II up to national referral hospital) was established using the HMIS national data and disaggregated survey data. Costs of supplies for diagnostic and laboratory services were estimated at the aggregate level and the breakdown by level is an estimate based on the knowledge of the service provision at hospitals, and distribution of rapid test kits to the lower levels of care. Similarly, the cost of vaccines, TB and leprosy medicines, family planning supplies and condoms was estimated at the national level since these 'public good' commodities are centrally procured and managed with the aim of fully meeting demand.

3. Other Supplemental Immunization Activities

Estimated figures for these activities over the plan period were obtained from the EPI Financial Sustainability Plan for 2001- 2011. All planned activities within the period had been captured and well costed based on the coverage, price of the vaccines, mobilization activities and the target population as outlined in the Financial Sustainability Plan 2001 – 2011.

4. The Minimum Health Care Package

The cost of delivering the Minimum Health Care Package was determined by costing the inputs required to deliver the package at different levels of health care. The inputs for delivering the package are specified in the Minimum Service Standards for delivering health services. In addition to the cross-cutting inputs already discussed above like human resources, essentials medicines and health supplies, medical equipment, other programme specific inputs were also identified, quantified by levels and then costed.

5. Operation & Maintenance costs

These are costs incurred on a recurrent basis for running all levels health facilities and systems. They include among others, maintenance costs, travel expenses, utility costs, office supplies, food and linen for in-patients, postage, and so on. Estimates for these expenses were based on a unit cost by level. Using earlier studies undertaken during the development of the Health Financing Strategy, estimates for utility expenses were made at all levels of service delivery.

6. Capital Costs

f) Buildings,
g) Medical equipment,
h) Transport,
i) Long term training.

Health Infrastructure Development Plan and Strategy for HSSP II

Good progress was made during HSSP I in developing adequate health infrastructure that is capable of supporting the delivery of quality health services. The HSSP II shall concentrate on consolidating the functionality of the existing health facilities to increase accessibility to health services and quality of health care delivery. In addition, the strategic plan will aim at strengthening the capacity of District and Central Engineering structures to adequately manage and maintain the health infrastructure.

In calculating the growth in cost requirements the following assumptions were made:

a) Population growth rate of 3.4% p.a
b) Inflation rate of 5%
c) Exchange rate of Shs.1800 to 1US$

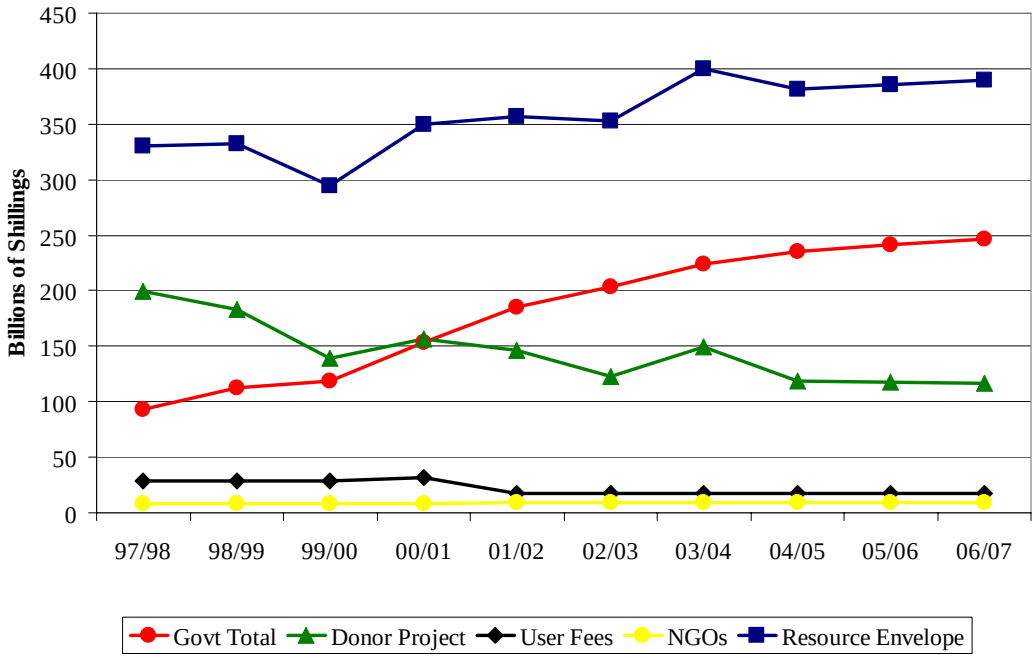
Table 5.1: Costing of the HSSP II (Billion Ug.Shs)

		2005/06	***2006/07***	***2007/08***	***2008/09***	***2009/10***
	RECURRENT COSTS	**535.07**	**675.39**	**761.43**	**836.43**	**926.86**
1	***Human resource***	***242.51***	***282.28***	***329.65***	***386.13***	***454.32***
	Salary and wages (includes lunch allowance)	154.82	185.99	223.4	268.29	322.16
	Salaries and wages for NGOs (shadow cost to gov't	47.31	49.68	52.16	54.77	57.51
	Supervision allowances	30.96	37.2	44.68	53.66	64.43
	In service training	9.41	9.41	9.41	9.41	10.22
2	**Medicines, vaccines and health supplies**	***168.96***	***261.01***	***297.76***	***309.41***	***317.48***
	Essential medicines, vaccines(BCG, OPV, measles), health supplies	77.82	93.04	104.94	116.95	131.68
	Pentavalent vaccines DPT-HepB- Hib)	27.19	28.31	29.15	30.34	31.73
	Additional cost of Hib included above	0	0	0	0	0
	FP & Condoms	9	10.4	11.5	12.5	13.5
	ARVs	21.6	55.62	67.86	72.9	77.94
	Additional cost of branded ACT for malaria	27.45	68.63	79.88	72.75	59.1
	ITNs	14.9	15.41	15.93	16.47	17.03
3	***Other Supplemental Immunisation activities***	***7.35***	***10.32***	***2.14***	***2.25***	***9.11***
	Vaccines (1US$:1800UgShs)	3.28	2.66	0.61	0.66	2.27
	Other activities	4.07	7.66	1.53	1.59	6.83
4	**Minimum Health Care Package**	**144.17**	**152.53**	**161.4**	**170.81**	**180.79**
5	Operational & Maintenance costs	***116.25***	***121.78***	***131.88***	***138.64***	***145.96***
	Patient Feeding and Linen	25	27.1	29.38	31.84	34.52
	Utilities	19.36	20.91	22.58	24.39	26.34
	Capital maintenance	35.88	36.11	40.67	41.3	42.02
	Replacement costs	8.901	9.346	9.813	10.304	10.819
	Travel	11.01	11.56	12.14	12.74	13.38
	Administration	10.19	10.7	11.24	11.8	12.39
	HMIS Supplies	1.91	1.85	1.65	1.63	1.63
	Research and Development	4	4.2	4.41	4.63	4.86
6	**CAPITAL COSTS**	**104.58**	**107.02**	**98.48**	**103.63**	**109.01**
	Buildings (construction & renovation; energy sources)	65.03	64.91	54.02	56.72	59.56
	Medical equipment	13.04	24.6	25.83	27.12	28.47
	Vehicles & bicycles	21.96	12.45	13.08	13.73	14.42
	Long term training	4.56	5.06	5.56	6.06	6.56
	OVER ALL TOTAL	**783.82**	**934.94**	**1021.31**	**1110.87**	**1216.67**
	Resource envelope (LTEF)	508.66	504.31	527.23	573	649
	gap	-275.16	-430.63	-494.08	-537.87	-567.67
	Population (in millions)	26.73	27.64	28.58	29.55	30.55
	Per capita expenditure	29	34	36	38	40
	US$ per capita; X rate 1US$: 1,800	16.3	18.8	19.9	20.9	22.1

5.4 SHORT - MEDIUM TERM COSTING SCENARIO

Given the unpredictable nature of some of key financing mechanisms to the sector, it is difficult to project with accuracy the volume of financing available for the HSSP II. The best guide is the MTEF and LTEF. Figure 5.1 shows the growth in health sector financing over the period of the next MTEF.

Figure 5.1: Resources available to fund the HSSP II at 2003/04 prices



The Short - Medium Term Costing Scenario is therefore based on the current financial projections as contained in the Medium Term Expenditure Framework (MTEF) provided by Ministry of Finance, Planning and Economic Development. Table 5.2 shows the Short - Medium Costing Scenario for HSSP II.

It must be emphasized that if no additional resources are found, the health sector will not achieve the targets and goals outlined in the HSSP II. The targets will therefore be reviewed annually in line with the Budget Framework Papers (BFP).

SHORT - MEDIUM TERM COSTING OF HSSP II

		2005/06	2006/07	2007/08	2008/09	2009/10
	RECURRENT COSTS	**452.88**	**504.74**	**546.52**	**586.69**	**648.41**
1	**Human resource**	***145.2***	***153.77***	***162.77***	***172.22***	***182.13***
	Salary and wages (includes lunch allowance)	*108.28*	*115*	*122.06*	*129.48*	*137.26*
	Salaries and wages for NGOs (shadow cost to gov't	29.39	30.86	32.4	34.02	35.72
	Supervision allowances	16.24	17.25	18.31	19.42	20.59
	In service training	7.53	7.91	8.3	8.72	9.15
2	**Medicines, vaccines and health supplies**	***136.06***	***168.94***	***188.29***	***204.93***	***229.27***
	Essential medicines, vaccines(BCG, OPV, measles), health supplies	76.37	85.33	94.98	103.24	113.96
	Quadravalent vaccines DPT-HepB)	13.67	13.14	12.7	13.22	13.82
	Additional cost of Pentavalent (Hib)	13.52	15.17	16.45	17.12	17.91
	FP & Condoms	9	10.4	11.5	12.5	13.5
	ARVs	10.8	21.6	24.84	28.57	32.85
	Additional cost of generic ACT for malaria	12.4	24.08	29.38	32.5	26.6
	ITNs	9.3	9.62	9.94	10.28	10.63
3	**Supplemental immunisation Costs**	***7.35***	***10.32***	***2.14***	***2.25***	***9.11***
	Vaccines (1US$:1800UgShs)	3.28	2.66	0.61	0.66	2.27
	Other activities	4.07	7.66	1.53	1.59	6.83
4	**Minimum Health Care Package**	**64.45**	**68.5**	**72.43**	**76.58**	**83**
5	**Operational & Maintenance costs**	***99.82***	***103.21***	***120.9***	***130.72***	***144.9***
	Food and Linen	19.5	20.48	21.5	22.57	23.7
	Utilities	14.01	14.65	25.23	31.56	42
	Capital maintenance	35.88	36.11	40.67	41.3	42.02
	Replacement costs	5.56	6	6.49	7	7.56
	Travel	11.01	11.56	12.14	12.74	13.38
	Administration	10.19	10.7	11.24	11.8	12.39
	HMIS supplies	1.66	1.61	1.44	1.42	1.42
	Research and development	2	2.1	2.21	2.32	2.43
6	**CAPITAL COSTS**	**73.96**	**81.29**	**57.46**	**52.75**	**52.88**
	Buildings (construction & renovation; energy sources)	43.68	46.63	35.75	26.6	26.6
	Medical equipment	24.11	28.71	16.11	16.11	16.11
	Vehicles & bicycles	3.55	3.2	2.7	5.7	5.7
	Long term training	2.63	2.76	2.9	4.34	4.47
	Total Envelope	**526.85**	**586.03**	**603.98**	**639.44**	**701.3**
	Resource envelope (MTEF/LTEF)	**508.66**	**504.31**	**527.23**		
	Deficit	-18.19	-81.72	-76.75		
	Total excluding NGO wages	**497.46**	**555.17**	**571.57**		
	Deficit	**-62.08**	**-114.26**	**-71.07**		
	Population (in millions)	**26.73**	**27.64**	**28.58**		
	Percapita expenditure	**19,711**	**21,204**	**21,135**		
	US$ per capita; X rate 1US$: 1,800	**10.95**	**11.78**	**11.74**		

Addressing the financing gap
Closing the financing gap will therefore involve careful examining the ways of maximizing efficiency as well as mobilizing additional resources within the prevailing context of macroeconomic considerations.

a) Growth in the Government of Uganda Budget

As the Health Financing Strategy of 2002 showed the only financing mechanism which has proved to be effective at raising large sums of resources, efficient in raising and allocating funds and equitable in terms of reaching the poor and vulnerable has been the GoU health budget. Therefore it remains the position of the MoH that the GoU budget should be the primary mechanism used to close the health financing gap. It will therefore be the utmost priority of the Health Sector Working Group to use the type of analysis provided in the HFS (see below) to lobby for a greater health budget.

Other public funding mechanisms like project funding will also be explored but must be discussed within the Sector Working Group.

Research/analysis and advocacy
The health sector is in the process of putting up a taskforce on Macroeconomics and Health to carry out analytical work related to the health sector to inform planning and financing of health services. The Task Force composed of multi-sectoral stakeholders shall conduct relevant research and assemble evidence to guide policy and resource allocation.

b) Improving efficiency

The concept of efficiency means producing a desired output at least cost or producing the maximum quantity for a fixed budget. A lot of emphasis will be put on efficient utilisation of resources to allow a resource-constrained system to "buy" more outputs and outcomes. Cost analysi.s (relative costs of production of identified outputs; staff productivity) will be done and efficiency indicators determined which would be measured regularly. Benefit incidence analysis will be carried out regularly.

During the implementation of HSSP I, some efficiency losses were noted in programming, budgeting and implementation processes. The level of coordination at Department, Division and Implementation level did not always produce the necessary integration nor favor the most rational allocation of resources to the priority areas. Implementation did not conform to the roles and responsibilities of the different levels and at the community level, the vertical implementation of multiple initiatives resulted in duplication of efforts and waste of resources. Earmarked project-specific funding that did not always conform to HSSP needs and priorities frequently aggravated this situation.

Further means and possibilities of integrating the delivery of the Minimum Health Care Package need to be explored and considered, especially in areas of capacity building, in-service training, planning and health infrastructure development. There is need for stronger coordination of technical programs at the national level and enforcing implementation according to roles and responsibilities of the different levels. The multiple community initiatives will also be harmonised.

c) Exploitation of linkages and intersectoral collaboration:

The National Health Policy recognizes that health outcomes are influenced by many factors in other sectors. Some of these other sectors have budgets for carrying out some health related activities and so the challenge is for the different programmes to identify such activities and work with the responsible sectors, using their approved budgets for the activities, and ensure their implementation. Inter-ministerial collaboration will be strengthened with key ministries for example the Ministry of Gender which has been charged with community development; Ministry of Education and Sports in the area of school health; Ministry of Agriculture, Animal Industries and Fisheries (MAAIF) in the control of Zoonotic diseases and the Water Sector for water and sanitation activities. This will minimize duplication and wastage of resources and promote a spirit of partnership.

CHAPTER 6: IMPLEMENTATION OF THE HEALTH SECTOR STRATEGIC PLAN II

Introduction
The HSSP I detailed out the Uganda National Minimum Health Care Package (UNMHCP) and the framework for its delivery. In addition the National Health Policy and the HSSP I articulated a number of principles to guide health service delivery which included due consideration for efficiency, equity and quality in the provision of the UNMHCP.

This chapter presents the implementation plan for the HSSP II. The implementation plan builds on achievements over the period of the HSSP I and lays down strategies to consolidate and extend this performance in the period 2005/06 to 2009/10. HSSP II will therefore guide the different stakeholders on how best to deliver the UNMHCP to ensure improved health outcomes for all Ugandans, and in particular how best to target the most vulnerable groups with public resources.

Goal: Efficient and equitable delivery of a high quality UNMHCP within available resources

Broad Strategies
- Delivery of an integrated UNMHCP, given SWAp and decentralisation,
- Scaling up priority interventions, and combining these effectively to produce the targeted outputs and outcomes, in view of resource constraints
- Improving Quality of Care
- Improving Responsiveness and Accountability to the consumers to facilitate increased client satisfaction, and thus more utilisation of the necessary services;
- Explicit consideration of vulnerable communities and individuals in the provision of the UNMHCP;
- Appropriate health services in conflict and post-conflict situations;
- An appropriate supervision, monitoring and evaluation framework for the provision of the UNMHCP;

6.1 Delivery of the integrated UNMHCP in the era of SWAp and Decentralisation

6.1.1 Decentralization and heath service delivery
The HSSP II will be implemented through the decentralised system with clear roles for the central, district and lower levels of government in the delivery of health services (see Chapter 2 on the National Health System). The HSSP I was a period of transition with the central government learning to concentrate on the policy and the strategic issues and move away from the more operational and implementation issues that it was involved in before. The local governments on the other hand have had to learn to take on their responsibilities. In particular, a new way of work, the Health sub-district strategy was introduced at the beginning of the HSSPI, whereby routine management and delivery of health services were devolved further to a level below the district.
There are still areas of challenges. Some technical programmes such as the control of vector-borne diseases were left to run as vertical programmes resulting in poor ownership at the local government level. Some of the national level institutions (e.g. Uganda Blood Transfusion Services, Natural Chemotherapeutics Research Laboratory) and the regional level

(especially the Regional Referral Hospitals) are sometimes not adequately involved and assessed as part of the National Health System.

During the implementation of the HSSP II, emphasis will be put on making sure that the different levels carry out their mandated functions. This will be achieved through:

- Development of clear indicators for the different levels of the sector given their mandate. These indicators with clear five-year and annual targets will be included in Volume II of the HSSP II;
- Resource allocation will depend on the responsibilities/functions of the different levels- for example funds for service delivery should be allocated to HSDs and the LLUs, and clearly reflected in the workplans.
- Annual work-plans will be developed at the different levels for the operationalisation of the mandates;
- Quarterly, annual, and mid-term reviews will be carried out to ensure adherence of the different levels with the responsibilities/functions laid out for them;
- Frequent assessment at the different levels including comparison of performance between like entities will be carried out to encourage competition and better performance. The District League Table was first constructed in the Annual Health Sector Performance Report 2002/03, and Hospital Performance Assessment using the Standard Unit of Output in the Annual Health Sector Performance Report 2003/04.

6.1.2 The SWAp, and working together as partners in the health sector

At the time of development of the National Health Policy and HSSP I stakeholders in the health sector agreed to a Sector-wide Approach to health development (SWAp) whereby all stakeholders in the sector agree to one programme of work (the Health Sector Strategic Plan) and the point of involvement of the various players. This same approach is being adopted for the HSSP II, with particular effort made during its development to agree on the programme of work and how the different stakeholders can contribute to it optimally. A Memorandum of Understanding (MoU) indicating the different roles and obligations for the different stakeholders was drawn up for HSSP I and it has been updated for the context of the HSSP II. The different stakeholders' roles are laid out in Chapter 2 the National Health System.

Over the HSSP I several development partners withdrew from direct involvement in service delivery and emphasis was placed on providing financial, technical and management support through the broad framework of SWAp using government procedures for disbursement, procurement and overall management. There are still some projects being implemented in partnership with the central and local governments. During the HSSP I Global Initiatives (e.g. GFATM, PEPFAR, GAVI) came into existence, with direct disbursement of funds to districts and both public and private providers of different health services for specific activities. The challenge for HSSP II is to build these appropriately into the programme of work as described at the various levels.

During the HSSP I a lot of progress was made in improving partnership with the Private Sector and specifically the Facility-Based PNFP providers. However there are still challenges in dealing with the Non-facility based PNFPs, the PHPs and the TCMPs. The National Health Accounts for the FYs 1998/99 to 2000/01 for example showed that the PNFPs (both facility based and non-facility based, but mostly the latter) control more resources than the

public entities[15]. It is therefore important that in the implementation of the HSSP II this is kept in sight, and efforts made to make sure that these funds are directed towards the priorities in the HSSP II, and inefficiencies minimised. This will be particularly crucial given the level of prioritisation given by the Global Initiatives like PEPFAR and GFATM to involvement of the private sector.

The HSSP II will build on the experience of the HSSP I to further increase the appreciation of the role of government as overall steward, and the other stakeholders being accountable to government and through government to the population. This will enable the efficient and equitable utilisation of all resources, from the government budget, global initiatives, development partners, the local governments and households while minimizing duplication and overhead costs. This will be achieved through the following:

- The different roles and responsibilities of the government (at various levels) and the development partners will be further elaborated in the MoU for HSSP II implementation, which will be built on the MoU of the HSSP I and lessons learnt during HSSP I implementation;
- Regular assessment of performance against these roles and functions will be carried out – quarterly, by HPAC and the Inter-agency Coordination Committees, and annually by the Joint Review Mission. It is particularly required that expenditure information by the Donor Projects and Global Initiatives (where, how much, alignment with HSSP and annual priorities) should be made regularly available.
- The coordination and consolidation of activities carried out by different players – public, PNFP, PHPs and CSOs will continue, with particular effort focused at the district and HSD levels;
- Involvement of the community is highlighted in Chapter 2 and 3 the National Health System and in this Chapter under Section 6.5.

6.1.3 Delivering an integrated package of services

The new clustering of the different elements of the UNMHCP in the HSSP II has been in emphasis of the need to facilitate the provision of the UNMHCP as an integrated package of services. This is particularly pertinent at the service delivery levels where the same health workers and similar inputs are used to provide the whole range of services to the population. The horizontal linkages between the clusters however need to be further emphasised. It is clear for example that malaria and other communicable diseases are the major causes of ill-health in children, and that health promotion and education can go a long way in preventing some of these diseases.

Further integration during the HSSP II will be achieved through:

- Use of Generic Planning Guidelines – these have been used during the HSSP I for district and HSD work-plan preparation and are being updated to further help the different entities to work towards the provision of an integrated package of services. These guidelines put emphasis on:
    - Planning by level of the health service delivery system, with the utilisation of generic inputs to produce activities over a range of disease programmes e.g. case management of patients, outreaches, supervision visits;
    - Minimum service standards for the different levels of care – centre, district, hospital, HC IV, HC III, HC II and the community level, with clarity on what

[15] Households Out-of Pocket is largest at 42%; PNFPs at 32%, and public financing intermediaries lowest at 26% - NHA Report 1998/99 to 2000/01.

services should be delivered for the different components of the package (promotive, preventive, curative and rehabilitative)

- Use of Generic Inputs and logistics systems - allocation of these inputs is determined by level of care and therefore by health care needs, and the minimum service standards and not a specific programme. The following provide some examples of how this will encourage integration:
    - Financial resources – the Primary Health Care Conditional Grant as the major source of funds at the operational level rather than programme-specific funding;
    - Human resources – recruitment by level; and training for skills for the delivery of the UNMHCP – operationalisation of the In-Service Training Strategy is expected to take place in the early phase of the HSSP II; and
    - Essential Medicines and Other Health Supplies – a comprehensive and integrated logistics system has been developed during HSSP I and will be further strengthened in HSSP II;
- Generic Supervision, Monitoring and Evaluation Framework – this is discussed further in Sections 6.6 and 6.7 and includes:
    - a comprehensive Performance assessment framework which is included in the district Planning Guidelines;
    - the use of the integrated Teams for Supervision and Monitoring – the Area Teams; and
    - the use of generic Quality of Care tools like the National Supervision Guidelines and the Yellow Star Checklists.

6.2 Scaling Up of the Priority Interventions

The Uganda National Minimum Health Care Package includes a set of interventions which are known to improve the population's health, with particular emphasis on improvements in child and maternal morbidity and mortality. During the HSSP I a number of interventions such as HBMF, VCT, and PMTCT were initiated in the country but most of these have not yet achieved geographical and/or functional coverage throughout the country. This was partly due to the inadequacy of funding, but also due to the fragmented prioritization process in the sector, with often new initiatives taken on before old ones have been rolled out across the country.

During the HSSP II explicit and transparent mechanisms for prioritization will be implemented at all levels. The process of prioritization will be guided by:

- long term targets as set out in the Vision 2025, the Millennium Development Goals and the National Health Policy;
- medium term targets as set out in the PEAP, HSSP I and HSSP II; and
- short term targets as set out in the Annual Budget Framework Papers, and by the National Health Assembly and Joint Review Mission and the work-plans at the various levels.

All public resources (government budget including donor budget support, Donor Projects and Global Initiatives) should be aligned with these priorities.

A major focus of the HSSP II will be to scale up interventions initiated in the HSSP I both in terms of geographical and functional coverage to ensure the targeted benefits reach the

population, as opposed to starting on yet new interventions. Focus here is put on the interventions in the UNMHCP programmes and systems that will provide most momentum for the sector as regards maternal, infant and child mortality as indicated in the MDGs, National Health Policy, PEAP and the HSSP I . Scaling up these interventions will not only ensure wider and more equitable coverage, but will also lead to efficiency gains from synchronized delivery of the different aspects of the UNMHCP. For the HSSP II therefore all efforts will be made to ensure:

- Completion of decentralization of routine management and delivery of health services to the HSD level. This requires that appropriate capacity and facilitation in terms of human, financial, and logistical resources are in place for the HSD;
- Operationalisation of all the HCIVs to avail emergency surgical and obstetric services including blood transfusion services;
- Availing Basic Emergency Obstetric Care (BEmOC) at the HC IIIs and Comprehensive Emergency Obstetric Care (CEmOC) at HC IVs and Hospitals;
- HIV/AIDS prevention and care – provision of VCT, and PMTCT at all HC III and higher level units; and provision of ART at all HC IV and higher level units;
- Malaria prevention and control
    - provision of adequate preventive materials (ITNs) - free/heavily subsidised ITNs will be made available for the most vulnerable – children and pregnant women; and
    - medicines and supplies at the health unit and community levels (HBMF);
- TB CB-DOTS to be scaled up to the whole country;
- Availing appropriate and adequate vaccines;

The cost of providing these has been elaborated in Chapter 5 of this document. The challenge facing the sector during the HSSP II is to make sure that the push for one single intervention does not compromise the capacity of the sector to provide a good quality UNMHCP to the population, and in particular there is need to balance these initiatives with the capacity of the sector to avail basic drugs and decent wages to health workers – which are very key inputs into the health services. The ideal and realistic scenarios in Chapter 5 clearly indicate this. The realistic scenario (based on availability of funds in the MTEF) aims at gradual coverage of the country with the basic components of the UNMHCP.

Given the very limited financial resources choices have to be made: for example in the absence of continuing support from the Global Initiatives (GAVI and GFATM specifically) it does not seem possible given the medium term projections by MoFPED to maintain the Pentavalent Vaccine, free Anti-retroviral therapy (ARV) and artemesin-based combination therapy (ACT) for malaria.

6.3 Quality of Care

The quality of care was an important component of HSSP I. However, during the implementation of HSSP I, emphasis was focused on access to health services, both geographical and financial, and less on the quality of services. This was because of the poor access to services at the start of the HSSP I. The HSSP II will build on accomplishments of the HSSP I with emphasis on functional scaling up and improvements in quality of services.

Objective: ensure good quality health services given available inputs for maximum outputs and efficient utilisation of resources

Strategies

- develop and disseminate standards of quality health services to all health service delivery points;
- ensure service providers use the standards and guidelines by:
    - establishing and strengthening a regular supervision system using agreed checklists – see Section on Support Supervision for more on this.
    - facilitate establishment of internal quality assurance capacity at all levels of health services;
    - enhance awareness and understanding among the health workers of the importance of quality health services including use of health training schools curricula and in-service training.
- Involve the community in quality of care – more of this in section 6.5.

6.4 Responsiveness, Accountability and Client Satisfaction

The responsibility for health primarily lies with individuals, households and communities. The elaborate structure of the National Health System is in place to facilitate the individuals, households and communities to attain and sustain good health. The individuals, households and communities therefore need to be empowered to take their due role as health producers and consumers. The involvement of communities in producing health has been articulated in Chapter 3. This section concentrates on the role of individuals and communities as consumers of health services.

The utilisation of health services is a combination of the supply side, and the demand side. The improving utilisation of health services during the HSSP I (as shown by improvements in OPD utilisation, immunisation) is a sign that supply and demand have been moving in the same direction. The supply side issues include: access to health services both geographical and financial. These are dealt with in the other areas of this document. The demand side issues are: perceptions of quality, and individual/household characteristics which may be associated with cultural and religious affiliation and the socio-economic status of the individual/household. However utilisation of in-patient services and especially maternity services is well below desired levels to produce improvements in health status especially to make much needed decrease in maternal and child morbidity and mortality. This low utilisation shows that the maternal health services supply has not yet reached the level to elicit appropriate demand. This points to a gap the health systems' capacity to respond to consumers' demands.

The Mid-term Review of the HSSP I examined the current framework through which consumers are able to provide input into the health system. This analysis showed that currently the involvement of the communities as consumers of health services is still poor. There are some structures/mechanisms through which the consumers are expected to provide input into making the health system more responsive to their needs. The implementation of the HSSP I benefited from application of participatory mechanisms. In particular, the abolition of User Fees was as a result of country-wide complaints documented in the first Participatory Poverty Assessment report. Civil society has also contributed to several debates, and more recently has advocated for more funds for health care. However a

lot more can be done to foster the role of individuals/households/communities in playing their due role as consumers of care. Some studies carried out by civil society organizations have indicated that the public are largely unaware of their rights, and of channels for complaints and seeking redress[16].

During the period of the HSSP II, the sector will make overt effort to encourage community responsiveness and ownership of health services through a number of ways.

Objective: Establish dynamic interactions between health care providers and consumers of health care with the view to improving the quality and responsiveness of health services provided;

Strategies

- Reactivate and build capacity of Health Unit Management Committees in government and PNFP health units throughout the country;
- Continue working with political and administrative leaders at all levels of government in health services delivery;
- Work with civil society organisations, especially those working in the area of health consumer rights such as Uganda National Health Consumers' Organization to build individuals/communities awareness of their rights and obligations;
- Carry out and/or participate in surveys (National Service Delivery Surveys, Participatory Poverty Appraisals, etc.) and other studies that can provide more information about client satisfaction and gender responsiveness;
- Step up/Institutionalize other ways and means of receiving feed-back from communities including: suggestion boxes at health units; radio and TV talk shows; and telephone call centres with a help-line;

The indicator on client satisfaction although included in the HSSP I was never measured over the period 2000/01 to 2004/05. A client satisfaction survey shall be carried out at the beginning of implementation of the HSSP II which will provide baseline information that can in future be used to determine trend of performance.

6.5 Equitable access for vulnerable communities and individuals

The health sector considers vulnerable individuals/high-need groups to be: poor people, children, orphans, the elderly, women, displaced persons (refugees and internally displaced), nomads, and people living in areas with insecurity. The Mid-Term Review Report of the HSSP I[17] noted that some progress had been made in improving the access of the most vulnerable individuals to health services.
This was particularly accomplished through:

- Increasing the funding to Primary Health Care services in absolute and relative terms – this is targeted at the peripheral health units which benefit many of these vulnerable individuals;
- Abolition of user fees in government units and increased subsidies which have led to decrease of fees in PNFP units; and

[16] Uganda National Health Consumers Organization study
[17] MTR of the HSSP 2003 – pages 28, 68-73

- Targeted use of the Primary Health Care Conditional Grant to increase funding for populations that have most need.

This investment has paid dividends as shown by the increasing use of services by these categories of people in the community as shown by a number of studies and reports[18]. Improvements have been registered in access especially for the poor. Data from National Household surveys (1997, 2000, 2002) and a longitudinal study on abolition of cost sharing have shown that the poor are using public facilities more than the richer segments of population following abolition of cost sharing.

The above studies have also shown that there is room for improvement - in particular there are concerns that since abolition of User Fees, proportionately fewer children are utilising OPD services than adults, and that orphans are being rationed more than other children. The low utilisation of health units for deliveries is a pointer that we have not yet succeeded in meeting women's needs. The gender dimensions influencing the health seeking behaviour of women have been documented in a number of reports.[19] These include women lacking financial and decision making powers in households regarding access to healthcare services and generally having to seek permission from their husbands before seeking care especially when they have to travel long distances to health unit. Time spent at the health unit, low level of education; a woman might not be willing to leave the household for an uncertain period of time because of childcare or household work. Supply side factors that have affected women's health seeking behaviour include absence of qualified staff, lack of equipment, drugs and supplies as well as the attitude of health workers.

The way of life in some parts of the country has particular implications for the health status and health-seeking behaviour of the communities. In the North East of the country (Karamoja) the people are nomads and have specific cultural beliefs and behaviours which have resulted in poor health outputs and outcomes[20]. The fishermen and their families on the several islands in Lake Victoria and other water bodies in the country have particular health needs. Some initial research work has been done under the HSSP I to understand the health needs of such populations, which will inform efforts for affirmative action during the implementation of the HSSP II. The HSSP II approach to health services in the conflict and post-conflict areas of Northern Uganda is detailed out in Section 6.7.

Objective: Provide appropriate and sustainable health services for vulnerable communities and individuals in line with equitable delivery of the UNMHCP

Strategies

Reaching the poor, children, the elderly and orphans

- Equitable resource allocation: special consideration for poorer districts (and other entities) in the financial resource allocation formula will be made through, incorporating poverty indices of the different districts to ensure that poorer districts get proportionally more funds.

[18] MTR of the HSSP, Uganda National Household Survey 2002/03, and Abolition of User Fees study – 2001, 2002 Reports.
[19] UPPAP2, 2002; MoFPED, Infant and Maternal Mortality in Uganda: Causes, Interventions and Strategy; MoGLSD/MoFPED, Engendering Uganda's Poverty Eradication Initiatives: A Desk Review on Gender and Poverty, 2003
[20] see Annual Health Sector Performance Report FY 2003/04

- Subsidies for the PNFP facility based sector: the government will continue to subsidize the cost of service delivery for PNFPs to enable them reduce the fees charged. This will improve financial access for the poor especially in areas where there are no public facilities.
- Infrastructure: emphasis will be put on consolidating existing infrastructure but special consideration for new construction will be made for under served areas.
- Community mobilization: this will be intensified for marginalized groups like orphans, under fives, the elderly and women.
- Capacity building: in order to improve access especially for expectant mothers, and under fives, the capacity of health workers in managing these conditions will be given due emphasis e.g. management of common childhood illnesses will be improved using IMCI guidelines, and Antenatal Care with guidelines for Goal Oriented Antenatal Care. In addition, availability of essential inputs like drugs will be improved at the health facility level.

Gender

- Improving reproductive health outcomes: this will remain a priority area of focus for HSSP II. Strategies identified in this area are outlined in Chapter 3 in the cluster on Maternal and Child Health.
- Community mobilisation: to address gender dimensions at household level community mobilisation will target men to make them aware of the importance of women seeking health care. Mobilisation activities will also target women on the importance of them seeking health care for themselves and their children.
- More appreciation of the effect of gender on health and health-seeking behaviour will continue to be sought through reviews and field studies so as to provide more information for appropriate policy development and resource allocation;
- Capacity Building of health workers at all levels will continue to take place to ensure mainstreaming of gender issues.

Affirmative action for the Karamoja Region and other Nomadic Populations

- Mobilize and allocate resources to the Karamoja region as required in line with equitable delivery of the UNMHCP;
- Develop appropriate health services delivery models for populations with peculiar health needs (for example mobile health services for nomads in Karamoja) by adapting HSSP norms to the region's needs for the UNMHCP and UNMHCP support systems namely: Health Infrastructure, Human Resources, Essential Drugs Medicines and Supplies, Diagnostic Services, and Information for Decision Making;
- Strengthen community ownership and leadership of health programs in view of the strong cultural and socio-economic linkages with health-seeking behaviour and health status in these communities;

6.6 Appropriate health services in conflict and post-conflict situations

The situation in the North has acutely deteriorated during the last year. This region with about 20% of Uganda's population has approximately 1.7 million Internally Displaced persons (IDPs) living in about 180 camps. There are also about 250,000 refugees from Sudan and DRC living in this region. Available data suggest a significantly worse health situation in the North compared to the rest of the country. The HSSP II provides a framework for special approaches for delivery of health services in the North. These need to be well coordinated

with other key government documents, such as the PEAP Pillar 3 on Security, conflict resolution and disaster management, the IDP Policy and the Recovery and Development Programme for the North.

Objective: ensure equitable access by people in conflict and post-conflict situations to the UNMHCP

Strategies:

- Provide the UNMHCP to people in conflict and post-conflict situations with particular emphasis on:
  - Basic health services including disease prevention and health promotion, mobile forms of primary health care, and appropriate referral;
  - Psychological and physical rehabilitation especially for children, mothers and returnees;
  - providing prevention and control services against infectious diseases whose spread is increased in conflict and post-conflict situations, including immunisable diseases and HIV/AIDS;
- Develop mechanisms for the provision of appropriate UNMHCP Support Systems for conflict and post-conflict areas, especially for
  - Infrastructure and Logistics by provision of appropriate means of transport and communication. In case of resettlement there would be need for planning for short-, medium-, and long term solutions for infrastructure and logistics needs.
  - Human Resource for Health by appropriate staff remuneration including accommodation, transport, and special allowances; affirmative action with catch-up recruitment against norms; support to Community Resource Persons (CORPS) or Village Health Teams (VHTs) who are carrying out a lot of activities given the poor staffing levels;
- The challenges in conflict and post-conflict situations attract several stakeholders, and strong coordination of financing and implementing entities is crucial, with particular focus on:
  - Effective use of all public resources with particular requirement for more effective coordination given the multitude of players;
  - Flexible financing mechanisms with appropriate mechanisms for Monitoring and Evaluation.

6.7 Supervision for the Implementation of the HSSP II

Supervision, Monitoring and Mentoring is an essential aspect of health system, and important in determining quality of health services and the efficiency of the system. During the five year implementation of the HSSP I the following achievements were attained: key support supervision guidelines were developed and disseminated to all districts; a quality of health care strategy (Yellow Star Program) was developed and introduced to 35 districts[21]; and supervision and other mentoring visits were carried out at the different levels.

The Mid-Term Review of HSSP I[22] found that Supervision, Monitoring and Mentoring of the health sector needed improvement in a number of areas. In response to the recommendations of the Mid-Term Review of HSSP I an Area Team Strategy for coherent and effective

[21] AHSPR 2003/04
[22] MTR of the HSSP Report 2003

support to districts and HSDs for the remaining period of HSSP I and the HSSP II was developed.

Objective:
To provide regular and appropriate supervision of the different entities of the health sector as a means to ensuring efficient and equitable delivery of good quality health services

Implementation Strategies:
The Supervision, Monitoring and Mentoring framework for the HSSP II caters for the different needs at the different levels of implementation. This framework includes the following components:

- Supervision and Monitoring to and by local governments;
- Supervision and Monitoring of Hospitals and lower level health units by technical health workers;
- Supervision of central programmes within MoH and other central institutions;

Supervision and Monitoring to and by local governments
The Area Team Strategy[23] introduced in the latter half of the HSSP I will be improved upon in the HSSP II period. A team of officials from various programmes of the MoH and other central and regional level institutions will ensure appropriate and continuous support to the local governments. Peer support and Resident Technical Assistance will be provided as required.

Within the local governments the political, administrative and technical leaders will supervise service delivery at the various levels. Technical support supervision will be provided by the District Health Management Team at the Health sub-District level, and the Health sub-district will supervise the Lower Level Units in their catchment area.

The Expected Outputs are:
- Quarterly Area Team Reports
- DHT Quarterly Supervision Reports
- Technical and Support Programme Specific Reports
- HSD Monthly Supervision Reports

Supervision and Monitoring to and from Hospital
Specialist outreach programmes from National and Regional Referral Hospitals will be strengthened so that hospitals and LLUs are regularly and effectively supervised.

Expected Output
- Specialists Reports as components of Area Team Reports

Supervision of central programmes at the MoH and other central level institutions
All MoH programmes and other central level institutions in the health sector like Mulago National Referral Hospital, Butabika National Referral Hospital, Uganda Blood Transfusion Services, Public Health Laboratories and other institutions shall carry out regular supervision and monitoring of the health care delivery system. These will include organised self-assessment, regular meetings at the various levels, and reports which will be presented and

[23] Area Team Strategy Ministry of Health 2004

discussed at the Quarterly Review Meetings of the Health Sector. The Top Management Committee of the MoH will provide supervisory support to all programmes and institutions.

Expected outputs

- Quarterly Performance Assessment Reports

Tools for Supervision, Monitoring and Mentoring

Supervision, Monitoring and Mentoring will employ various tools that are agreed within the health sector and these will include:

- Generic Guidelines and Checklists – Area Team Checklists, Planning and Resources Allocation Guidelines, National Supervision Guidelines, Yellow Star
- Programme Specific Guidelines and Standards

6.8 Monitoring Framework for the HSSP II

The HSSP II has been developed in the context of the Millennium Development Goals and the Poverty Eradication Plan. As such the HSSP II Monitoring Framework has been developed in consideration of the MDGs and the PEAP Monitoring Framework. In the same manner the HSSP II indicators and targets have been set after due consideration of global and national indicators and targets and the resources (financial, human) and circumstances under which the health sector is operating in Uganda today.

The HSSP II like the HSSP I will be implemented through the Sector-Wide Approach to health development (SWAp). The SWAp particularly highlights the use of joint reporting, monitoring and evaluation mechanisms, structures and indicators for all the stakeholders in the sector. The same structures used under the HSSP I will continue to be used, namely: the Memorandum of Understanding, the Joint Review Missions (JRM), National Health Assembly (NHA) and the Health Policy Advisory Committee (HPAC). This has been described in more detail in Chapter 2 on the National Health System.

6.8.1 HSSP II Indicators

The health sector performance will be monitored using a set of agreed indicators at national, programme, district and hospital levels. Lessons learnt from using the HSSP I national level indicators to measure sector performance have been utilized in coming up with a list of 24 national level indicators to be used to measure performance against the HSSP II. The national level indicators used in the HSSP I have been maintained, but in addition a few new indicators have been added (to make a total of 24 indicators) with a view to: focus on efficiency in the sector, and to further highlight the level of priority of some health conditions like maternal and infant health, and malaria. Due consideration has been made to the regular (preferably annually) availability of data on these indicators. The national level indicators are shown in Table 6.1.

In addition to the national level indicators, programme, district and hospital level indicators have been developed to facilitate regular performance assessment at the various levels and to provide an opportunity for comparing entities at these levels. These indicators are presented in the HSSP II Volume II.

6.8.2 Sources of Information for Monitoring the HSSP II

The HMIS is the major tool for collecting information for Monitoring the HSSP II. The strategies to be employed for focusing and strengthening the HMIS to play its due role in the monitoring of the HSSP II have been laid out in Chapter 4 Section …… In addition to the HMIS the sector will use information from other sources which will include:

- Surveys commissioned by the MOH – these may be carried out directly by programmes within the MOH or contracted out; it is planned that these include:
    - Client satisfaction surveys, which will be needed to determine a baseline, mid-term and end of HSSP II values;
    - Mapping/population survey to determine geographical access to health services including functional coverage of the UNMHCP; including a Geographical Information Service (GIS);
    - Use of the Burden of Disease or other appropriate methodology like comprehensive Sentinel Surveillance Sites;
- Surveys in other institutions – these include the National Household Surveys, Demographic and Health Surveys, and National Service Delivery Surveys.
- Studies in the health sector – a number of studies are done every year at national and lower levels, by various entities
- Support Supervision Reports for the different levels of care.

6.8.3 Monitoring Performance of the HSSP II

Regular reports using the HMIS and other sources of data will be used to assess progress against agreed indicators and targets and will include:

- Quarterly Reports
- Annual Performance Reports
- Mid-term Review and End-term Evaluation

Quarterly Reports
These will be produced by the different levels and used both for self assessment and by supervisors to determine progress or lack of it.

Annual Health Sector Performance Reports
The Annual Health Sector Performance Report (AHSPR) was institutionalised during the HSSP I, and has been very useful in highlighting areas of progress and challenges in the health sector. Effort was made every year to make the Report more informative and analytical. During the HSSP II the Report is expected to continue playing its due role in Health Sector Monitoring. The different levels of health services delivery are expected to compile their reports. These reports should be used by these levels to critique performance, and then submitted to the national level for compilation of the AHSPR **by the end of August every year.** The AHSPR is the agreed document for monitoring HSSPII and should be used by al stakeholders for this purpose. The AHPSR is presented by the MOH to health sector stakeholders and discussed at the Joint Review Mission held October-November every year.

The AHSPR will include an assessment of performance at and within the different levels, and will utilize the following for this purpose:

- District League Table
- Hospital League Table or other objective assessment of performance
- Mechanisms will be developed to compare Central level programmes performance.

Mid term Review and End Term Evaluation

A Mid-Term Review of the HSSP I was done after two and half years of implementation and a report finalized in 2003. An End Term Evaluation of the HSSP I will be carried out within the FY 2005/06. A Mid-Term Review of the HSSP II covering the period July 2005 to December 2007 shall be undertaken in 2008. This will coincide with the end of the 10 year National Health Policy (1999) period.

Table 6.1: Indicators for Monitoring the Health Sector Strategic Plan II

	Category	Indicator	Purpose (what it measures)	Baseline Value 03/04	2004/05 value	2005/06 value	2006/07 value	2007/08 value	2008/09 value	2009/10 target	Data Source
1	Input	Percentage of Government of Uganda (GoU) budget allocated to health sector	Commitment of GoU to health	11.6%	11.1%	11.1%	11.0%	12.3%	13.4%	13.2%	MOH/ MOF Reports
2	Input	Percentage of PHC conditional grants released on time to the sector (non-salary recurrent and capital)	Level of government honouring of its commitment to the health sector.	97%	100%	100%	100%	100%	100%	100%	MoH/MFPED
3	Input	Total public (GoU and donor) allocation to health per capita	Magnitude of resource allocation	$7.8	$7.8	$10	$12	$14	$16	$18.0	MOH/ MOH Reports
4	Process	Percentage of disbursed PHC conditional grant that are expended	Absorption capacity at the district level	99%	99%	100	100	100	100	100%	PHC monitoring reports
5	Process	Proportion of districts submitting Health Management Information System (HMIS) monthly returns to MoH on time	management capacity through timelines of reporting system	85%	85%	90%	95%	100	100	100%	HMIS reports
6.	Process	Proportion of districts submitting quarterly assessment reports	Utilization of HMIS data	5%	20%	30%	40%	50%	60%	90%	HMIS Reports
7	Process	Percentage of facilities without any stock outs of first line antimalarial drugs/ Fansidar , measles vaccine,Depo Provera, ORS and cotrimoxazole	Drug management protocols	40%	45%	50%	55%	60%	70%	80%	HMIS/ Reports/ Records review
8	Process	Percentage of the population residing within 5kms of a health facility (public or private not for profit)	Geographical access	72%	75%	78%	80%	82%	83%	85%	1.Mapping of health facilities 2.Population based surveys
9	Process	Percentage of the health units by level providing all components of the National Minimum Health Care Package (NMHCP)	Functionality	survey to determine baseline 1st quarter HSSP II							
10	Process	Percentage of Health units providing EMOC	Quality of obstetric care	14%	20%	25%	30%	40%	50%	60%	HMIS Surveys
11	Output	Percentage of children < 1yr receiving 3 doses of DPT/Pentavalent vaccines	Utilisation (a PEAP indicator).	83%	85%	86%	87%	88%	89%	90%	HMIS

	Category	Indicator	Purpose (what it measures)	Baseline Value 03/04	2004/05 value	2005/06 value	2006/07 value	2007/08 value	2008/09 value	2009/10 target	Data Source
12	Output	Proportion of approved posts that are filled by health professionals.	Level of staffing – implementation of HRH policy	68%	75%	80%	85%	85%	88%	90%	Annual HU/ District reports
13	Output	Couple Year Protection(CYP)	Utilisation of FP Services	223,686	246,055	282,963	325,407	374,218	430,351	494,908	HMIS
14	Output	Proportion of surveyed population expressing satisfaction with the health services	Quality of service delivery	Baseline to be decided before HSSP II						80%	Community surveys Client satisfaction Surveys
15	Output	Urban/rural specific HIV sero- prevalence rates	HIV infection	urban rural National	 6.2%					 4.4%	ACP reports ANC reports
16	Output	Percentage deliveries taking place in a health facility (GOU and PNFP) Deliveries supervised by a health professional	Utilisation	24.4% 38%	25%	30%	35%	40%	45%	50% 60%	HMIS UDHS
17	Output	Total Gov. and NGO /Capita OPD utilization	Utilisation	0.72	0.78	0.84	0.90	0.96	1.0	1.0	HMIS reports/records review
18	Output	Caesarian Sections per expected pregnancies (Hospital)	Level of EmOC coverage	1.5%	4%	6%	7%	8%	9%	10% Consult RH	HMIS reports/ Records review
19	Output	Proportion of Tuberculosis cases notified compared to expected	Effectiveness of surveillance system	49%	52%	55%	60%	65%	67%	70%	NTLP reports
20	Output	Proportion of Tuberculosis cases that are cured	Quality of care	62%	65%	70%	80%	85%	85%	85%	NTLP reports
21	Output	Proportion of children under 5 years with fever who receive malaria treatment within 24 hrs from a community drug distributor	Access to care	48%	55%	60%	65%	70%	70%	70%	HMIS
22	Output	% of fever/uncomplicated malaria cases (all ages) correctly managed at health facilities	Access to effective malaria case management	60%	65%	75%	85%	90%	95%	100%	facility based surveys
23	Output	Proportion of pregnant women receiving a complete dose of IPT2	No. of mothers covered	24%	30%	40%	50%	60%	70%	75%	HMIS
24	Output	Percentage of House holds with at least one ITN	Coverage with preventative Malaria interventions	23.5% (estimate in rural areas)						70%	House hold Survey

*** this is based on data from 18 districts**

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