
**GOVERNMENT OF UGANDA**
**Ministry of Health**

# HEALTH SECTOR STRATEGIC PLAN III
# 2010/11-2014/15

**TABLE OF CONTENTS**

## FOREWORD BY MINISTER OF HEALTH

## ACKNOWLEDGEMENTS

## LIST OF ACRONYMS

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

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

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

## EXECUTIVE SUMMARY

# 1. INTRODUCTION

## 1.1 Context and rationale for development of the HSSP III

The first Health Sector Strategic Plan (HSSP I) for Uganda covered the period 2000/012004/05 and it guided the Government of Uganda's (GoU) health sector investments led by the Ministry of Health (MoH), Health Development Partners (HDPs) and other stakeholders over this period. Continous monitoring through quarterly and mid-term reviews were done to assess key achievements and challenges during the implementation of the HSSP I and this formed the basis for the development of the second HSSP (HSSP II) for the period 2005/06-2009/10. The HSSP II will be completed in June 2010. It was therefore necessary that a third HSSP (HSSP III) be developed, in line with the National Development Plan (NDP), that will guide the health sector investments for the next five years starting from July 2010 to June 2015. The HSSP III provides an overall framework for the health sector and its major aim is to contribute towards the overall development goal of the Government of Uganda (GoU) of accelerating economic growth to reduce poverty as stated in the National Development Plan (NDP) 2010/11-2014/15.

The GoU, with the stewardship of the MoH, has also developed the second National Health Policy (NHP II) that covers a ten year period 2010/11-2019/20. The HSSP III has therefore been developed to operationalise the NHP II and the health sector component of the NDP. The plan details the priority interventions as identified during the mid-term review (MTR) of the HSSP II by external independent consultants, TWGs, districts and agreed upon by all stake holders. The HSSP III acknowledges that resources are limited; hence as was the case in HSSP I and II, it has identified a minimum health care package that will be accessible to all people in Uganda. The development of the HSSP III has taken into consideration a wide range of policies, the new emerging diseases, the changing climatic conditions and issues of international health. The process also took into consideration the international treaties and conventions to which Uganda is a signatory more especially (i) the Millenium Development Goals (MDGs), three of which are directly related to health and most others address determinants of health; and (ii) the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness. The aim of reviewing policies and plans during the development of the HSSP III was to harmonise the strategic plan with the other existing sector and inter sectoral documents.

## 1.2 Development Process for the HSSP III

At the beginning of 2009 the MoH formed a Task Force (TF) to oversee the development of the NHP II and the HSSP III. The membership of this TF was drawn from the different Departments of the MoH, universities, the private sector, Civil Society OrganisationsOrganisations (CSOs) and HDPs. The involvement of the different stakeholders was important in order to ensure ownership of the plan. The TF was chaired by the Director General of Health Services in the MoH. In order to facilitate the drafting of the NHP II and the HSSP III, 12 TWGs namely Sector Budget Support Working Group, Hospital, Nutrition, Human Resource (HR), Maternal and Child Health (MCH), Environmental health, Health Promotion and Education (HPE), Public Private Partnerships in Health (PPPH),Health Infrastructure Development and Management (HIDM), Medcines and Supplies Management and Procurement, Communicable Diseases, Non-Communicable Diseases (NCDs) and Supervision, Monitoring, Evaluation and Research (SMER) were formed. With support of Consultants identified by the health sector, TWGs developed the objectives, strategies andf interventions as contained in this

HSSP III. The specific tasks of the TWGs are outlined in Annex 1. A Lead Consultant was recruited to facilitate the process of developing the HSSP III. In addition, other consultants were recruited to work with the TWGs. There were also consultations with a wide range of health experts in order to get their inputs into specific issues related to the development of the HSSP III. A review of a wide range of health sector documents was done to provide an in-depth analysis and understanding of the sector such as the HSSP I and its final evaluation report, HSSP II and its MTR report and the thematic paper on health and nutrition of the National Development Plan. There were also consultations with district local Governments during National Health Assembly (NHA) and Joint Review Mission (JRM), District planning workshops and Technical Review Meetings. Health Development Partners and Civil Society and other Ministries have expressly been consulted and involved during the development of HSSPIII.

The HSSP III consists of 9 chapters. Chapter 2 provides a brief overview of the health sector especially looking at the organisation of the sector and the delivery of health services in Uganda. Chapter 3 is a review of the progress made in the health sector mainly based on review of documents such as the MTR of the HSSP I and II, the annual health sector performance reports (AHSPR) and reports from Uganda Bureau of Statistics (UBOS). The chapter further identifies issues that need to be addressed in HSSP III. Chapter 4 analyses the major factors, both internal and external, that are likely to impact on the performance of the health sector in the next 5 years of the HSSP III. Chapter 5 presents the goal, vision, mission, values and priorities of the health sector. The objectives, strategies and national targets for the HSSP III are presented in Chapter 6. Chapter 7 presents implementation arrangements including audit procedures, procurement and logistics management for the HSSP III at both the national and district levels. Chapter 8 presents monitoring and evaluation of the HSSP III whereas Chapter 9 is on financing of the plan.

## 2. BACKGROUND[1]

The National Health System (NHS) in Uganda constitutes of all institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. It is made up of the public and the private sectors. The public sector includes all Government health facilities under the MoH, health services of the Ministries of Defence (army), Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of Private Health Providers (PHPs), Private Not for Profit (PNFPs) providers and the Traditional and Complimentary Medicine Practitioners (TCMPs). This section describes the organisation and management of the health sector and delivery of health services in Uganda.

### 2.1 Sector organisation, function and management

The MoH provides leadership for the health sector: it takes a leading role and responsibility in the delivery of curative, preventive, promotive, palliative and rehabilitative services to the people of Uganda in accordance with the HSSP II. The provision of health services in Uganda has been decentralised with districts and health sub-districts (HSDs) playing a key role in the delivery and management of health services at district and health subdistrict (HSD) levels, respectively. Unlike in many other countries, in Uganda there is no 'intermediate administrative level (province, region). The health services are structured into National Referral (NRHs) and Regional Referral Hospitals (RRHs), general hospitals, health centre IVs, HC III and HC Iis. The HC I has no physical structure but a team of people (the Village Health Team (VHT)) which works as a link between health facilities and the community.

[1] This section is based on the HSSP II, the MTR of HSSP II and the AHSPRs and the NHP II.

### 2.1.1 The Ministry of Health and national level institutions

The core functions of the MoH headquarters are:

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

Several functions have been delegated to national autonomous institutions. They include specialised clinical services (Uganda Cancer Institute, Uganda Heart institute), specialised clinical support services (Uganda Blood Transfusion Services (UBTS), Uganda Virus Research Institute, National Medical Stores and National Public Health Laboratories), regulatory authorities such as various professional councils and the National Drug Authority (NDA) and research institutions. The Uganda National Health Research Organisation (UNHRO) coordinates the national health research agenda, whilst research is conducted by several institutions, including the Uganda Natural Chemotherapeutic Research Laboratory. The Health Service Commission (HSC) is responsible for the recruitment, deployment, promotion and management of HRH on behalf of the MoH, including handling requirements for, and terms and conditions of service. In the districts, this function is carried out by the District Service Commissions. The Uganda AIDS Commission (UAC) coordinates the multisectoral response to the HIV/AIDS pandemic.

### 2.1.2 National, Regional and General Hospitals

The National Hospital Policy, adopted in 2005, spells out the role and functions of hospitals at different levels in the NHS and was operationalized during the implementation of the HSSP II. Hospitals provide technical back up for referral and support functions to district health services. Hospital services are provided by the public, PHPs and PNFPs. The public hospitals are divided into three groups namely[2]:

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

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

[2] Ministry of Health. (2005). *National Hospital Policy*. Kampala: Ministry of Health.

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

NRHs provide care for a population of 30 million people[3], RRHs for 2 million people while general hospitals provide for 500,000 people. All hospitals are supposed to provide support supervision to lower levels and to maintain linkages with communities through Community Health Departments (CHDs). Currently, there are 56 public hospitals: 2 NRHs, 11 RRHs and 43 general hospitals. There are 42 PNFP and 4 PHP hospitals. The operations of the hospitals at different levels are limited by lack of funding. With decentralisation, the public general hospitals are managed by the MoLG through district local governments. The RRHs, even though they have been granted self accounting status, are still managed by the MoH headquarters. The NRHs, namely Mulago and Butabika, are fully autonomous. All PNFP hospitals are self accounting as granted by their respective legal proprietors.

### 2.1.3 District health systems

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

### 2.1.4 Health sub-district (HSD) system

The HSDs is a lower level after the district in the hierarchy of district health services organization. The health Sub District is mandated with planning, organization, budgeting and management of the health services at this and lower health center levels. It carries an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities including those carried out by the PNFP, and PFP service providers in the health sub district;

### 2.1.5 Health centres III, II and I

HC IIIs provide basic preventive, promotive and curative care and provides support supervision of the community and HC II under its jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HC IIs provide the first level of interaction between the formal health sector and the communities. HC IIs only provide out patient care and community outreach services. An enrolled comprehensive nurse is key to the provision of comprehensive services and linkages with the village health team (VHT).

A network of VHTs has been established in Uganda which is facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health services. The VHTs are responsible for:

[3] Ministry of Health. (2009). Annual health sector performance report 2008/2009. Kampala: Ministry of Health.

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

While VHTs are playing an important role in health care promotion and provision, coverage of VHTs is however still limited: VHTs have been established in 75% of the districts in Uganda but only 31% of the districts have trained VHTs in all the villages[4]. Attrition is quite high among VHTs mainly because of lack of emoluments.

### 2.2 Health service delivery in Uganda

The delivery of health services in Uganda is done by both the public and private sectors with GoU being the owner of most facilities. GoU owns 2242 health centres and 59 hospitals compared to 613 health facilities and 46 hospitals by PNFPs and 269 health centres and 8 hospitals by the PHPs[5]. Because of the limited resource envelope with which the health sector operates, a minimum package of health services has been developed for all levels of health care for both the private and the public sector and health services provision is based on this package. Over the period of implementing the HSSP III, structures will be put in place in order to ensure that all people in Uganda have equitable access to the basic package of health care.

#### 2.2.1 The public health delivery system

Public health services in Uganda are delivered through HC IIs, HC IIIs, HC IVs, general hospitals, RRHs and NRHs. The range of health services delivered varies with the level of care. In all public health facilities curative, preventive, rehabilitative and promotive health services are free, having abolished user fees in 2001. However, user fees in public facilities remain in private wings of public hospitals. Although 72% of the households in Uganda live within 5km from a health facility (public or PNFP), utilisation is limited due to poor infrastructure, lack of medicines and other health supplies, shortage of human resource in the public sector, low salaries, lack of accommodation at health facilities and other factors that further constrain access to quality service delivery.

The MoH acknowledges that 75% of the disease burden in Uganda is preventable through improved hygiene and sanitation, vaccination against the child killer diseases, good nutrition and other preventive measures such as use of condoms and insecticide treated nets (ITNs) for malaria. Health Promotion and Education and other health social marketing strategies promote disease prevention, uptake and utilization of services, care seeking and referral. Other players in service provision and promotion include the media, CSOs and community strucutures such as the village health team VHT.

[4] Ministry of Health. (2009). *Annual health sector performance report 2008/09*. Kampala: Ministry of Health.
[5] Ministry of Health. (2008). *National health accounts financial year 2006/07*. Kampala: Ministry of Health.

A study conducted in 2008 on user's satisfaction and understanding of client experiences showed that in general clients were satisfied with physical access to health services (66%), hours of service (71%), availability and affordability of services including the providers' skills and competencies among other things. However, they were dissatisfied with a wide range of issues such as long waiting times and unofficial fees in the public sector, quantity of information provided during care and other behavioural problems relating to health workers. The clients were also more satisfied with community health initiatives because they provide free services and it gives them an opportunity to participate in health services management. Some of the recommendations from this study include improvement of service availability, improving staffing levels, sustaining a reliable drug supply and removal of unofficial fees, among other recommendations[6].

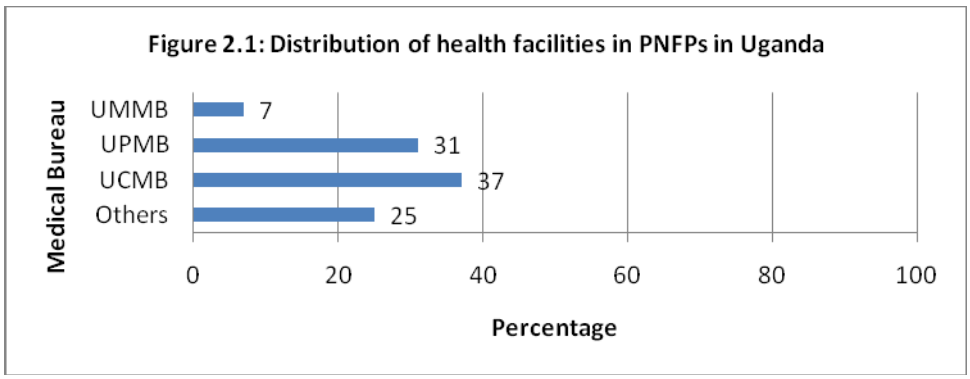
### 2.2.2 The private sector health care delivery system

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

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

The PNFP sub-sector is divided into two categories: Facility-Based (FB-PNFPs) and the Non-Facility Based PNFPs (NFB-PNFPs). The FB-PNFPs provide both curative and preventive services while the NFB-PNFPs mainly provide preventive, palliative, and rehabilitative services. The FB-PNFPs account for 41% of the hospitals and 22% of the lower level facilities complementing government facilities especially in rural areas. After several years of expansion in number and scope of their facilities, the sub-sector has now opted for a phase of consolidation of its services. Besides health units and hospitals, the PNFPs currently operate 70% of health training institutions. More than seventy five percent (75%) of the FB-PNFPs exist under 4 umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB). Figure 2.1 below shows the proportion of facilities owned by these bureaux:

[6] Jitta, J., J. Arube-Wani and H. Muyiinda. (2008). *Study of client satisfaction with health services in Uganda.* Final report submitted to Ministry of Health.MoH.




Nearly 70% of the facilities are owned by the UCMB and UPMB. The GoU subsidises PNFPs and the level of subsidies has remained constant at around 20% of total revenue for the PNFP facilities over the last few years. Both the PNFPs and PHPs charge user fees as a strategy of raising funds for running their facilities. PNFPs also depend on donors to finance their activities. The PNFPs have a larger presence in rural areas while the PHPs are largely in urban areas. The PNFPs are better integrated with the MoH compared to the PHPs. Relevant legislation exists that provides for licensing and regulation of health professionals who engage in private practice.

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

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

A study done by Partners for Health Reform plus (PHRplus) in 2006 in collaboration with the Public-Private Partnership for Health (PPPH) Desk of the MoH (MoH) found that the number of PHPs health facilities in Uganda accounted for 46% of the total. The estimated number of staff employed in the PHP sub-sector nationwide was 12.8%. The GoU and PNFPs together employ about 30,000 health workers. Dual employment is common and 54% of the doctors working in the private sector also work in the government sector, whereas more than 90% of the nurses, midwives and nursing aides in the private sector work full time in this sector. A total of 9,500 health professionals were estimated to be working exclusively in the private sector, including more than 1,500 doctors. More than 80% of these doctors are employed within the central region and the major municipalities nation-wide.

The PHPs have a large urban and peri-urban presence and provide a wide range of services, mainly in primary and secondary care. Few PHPs provide tertiary services. Curative services are widely offered whereas preventive services are more limited, with the exception of family planning, offered by three-quarters of PHP facilities. While more than 90% of PHP facilities offer malaria and STD treatment, only 22% offer immunization services. About 40% of the PHPs provide maternity, post abortion care and adolescent reproductive health services. Across the population of PHP facilities, this translates into almost 900 private sector service delivery points for these important services. Difficulties in accessing capital and other incentives have limited the development of certain aspects of service delivery in the private sector.

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

Approximately 60% of Uganda's population seek care from TCMPs (e.g. herbalists, traditional bone setters, traditional birth attendants, hydro-therapists, spiritualists and traditional dentists) before visiting the formal sector. TCMPs are available in both urban and rural areas even if the service provided are not consistent and vary widely. Many traditional healers remain unaffiliated. Most TCMPs have no functional relationship with public and private health providers. This results into late referrals, poor management of various medical, surgical, obstetric conditions and high morbidities and mortalities. Non-indigenous traditional or complimentary practitioners such as the practitioners of Chinese and Ayurvedic medicine have emerged in recent years. A regulatory bill and policy framework for TCMPs is awaiting cabinet approval and it is essential to establish functional relationship between the TCMP and the rest of the health sector.

## 3. ACHIEVEMENTS AND CHALLENGES OF HEALTH SECTOR STRATEGIC PLAN II

Since early 1990s, GoU has given high priority to improvement of the health status of the people of Uganda as evident in the development and implementation of the NHP I and the HSSP I and II. The NHP I and the HSSPs I and II aimed at improving health care delivery through efficient health management reforms. Health indicators have improved over the last ten years of the NHP I, HSSP I and II but they still remain unsatisfactory and disparities exist throughout the country. While such progress has been made the MTR of the HSSP II and AHSPRs also highlight the enormous challenges that remain if Uganda is to achieve the MDGs by 2015. This section reviews the achievements and challenges in the implementation of the HSSP II.

### 3.1 Health status of the people of Uganda

The Uganda demographic and health survey (UDHS) is a tool that is used to measure progress on some important health indicators namely infant mortality rate (IMR), child mortality rate (CMR), maternal mortality ratio (MMR), total fertility rate (TFR), contraceptive prevalence rate (CPR) and prevalence of malnutrition disorders such as stunting, under-weight and wasting. Table 3.1 below shows the trends on these indicators between 1995 and 2006 when the last UDHS was conducted:

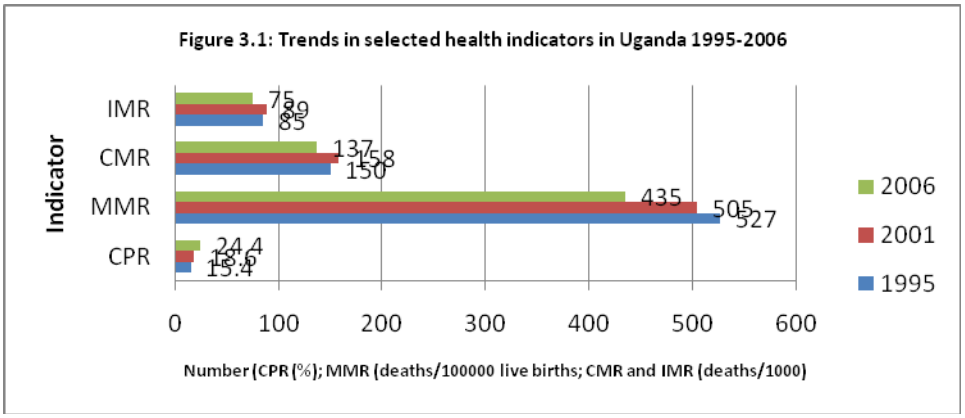



Figure 3.1 above generally shows that between 1995 and 2006, CMR declined from 156 to 137 deaths per 1,000 live births; IMR decreased from 85 to 75 deaths per 1000 live births; MMR reduced from 527

to 435 per 100,000 live births; and the CPR increased from 15.4% to 24.4%. In 2000 the NMR was at 33% per 1000 live births but this went down to 29% in 2006. The TFR over this period has not changed much from 6.9 in 1995 to 6.5 in 2006. This high TFR contributes significantly towards the high population growth rates being experinced in Uganda and will have implications on delivery of and access to health care. These indicators, although unsatisfactory, generally demonstrate that the health status of the people of Uganda improved over the reference period. The 2005/06 DHS also brings on board health challenges related to Sexual Gender Based Violence in all the regions of the country. This was a new area addressed in the HSSP II which will be consolidated in HSSP III.

Despite the fact that the proportion of people living below the poverty line has significantly declined from 52% in 1992 to 31% in 2005, Uganda remains one of the poorest countries ranking 145 on the global Human Development Index. Far more people live below the poverty line in Northern Uganda (64.8%) than in other regions. A direct relationship has been demonstrated between poverty and incidence and prevalence of malaria, dysentery and diarrhoea as they are more prevalent among the poor compared to the rich. The lack of a comprehensive social security system makes the poor more vulnerable in terms of affordability and choice of health provider.

### 3.2 Food and nutrition in Uganda

The Constitution of the Republic of Uganda recognises the importance of food and nutrition and further provides that the state shall encourage and promote nutrition through mass education and other appropriate means in order to build a healthy state. The Constitution mandates the MoH and the Ministry of Agriculture to set minimum standards ensure quality and develop relevant policies in the area of food and nutrition. Following this mandate, GoU has demonstrated its commitment by formulating the Uganda Food and Nutrition Policy (UFNP) which provides a framework through which minimum standards, strategies and guidelines have been developed by the relevant ministries. The UFNP provides for the establishment of the National Food and Nutrition Council which has the responsibility of coordinating food and nutrition activities in Uganda[7].

Nutrition also constitutes one of the priority areas or components of the UNMHCP. Food and food supplements are the primary medicines used in promotive nutrition, prevention of malnutrition and therapeutic diets used in treatment of the malnourished. However, anthropometric and other equipment for managing and monitoring nutrition programmes are found in very few health facilities. In the past 5 years, nutrition interventions have led to a reduction in underweight and stunting from 23% to 16% and 41% to 39%, respectively and a sustained proportion of households consuming iodized salt above 95%. However, the majority of other nutrition indicators remain unacceptably poor.

Although Uganda's climate is conducive for production of a wide variety of crops, the country continues to experience problems of malnutrition, famine and hunger especially among vulnerable populations e.g. underweight among under-five children. The recent climatic changes coupled with unstable global and the national economy have exacerbated the situation among the population. The low prioritization and commitment for nutrition in the health sector in the past has led to inadequate resource allocation, both human and financial, to implement nutrition interventions at all levels. Nutrition is a cross cutting issue and requires the involvement and effective coordination of multiple sectors and stakeholders.

[7] See Ministry of Health. (2003). *The Uganda Food and Nutrition Policy*. Kampala: Ministry of Health.

### 3.3 The Uganda National Minimum Health Care package

The HSSP II defines the Uganda National Minimum Health Care package (UNMHCP) and it has four clusters namely: (i) Health Promotion, Disease Prevention and Community Health Initiatives; (ii) Maternal and Child Health; (iii) Prevention and Control of Communicable Diseases; and (iv) Prevention and Control of Non-Communicable Diseases (NCDs). Emphasis during the implementation of the HSSP II was placed on a limited set of interventions which have been proven effective in reducing morbidity and mortality. This section summarizes progress that has been made in reaching targets as were set in the HSSP II for each of the clusters of the UNMHCP.

#### 3.3.1 Cluster 1: Health promotion, Environmental Health and Community Health Initiatives

This cluster aims at increasing health awareness and promoting community participation in health care delivery and utilisation of health services. While IEC materials were distributed in all health facilities in Uganda, the implementation of the VHT strategy was not satisfactory: only 31% of the districts have trained VHTs in all the villages[8] mainly because of inadequate funding and trained health educators. Where VHTs are functional, they have contributed to increasing health awareness, demand and utilisation of health services and significantly led to decongestion at health facilities as they timely treat minor illnesses. VHTs have further helped to increase community participation in local health programmes.

The 1997 Kampala Declaration on Sanitation (KDS) guides the promotion of hygiene and sanitation in Uganda but indicators are still poor for example national latrine coverage is at 62.4% and this is below the target of 70% at the end of HSSP II[9]. The situation is worse in some districts such as Abim, Kabong, Kotido Nakapiripirit in other rural and slum areas.where latrine coverage is less than 10%. Housing conditions are also poor with three quarters of the households having floors made of earth, sand or dung. Only 14% of the persons wash hands with soap against a target of 70%. Overall during the HSSP II period there was a decrease in the incidence of diarrhoeal diseases. The annual incidence of cholera fell from 15/100,000 in 2005 to 3/100,000 in 2009 and that of dysentery decreased from 288/100,000 in 2005 to 254/100,000 in 2009.There was also a decrease in case fatality rate of diarrhoeal diseases. Cholera Case Fatality Rate (CFR) fell from 2.5% in 2005 to 2.1% in 2009; dysentery CFR fell from 0.11% in 2005 to 0.08% in 2009; and Acute watery diarrhoea CFR fell from 1.2% in 2006 to 0.9% in 2009; but persistent diarrhoea CFR increased from 0.7% to 1.3%. Inadequate resources, high levels of poverty, inadequate awareness, poor enforcement of public health bye-laws and cultural factors in some regions (e.g. in Karamoja) are major challenges that have affected the implementation of environmental health programmes.

Basic health and nutrition services are being implemented as part of school health programmes in Uganda. The implementation of comprehensive school health programmes has been hampered by the lack of enforcement of guidelines by local governments and the absence of a school health policy and a MoU between the MoH and MoES. With regard to epidemics and disasters, by the end of the HSSP II, a comprehensive surveillance and reporting system had been put in place. A multisectoral epidemic preparedness and response committee has been formed in all districts and it has proved useful in managing epidemics but challenges exist: the shortage of staff with requisite skills to effectively manage epidemics still exists; resources for these activities are inadequate; and at district level even if they are put

[8] Ministry of Health. (2009). *Annual health sector performance report 22007/08*. Kampala: Ministry of Health.
[9] Ministry of Health. (2008). *Annual health sector performance report 22007/08*. Kampala: Ministry of Health.

in implementation plans they are not a priority. Very recently, the Policy on Mainstreaming Occupational Safety and Health was finalised. While the NHP calls for respect of the traditions of the people of Uganda, there are some cultural practices that delay seeking *appropriate* health care. Access to health facilities and health care in general for women is further influenced by decision-making processes in families: while 22% of married women make sole decisions on their own health care, in 40% the husband takes such decisions[10].

### 3.3.2 Cluster 2: Maternal and child health

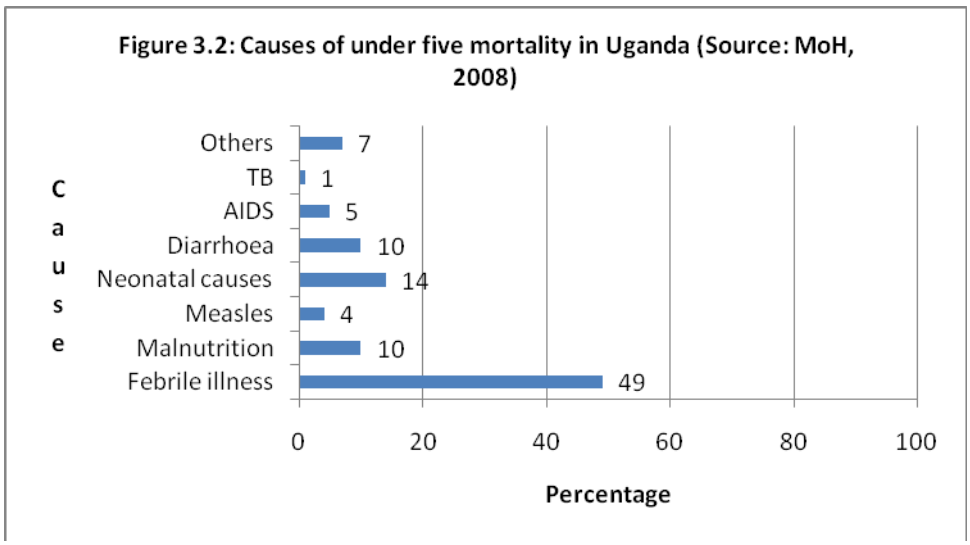
Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda[11]. Some progress has been made in the improvement of the health of mothers and children in Uganda over the implementation of the HSSP II. The Road Map to accelerate Reduction of Maternal and Neonatal Morbidity and Mortality and the National Child Survival Strategy were formulated in 2007 and 2009, respectively. The effective implementation of these strategies will contribute significantly towards achievement of MDGs 4 and 5 by 2015.

Sexual and reproductive health (SRH) core interventions have been rolled out but the proportion of pregnant women delivering in GoU and PNFP facilities is still low at 32% at the end of HSSP II against a target of 50%. The proportion of facilities providing appropriate EmoC is still low and so is access post natal care within first week of delivery which stands at 26%. About 15% of all pregnancies develop life threatening complications and require emergency obstetric care (EmOC). The national met need for EmOC is 40%[12]. Only 11.7% of women deliver in fully functional comprehensive EmOC facilities. The MMR for Uganda is still high at 435 deaths per 100,000 live births and the leading direct causes of these deaths are haemorrhage (26%), sepsis (22%), obstructed labour (13%), unsafe abortion (8%) and hypertensive disorders in pregnancy (6%)[13]. The main factors responsible for maternal deaths relate to the three delays – delay to seek care, delay to reach facilities and intra-institutional delay to provide timely and appropriate care. Slow progress in addressing maternal health problems in Uganda is due to lack of HR, medicines and supplies and appropriate buildings and equipment including transport and communication equipment for referral.

Most of the HC IVs are not providing comprehensive SRH services yet there are a number of reproductive health challenges at that level. The current uncontrolled high fertility of women with an average of 7 children per woman predisposes women to high risk pregnancies and subsequently increases chances of morbidity and mortality. Early sexual involvement of girls has sometimes led to unplanned and unwanted pregnancy with evidence of high incidence of unsafe abortions and its related complications in the age group. HIV prevalence among pregnant women attending ANC is estimated at 20-30%. As mentioned earlier, child morbidity and mortality are still high in Uganda. Neonatal deaths contribute 38% of all infant deaths, which is a significant proportion given that these deaths occur in one month out of the twelve months of infancy. This proportion has largely remained the same over the past 15 year (36.7% in 2000, 36.8% in 1995). Figure 3.2 below shows the major causes of under-five mortality in Uganda:

---

[10] UBOS. (2006). Uganda demographic and health survey. Kampala: UBOS.
[11] UBOS. (2002). *UDHS*. Kampala: UBOS
[12] Ministry of Health. (2009). *Annual health sector performance report 2008/09*. Kampala: Ministry of Health
[13] Ministry of Health.MoH. (2007) [Christopher please complete reference]




It is evident from Figure 3.2 that febrile illness is the major cause of under-five mortality in Uganda. Neonatal mortality is mostly caused by septicaemia/pneumonia (31%), asphyxia (26), prematurity (25), congenital abnormalities (7%), tetanus (2%), diarrhoea (2%) and other conditions (7%). Infections, birth asphyxia and complications of preterm delivery account for 82% of all newborn deaths[14]. Over a half of the total newborn deaths occur during the first week of life, mainly in the first 24 hours of life. The majority of newborn deaths result from infections, asphyxia, birth injuries and complications of prematurity. Low birth underlines 40-80% of newborn deaths.

Over the past years some achievements in child health have been recorded. For instance there has been an increased access to de-worming and micronutrient supplementation such as Vitamin A, which increased from 60 % (2004/05) to 69.5 % in 2008/09. The IMCI programme is progressing well, the proportion of sick children under 5 seen by health workers using IMCI guidelines has increased to 63% in 2008/09 from 45% in 2004/05. Child Days Plus are being implemented which have contributed to an increase in immunization coverage. Community growth promotion and monitoring has been piloted and results show improvements in screening and identification of underweight . The production of fortified food has since increased. The promotion of infant and young child feeding (IYCF) has been integrated into different programmes such as PMTCT, reproductive health and EPI and appropriate guidelines have since been developed. The proportion of children under 5 with fever, diarrhoea and pneumonia seeking treatment within 24 hours, those with acute diarrhoea receiving ORT and those with pneumonia receiving appropriate antibiotics increased over the period 2004/5-2006/7 when the last DHS was conducted. The new malaria policy provides for HBMF but the challenge is the availability of drugs for HBMF. The implementation of MCH interventions is hampered by inadequate human resource at service delivery outlets and inadequate supervision.

During the implementation of the HSSP II the number of static service delivery points for immunisation increased from 1950 to 2100 and this has contributed to high accessibility of immunisation services: the proportion of the children under 1 who received 3 doses of DPT/pentavaccine according to schedule was at 79% and 78% in 2008 and 2009, respectively. Countrywide social mobilisation campaigns have helped to increase demand for immunisation services specifically during Supplemental Immunization Activities (SIA). A 2007 cold chain and vaccine

[14] Ministry of Health.MoH. (2008). [Christopher – provide the reference]

management assessment showed insufficient storage at national and district levels and this led to the development of a 5 year replacement and expansion plan. With support from GAVI the GoU provides all the vaccines the country requires. Measles morbidity and mortality has been reduced by 90% over the period and in 2009, the country experienced a re-importation of WPV 1, after 13 years of non-polio circulation. Eight cases were confirmed polio in two districts of Amuru and Pader. The major challenges with regard to immunisation have been the declining funding for operational costs which was worsened by the suspension of GAVI ISS funding. An aging fleet of vehicles, irregular distribution of gas, vaccine and injection materials from the National level to the districts and peripheral units, shortage of gas cylinders, irregularities of outreaches, lack of child health cards and tally sheets for recording child immunisation are some of the challenges and lack of supportive supervision[15] are some of the major factors that hamper the effective implementation of the immunisation programme in Uganda.

### 3.3.3 Cluster 3: Communicable diseases control

Communicable diseases account for 54% of the total burden of disease in Uganda with HIV and AIDs, tuberculosis (TB) and malaria, being the leading causes of ill health. The HSSP II prioritised the prevention and control of HIV/AIDS, malaria, tuberculosis and diseases targeted for elimination.

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

The UAC, on behalf of GoU, has continued conducting IEC and community mobilisation campaigns with emphasis on abstinence, faithfulness and condom use. As a result, HIV/AIDS awareness has remained high. The MOT study conducted in 2008 showed that 130,000 new infections occurred in 2007. Eighteen percent (18%) of the new infections occurred through mother to child transmission (MTCT) while the majority of people newly infected were through heterosexual relations. Forty three percent (43%) of those new infections occurred among people in long term relationships, calling therefore for an increased focus on HIV prevention among couples and other high risk groups such as CSW. Some targets as set in the HSSP II have not been achieved: e.g. HIV prevalence in 2008/09 was estimated at 6.7% against a target of 3% in the HSSP II; HIV prevalence among women attending ANC was at 7.4% in 2007 against a target of 4.4%; and that only 50% of the HC IIIs were offering HCT services against a target of 100%. Some targets for 2008/09 were achieved e.g. 68% of the HC IIIs were offering PMTCT services against a target of 50% and 90% of the HC IV were offering comprehensive HIV/AIDS care with ART against a target of 75%[16]. HIV/AIDS is responsible for 20% of all deaths and a leading cause of death among adults. A total of 373,836 PLHIVs (by September 2008) in Uganda required ART but only 160,000 (52%) were on ART. As of September 2009, 200,213 patients were on ARVs of which 8.5% were children.

Condom distribution has increased to about 10 million per month, the number of health facilities providing HCT has increased and the uptake of ART, HCT and PMTCT services have increased even though as stated earlier some targets have not been reached. Various guidelines and standards for the prevention and control of HIV/AIDS have since been produced and disseminated while a public health approach was used to build capacity of health workers. While there has been an increase in uptake of HIV/AIDS services, procurement and logistics problems, lack of monitoring of HIV/AIDS care and treatment services, high costs of drugs and commodities and high reliance on donor support, including GFATM, for such commodities have slowed down the scaling up of priority services. This has been

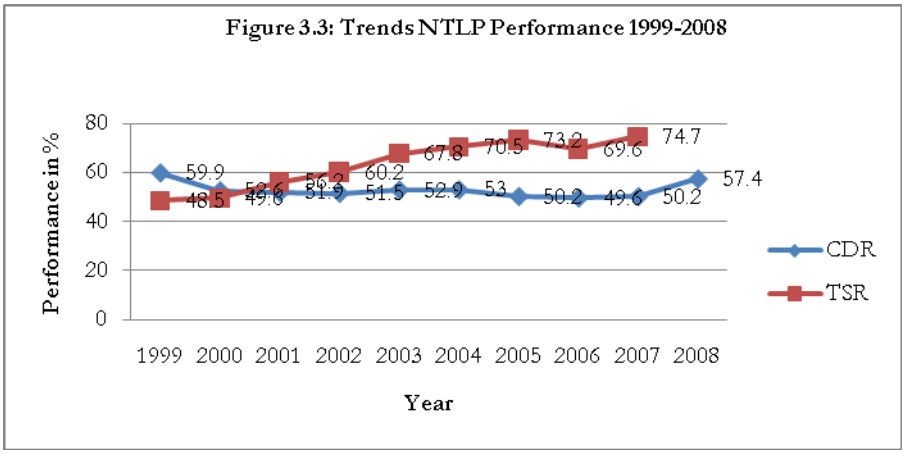
[15] Ministry of Health. (2009). *Annual health sector performance report 2008/09*. Kampala: Ministry of Health.
[16] Ministry of Health. (2009). *Annual health sector performance report 2008/09*. Kampala: Ministry of Health.

exacerbated by the limited physical infrastructure and human resource capacity at district and facility level for the delivery of comprehensive care. The verticalisation of the HIV/AIDS programme in a context where HRH is a major challenge has brought in problems such as the creation of parallel information systems.

### *(b) Tuberculosis and Leprosy*

The burden of tuberculosis is high in Uganda and it is ranked 16th by the WHO Global TB Report of 2008. WHO estimates put incidence of infectious TB cases at 136 and all TB at 330 per 100,000 populations annually. The HSSP II aimed to expand CB-DOTS to all districts as a means of attaining global case detection and treatment success targets of 70% and 85%, respectively, while minimising emergence of drug resistant TB. In the past one year the CDR increased from 50.3% to 57.4% and treatment success rate (TSR) improved from 68.4% to 75.1% and Figure 1.0 below shows trends the past ten years. However, Uganda still falls short of attaining the MDG target by 2015. Underperformance is due to a combination of factors including poor access to TB services; shortage of human resources especially laboratory and ZTLSs; poor quality DOTS service including poor recording and reporting, stock outs due to weak LMIS capacity, inadequate facilitation to SCHWs leading to inappropriate implementation of CBDOTS strategy; high HIV prevalence; low community awareness and a weak ACSM strategy among others. Persistent high default rates of over 20% in large districts Kampala, Mbarara and Masaka are other factors. During 2008, 4.7% of the newly registered smear positive cases died far short of the HSSP II target for Year 4 (FY 2008/09) of 3.1%. It must be acknowledged that it is difficult to reduce case fatality in the midst of HIV and late health seeking behaviour.

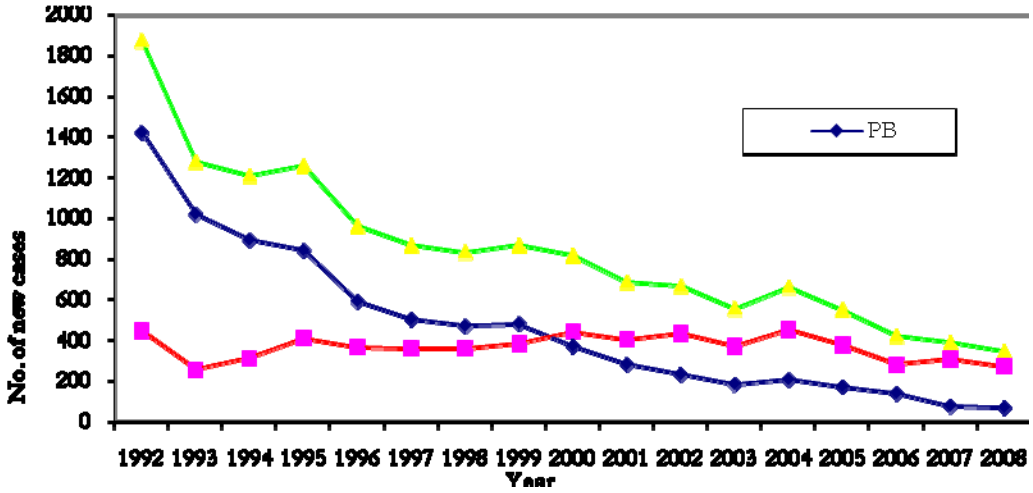
Uganda has adapted WHO generic TB/HIV collaborative guidelines to the country setting to address the dual TB-HIV epidemic. In 2008/2009, 63.6% (target 80%) of TB patients were counselled for HIV testing while 60% of them were tested. This was an improvement from 38% of the TB patients tested in 2007/08. Of the TB patients tested 60% of them were co-infected with HIV. CPT was provided to TB/HIV patients with an improvement from 53% to 59.2%. There was slight improvement of ART to TB/HIV patients from 13% to 14.2%. HIV testing and provision of CPT and ART are constrained by inaccessibility of the services especially ART, and frequent stock out of test kits and co-trimoxazole and associated poor recording and reporting.




**Source:** NTLP annual surveillance reports1999 – 2008.

In Uganda, the elimination of leprosy as a public health problem was achieved at the end of 2004. At the moment, leprosy is not considered an eradicable disease. Case detection rates are showing a gradual downward trend most marked in the MB types as can be seen in Figure 3.4 below.

**Figure 3.4: Trends of new leprosy case detection in Uganda, 1992 -2008**




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

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

## *(c) Malaria*

Malaria remains one of the most important diseases in Uganda in terms of morbidity, mortality and economic losses. The goal of malaria control in Uganda is to control and prevent malaria morbidity and mortality, as well as to minimize social effects and economic losses attributable to malaria. In order to achieve this, the malaria control programme endeavours to implement on a national scale a package of effective and appropriate malaria control interventions. The major interventions include the use of Long Lasting Insecticide-treated Nets (LLINs), early and effective case management, indoor residual spraying

(IRS), Intermittent Preventive Treatment of pregnant women (IPTp) and IEC/BCC. A nearly 20% reduction in malaria outpatient cases observed over the years has been attributed to improvement in IPT coverage, early home and community treatment of children with fever, ITN coverage and the IRS consolidation and expansion programme.

The proportion of children with malaria who receive effective treatment within 24 hours after the onset of symptoms has increased from 25% at the end of HSSP I to 71% in 2007/08 falling short of the 80% target for 2009/10. The proportion of pregnant women who receive IPT has increased to 42% in 2007/08 against the HSSP II target of 80%. Only 42% of the households have at least one ITN against a target of 70%. IRS approved in 2006 has since been consolidated and expanded in malaria endemic areas and 95% of the targeted structures for IRS in both endemic and epidemic areas were reached by the time HSSP II MTR was being done against a target of 80% in 2009/2010. The percentage of health facilities without stockouts of first line antimalarial drugs decreased from 35% to 26% in 2006/07 and 2008/09, respectively[17]. These initiatives have resulted into a rapid decline in malaria admissions. Major challenges that affected malaria prevention and control are shortages of ACTs due to inadequate procurement and delivery to health facilities and CMDs, irregular and inadequate expansion of IRS, inadequate capacity for malaria diagnosis, understaffing and inadequate partner coordination.

### *(d) Diseases targeted for elimination*

It is evident that Uganda is on course for diseases that have been targeted for elimination. For example WHO has certified Uganda as free of guinea worm transmission; however due to the threat of importation of cases from South Sudan the programme has to maintain high quality post-certification surveillance. Mass distribution of azithromycin and tetracycline for the control of trachoma is on-going. Integrated mass drug administration against onchocerciasis, schistosomiasis, lymphatic filariasis and soil transmitted helminths is ongoing and has been scaled up to most endemic districts. Even though Neglected Tropical Diseases (NTDs) are still prevalent, programmes are ongoing for their control and prevention Challenges mainly revolve around the lack of adequate funding for these programmes. The number of people who are at risk of getting onchocerciasis is 3,049,838. Onchocerciasis is endemic in 29 districts. Bi-annual treatment and vector elimination are being done in 14 districts with the overall aim of eradicating onchocerciasis in those districts. Measles control through vaccination remains one of the strategies for reduction of childhood morbidity and mortality by 2015 as stipulated in the Millennium Development Goals. During the period 2006-2010, two integrated Measles SIAs were conducted in 2006 and 2009, which offered a second opportunity for measles vaccination, thereby increasing the proportion of the population that is protected against measles. Measles confirmed cases decreased from 580 cases in 2006 to 22 cases in 2009. With regard to NNT, there has been a general decline in the number of confirmed NNT cases by 86% since the implementation of the high risk approach. Busoga region, 2nd phase and 3rd phase districts have shown a decline by 97%, 94% and 90% respectively. The reported national annual NNT incidence decreased from 0.35/1000 live births in 2006 to 0.06/1000 live births in 2009

### 3.3.4 Cluster 4: Prevention and control of NCDs, disabilities and injuries and mental health problems

As is the case in all developing countries, NCDs are an emerging problem in Uganda. This is why MoH established a Programme for the Prevention and Control of NCDs in 2006. NCDs include

[17] Ministry of Health. (2009). *Annual health sector performance report 2008/09*. Kampala: Ministry of Health.

hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness, cancer conditions, injuries as well as oral diseases. The increase in NCDs is due to multiple factors such as adoption of unhealthy lifestyles, increasing ageing population and metabloic side effects resulting from lifelong anteretroviral treatment. The majority of the NCDs are preventable through a broad range of simple, cost-effective public health interventions that target NCD risk factors. A baseline survey on risk factors and the magnitude of NCDs in Uganda planned as part of the HSSP II has todate not been conducted mainly because of lack of adequate funding. Uganda currently does not have comprehensive data on NCDs and their risk factors. A NCD Policy, strategic plan and standards and guidelines for managing NCDs are not available to guide interventions.

In terms of disabilities, 300,000 (10%) people in Uganda have hearing impairments while 250,000 are blind, the causes of which are largely preventable. The population of 60 years and above has increased from 4% to 6% between 1991 and 2002. Despite increasing demand, geriatrics services are non-existent. Currently, only 2% of the 25% of People with Disabilities (PWDs) have access to rehabilitation services. Uganda has adopted community based rehabilitation (CBR) as the main strategy to reach PWDs with services. Death from road traffic accidents has more than doubled over the past 10 years from 992 in 1993 to 1,996 in 2003. Uganda has the second highest accident burden, with over 20,000 road accidents annually and 2,334 fatalities in 2008 alone[18]. In 1998, Uganda lost 151.7 billion shillings through road traffic crashes accumulated from the 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 worlds GNP.

During HSSP II, sensitisation of the general population and school children about road traffic accidents was undertaken. Black spots on some of the major highways continued to be identified and marked. The programme strengthened orthopaedic workshops in 4 RRHs for production of assistive devices. Six orthopaedic technicians were trained in wheelchair technology and have been deployed in the RRHs. A wheelchair provision project was inaugurated. The MoH with support from HDPs established ENT and Eye Units in five districts and developed a Communication Strategy on hearing impairment. There was enhanced collaboration with the social development sector with respect to the community Based Rehabilitation initiative. In collaboration with stakeholders, a data collection tool on landmine survivors has been developed and surveillance activities conducted in five districts. In addition, a cataract survey was conducted in one district.

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

[18] Source [Dirk to provide]

Mental health is a major health problem in Uganda contributing 13% to the national disease burden. Butabika hospital is the only national referral mental health. In 2008/09 2,707 patients were first time admissions while 3,341 were re-admissions. Data from supervision reports shows that about 75% of attendances at Mental Health Clinics have some form of neurological problem commonly epilepsy, with cases of dementia on the increase especially among persons living with HIV/AIDS. So far, **6** Regional Mental Health Units have been constructed; the Mental Health Policy has been revised and other policies such as the Alcohol policy, the Tobacco control policy and the Tobacco Control Bill have been drafted. The implementation of mental health programmes is hampered by inadequate staffing, inadequate resource allocation and the lack of mental health drugs on the locak market among others[19].

### 3.4 Supervision, monitoring and evaluation (M&E)

The HSSP II spells out the systems for supervision, monitoring and evaluation of the health sector. There are three levels of supervision: (i) at the central level including central level institutions, (ii) local governments, and (iii) hospitals and lower level health units. The HSSP II recommended having quarterly Area Team (AT) reports, quarterly District Health Teams (DHTs) supervision reports, technical and support programme specific reports and HSD monthly supervision reports. The responsibilities of each level are clearly spelt out[20]. During the implementation of the HSSP I the AT supervision approach was adopted. ATs consist of officials from various departments in the MoH and other central and regional institutions and they have responsibility to provide integrated technical support and supervision to a group of districts. DHTs and HSDs supervise service delivery at government and PNFP facilities at different levels, except the national and RRHs. In addition to this, there are also clinical specialists outreach programmes from NRH and RRH to district and lower level facilities. TMC and SMC supervise central level institutions while the QAD ensures availability of standards and guidelines. The Yellow Star Programme (YSP), started in 2001, has been introduced in 54 districts and aims at strengthening supervision of lower level health units by districts but there are issues of sustainability that have to be addressed.

While systems for supervision, monitoring and evaluation exist, there are enormous challenges. AT visits have been irregular due to late release of funds, insufficient funds and inadequate transport arrangements. They have also been ineffective due to insufficient feedback to the districts. Also for other supervision and monitoring visits, transport was often inadequate. In general, there is also a lack of supervision skills, at all levels of the system. The implementationof the YSP is irregular and supervision of community programmes is limited[21]. The MTR even points out that the supervision mechanism for community health programmes is even less well known except in districts which have active VHTs. The envisaged joint supervision with PNFP staff is yet to take off and efforts at national level to organize and support clinical supervision of RRHs by NRHs and general hospitals by RRH clinicians have been limited. In general, technical supervision is weak and this has affected quality of service delivery. The Health Professional Councils are expected to inspect the private health practitioners' facilities.

The Annual Health Sector Progress Reports (AHSPRs) detail annual health sector performance and form the basis for discussions during the National Health Assembly. These annual reports are verified

[19] Ministry of Health. (2009). *Annual health sector performance report 2008/09*. Kampala: Ministry of Health.
[20] Ministry of Health.MoH. (2005). *Health sector strategic plan II 2005/06-2009/2010*. Kampala: Ministry of Health.MoH.
[21] Quality Health International Consultants. (2008). *Review of the supervision mechanisms in the health sector*. Final Report submitted to the Ministry of Health.MoH.

by the Joint Review Missions (JRM) during field visits. HPAC is expected to discuss quarterly performance reports and performance of agreed upon undertakings. The operations of the HMIS are affected by inadequate human and financial resources as well as excessive volumes of data collection that may not be relevant to the different levels of care and programme. Timeliness of reporting is currently estimated at 68%. The existence of parallel data collection systems for vertical programs such as HIV/AIDS puts a strain on HRH. Data analysis and utilisation for planning purposes is low and the private sector's contribution to the HMIS is modest. The capacity of the HMIS is still inadequate. Food and nutrition surveillance data is no longer being collected. The 2007/08 Auditor General's report also observes that there is poor reporting by districts, HSDs and HCs on their performance to higher levels and even where they report it is not timely.

### 3.5 Research

The MTR acknowledges that a lot of research is conducted in Uganda. The results of these studies are supposed to inform decision making hence contribute to improving delivery of and access to health care. Several institutions conduct health research in Uganda e.g. universities, autonomous institutions and other public institutions with diverse affiliations and districts. The Uganda National Health Research organisation (UNHRO) is the Secretariat for health and related research in Uganda and its Bill was passed by Parliament in 2009. The passing of this Bill gives the organisation the mandate to coordinate health research activities.

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

### 3.6 Health resources

#### 3.6.1 Health infrastructure development and management (HIDM)

The objective for the HIDM in the HSSP II was to ensure a network of functional, efficient and sustainable health infrastructure for effective health services delivery closer to the population. The number of health facilities in the public sector and the PNFPs has been growing from 1,979 and 606 in 2004 to 2,301 and 659 in 2006, respectively[22]. The establishment of more facilities ensures that people access health services within 5 km of their residence which was at 72% at the end of HSSP II aganst a target of 85%. The health facilities are being mapped to update the geographical access data. Over the period of the HSSP II some HC were upgraded to higher levels and this necessitated the construction of OPDs, theatres, maternity wards, staff houses as well as rehabilitating and equipping health centres. While this is the case, most facilities and equipment are in a state of disrepair. The 2008/09 annual health sector performance report says that only 40% of available equipments were in good condition and about 17% needed replacement. Rehabilitation of buildings and maintenance of medical equipment is not regularly done. Nutrition units which were attached to health units are functioning with limited capacity. Accommodation for staff remains a big challenge and is a major reason for low staff numbers,

[22] Ministry of Health.. (2008). *Mid term review of the HSSP II*. Kampala: Ministry of Health.

especially in hard to reach areas. ICT remains a challenge with prevalence among health facilities being at 6.4% mostly comprising of mobile phone, radio, TV and computers to a smaller extent.

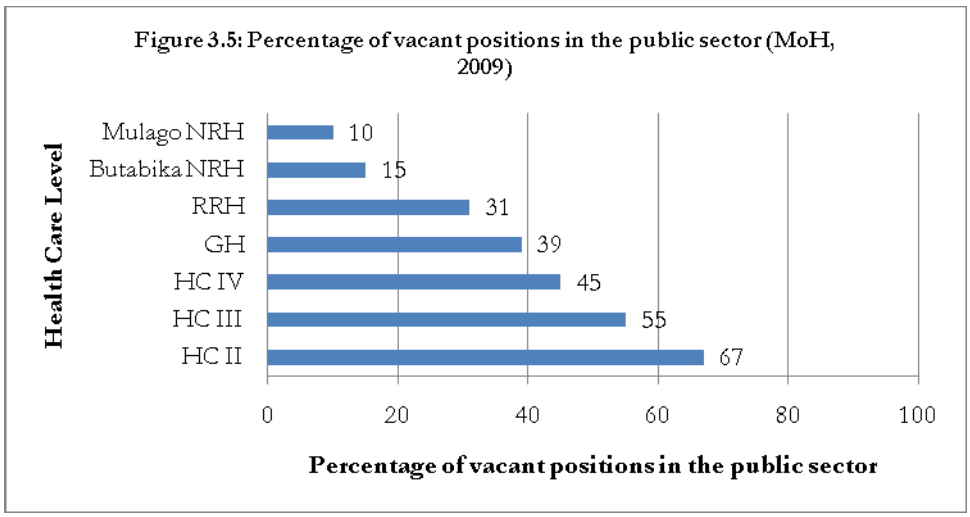
The existing infrastructure is therefore insufficient to ensure that the core functions of the health sector are carried out. Infrastructure therefore needs to be refurbished. Even though the MoH developed the National Health Infrastructure Development and Maintenance Plan in 2002 to harmonise planning, development and maintenance of health infrastructure, the plan is outdated and cannot address the needs of modern Uganda; hence the need for a new infrastructure development strategic plan. The National Medical Equipment Policy and Guidelines are currently being revised. Even though an Essential Medical Equipment list has been drawn, problems exist relating to procurement delays and the lack of funds. Inadequate staffing to effectively manage maintenance of infrastruture and allocation of inadequate funds for maintenance of infrastructure and equipment hamper the rehabilitation and maintenance of equipment and infrastrure.

### 3.6.2 Human resource management and development

Uganda, like many developing countries, is experiencing a serious human resources crisis in the health sector. HRHs are in short supply, both in numbers and in skills mix, to effectively respond to the health needs in Uganda. The HIV/AIDS epidemic presents additional demand on the HRs because of the special skills required for HIV/AIDS prevention and treatment, and the health workers themselves being affected by the disease. Although significant steps have been taken in the development of the HRH Policy and Strategic Plan 2005-2010, HRH development, deployment and utilization are still not rigorously directed in a sustainable manner, either at national or district level. The present number of health staff (Doctors, nurses, midwifes) available in the country, including the PNFP sector, amount to 59,000, with a ratio of 1 to 1,818 people[23]. It is estimated that 22% of these categories of health workers in the health sector is currently contracted by the PNFP sector and 21% by the private sector. Overall almost 40% of the HRH are working for the private sector, and there is no clear policy and guidelines to coordinate and optimise their use. In terms of training, emphasis for most curricula of health workers is on curative care. Despite the PNFP subsector producing the majority of PHC staff, recognition and inclusion of the PNFPs in national and district level decision-making fora for health training remains limited. Training of medical doctors and other health staff is governed by several institutions (MoH, MoE, PNFP training institutions, Professional Councils), with no clear leadership, line of responsibility and mandates. Often decisions taken by one sector affect the others and result in an overall reduced training capacity.

Figure 3.5 below shows the proportion of established posts filled at different levels of health care (HC II-NRHs). The majority of the vacancies in the public health sector are in HC IIIs up to the general hospitals with HC II having the highest number of vacancies at 67%. These HC IIs are located in rural communities and the absence of staff affects the way they seek care. Nurses are critically required especially at HC II-IV and yet most of the vacancies for nurses are at that level. The vacancy rates for nurses at HC II, III and IV are at 53%, 54% and 37%, respectively In November 2008 only 51% of the approved positions at national level were filled. This has not changed since then as shown in a recent report[24]. For all levels of health care and all cadres the HRH situation is critical.

[23] This is far below the recommended WHO minimum standard, which considers countries with less than 1 doctor, nurses or midwife per 439 people, in critical shortage of health workers.
[24] Ministry of Health. (2009). *Human resources for health bi-annual report*. Kampala: Ministry of Health.




There are a wide range of reasons why there are huge vacancies: insufficient training capacity, low remuneration and poor working conditions in the public and PNFP sectors, making it difficult for the sector to recruit and retain staff. The process of recruitment is complex and lengthy and it involves many stakeholders thus delaying recruitment. The lack of coordination and joint planning between the training schools and the MoH and the Health Service Commission causes a long gap between the times the health workers have come out of the training institutions and when they are hired in the health system. Attrition in PNFPs is high as health workers join the public sector and has been increasing in the past few years, following government's decision to increase salaries and incentives for civil servants. Migration of health workers is at alarming proportions due to more attractive salaries and opportunities abroad. There is also inequitable distribution of health workers among districts, between rural and urban areas and between public and private providers. Nearly 70% of medical doctors and dentists, 80% of pharmacists and 40% of nurses and midwives, are in urban areas serving 13% of the population[25].

In government, productivity is low due to high rates of absenteeism and rampant dualism. A recent study of the MoH, MoFPeD and the World Banks estimates the cost of absenteeism at 26 billion UGX annually. Absenteeism is the single largest waste factor in the public health sector in the country[26]. The poor attitude of health workers to clients affects utilisation of services. Health workers often do not feel accountable to client communities. Leadership and management of human resources are also weak at all levels. In terms of training, emphasis for most curricula of health workers is on curative care. Despite the PNFP subsector producing the majority of PHC staff, recognition and inclusion of the PNFP in national and district level decision-making fora for health training remains limited. Training of medical doctors and other health staff is governed by several institutions (MoH, MoE, PNFP training institution, Professional Councils), with no clear leadership, line of responsibility and mandates. Often decisions taken by one sector affect the others and result in an overall reduced training capacity.

### 3.6.3 Medicines and other health supplies

The National Drug Policy, operationalised through the Uganda Pharmaceutical Sector Strategic Plan[27], aims at ensuring the availability and accessibility at all times of adequate quantities of affordable,

[25] UBOS. (2002). Uganda population and housing census. Kampala: UBOS.
[26] World Bank, MoH, MoFPED; 2009, Fiscal space for health in Uganda
[27] It ended in 2006/07. A new one is being developed.

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

Over the period, all efforts were geared to improving availability of medicines. Absolute funding for medicines has increased. Training of health care workers of all levels of care was done. Support was provided to NMS and JMS to improve their business processes, management information systems and enterprise resource plans. Storage capacity at NMS and JMS were significantly expanded. A tool or framework to support integration of EMHS inputs and harmonise procurement was developed. The plan to operationalise the NDP was reviewed and the second NPSSP developed. A tool to guide interventions to promote rational use of medicines was developed. Mechanisms to integrate EMHS resources in form of a dedicated Essential Medicines Account were put in place. Support was provided to build institutional capacity of NDA. A modern school of pharmacy at Makerere University was constructed and equipped to address the acute shortage of pharmaceutical human resources. Pharmacy Section was upgraded to a Division (with four persons instead of 1) at the Ministry of Health Headquarters. The operationalization of medicines and therapeutic committees is ongoing in hospitals and HSDs. Tools for promoting rational use of medicines like the Essential Medicines List and the Uganda clinical guidelines were updated and are available in more than 90% of facilities.

While all these efforts are being made, availability of and access to medicines in Uganda continues to be a major problem. Only 30% of the EMHS required for the basic package are provided for in the national budget. Global Initiatives provide the bulk of resources needed for malaria, HIV and AIDS, tuberculosis, vaccines and reproductive health commodities e.g. in 2006/7 the contribution from the global initiatives was US$2.39 per capita out of the US$4.06 per capita spent on EMHS. The Medicines Credit Line budgets have stagnated while PHC grants for EMHS only slightly increased with low utilisation at approximately 55%. Delays in procurement, poor *quantification by* and *late orders from* facilities and poor records keeping are among the management issues that contribute to shortage and wastage of medicines in the public sector. A recent survey shows that even though 72% of the households were close to a public health care facility, only 33% of the households believe that medicines are available in public health care facilities. Medicines are 3-5 times more expensive in the private sector compared to the public sector procurement costs. For many people, medicines in the private sector are not affordable and this constitutes a major obstacle to households accessing medicines[28]. Another study shows that only 45.7% of the public health facilities had key essential medicines; the situation was a bit better in mission facilities at 57.5% and private facilities at 56.3%. The length of stock-out duration in public health facilities is at 72.9 days compared to 7.6 days per year for the mission facilities. Mean availability of originator and generic medicines on the EML is at 3.5% and 45.7%, respectively[29].

The private sector is poorly regulated and comprises of hospitals and clinics, retail pharmacies and both legal and illegal drug stores. Irrational use of medicines is widespread due to prescribing and dispensing by untrained or insufficiently trained personnel. Efforts to recruit pharmacy staff have been made at different levels, but serious shortfalls continue to prevail. Only 368 Pharmacists are registered with the

[28] Ministry of Health.MoH. (2008). *Access to and use of meedicines by households in Uganda*. Kampala: Ministry of Health.MoH.
[29] See Ministry of Health.MoH. (2008). *Pharmaceutical situation assessment*. Kampala: Ministry of Health.MoH.

Uganda Pharmacy Council[30]. Despite increased capacity to train pharmacists and dispensers, output is still insufficient to meet demands from both the public and private sectors. There is an emerging pharmaceutical industry in the country, with a limited productionfar below their installed capacity. As a result about 90% of all medicines are imported; and close to 95% of these are generic products. The challenge of counterfeit products on the market is becoming an increasing problem which needs to be urgently addressed.

The pharmaceutical sub-sector is better regulated. The number of pharmacists and pharmacy technicians is low and some people doing pharmacy work are not qualified. There are few pharmacists due to low outputs of pharmacists from the three universities (Makerere, KIU and Mbarara), Mulago Paramedical School trains pharmacy technicians. There is an emerging pharmaceutical industry in the country, with a limited production so far. About 90% of all medicines are imported, mainly from India and China, and about 60% are distributed by the private sector (Uganda Private Sector Mapping, Dec 2008). Only 5-7% of the imported drugs are 'branded' medicines, the remaining 93-95% being generic products. Counterfeit drugs are becoming an increasing problem. Large corporations e.g. banks and commercial firms have participated in public health initiatives and have been recognised and encouraged by government, but the extent of their involvement is still limited. With regard to laboratorry services, the Central Public Health Laboratories has the responsibility of coordinating health laboratory services in Uganda, developing policies and guidelines and training and implementing quality assurance schemes for laboratories. A comprehensive National Health Laboratory services policy was developed and this provides a framework for the future development of laboratory services in the country. The provision of good laboratory services laboratory support for disease surveillance is affected by low levels of funding for laboratory services, a weak regulary framework and the limited number of laboratory professionals in the country.

### 3.6.4 Health financing

This section provides a description of the health financing status in Uganda, health resources, financial mechanisms and levels of expenditure in the health sector. In Uganda, households constitute a major financing source of the National Health Expenditure at 49.7% and this is followed by Development Partners at 34.9%, Central Government at 14.9% and international NGOs at 0.4%[31]. Households spend about 9% of their expenditure on health, although no user fees are paid in lower level government health units and general wings of publicly owned hospitals. However, the private sector charges user fees. When medicines are not available in the public sector, patients buy from the private sector. As private health insurance, largely subsidized by employers on behalf of employees, is for a few, health expenditure remains high for most households. It is also known that while public health services are largely free many patients pay under-the counter fees in public institutions. Nearly 5% of the households in Uganda are experiencing catastrophic payments while 2.3% are impoverished because of medical bills. The establishment of the National Health Insurance Scheme, which is at an advanced stage, will cater for the majority of Ugandans.

Health Expenditure from public sources in absolute terms has increased in the past 10 years, however, as a percentage of the total Government spending, has actually decreased. In recent years, government's allocation to health as a percentage total government budget has been on average 9.6%. It thus remains below the Abuja Declaration target of 15%. There is inadequate funding to provide the UNMHCP in all

[30] Ministry of Health.MoH. (2009).*Human resources for health bi-annual report*. Kampala: Ministry of Health.MoH.
[31] UBOS Household Survey Report

facilities as envisaged: the per capita cost was estimated at USD 41.2 in 2008/09 and will be rising to USD 47.9 in 2011/12 (or UGX 2.75 billion) yet the health budget according to the MTEF was estimated at USD 12.5 per capita in 2008/09, demonstrating a shortfall of almost USD29. This trend has important implications for service delivery during the HSSP III period as it will imply the need for further priority setting, based on the UNMHCP. If the population growth is not controlled, the current population growth rate will have an escalating effect on the total health envelope required.

Efficiency is currently not well addressed in the way resources are mobilized, allocated and used. Most HDPs, including the GFATM and GAVI, now channel resources through budget support, but a portion of external funds remains off budget. In the medium term, donor project funding allocation has declined. During the FY 2005/06 and 2006/07 the amount within the MTEF decreased from UGX 269 billion to UGX 189 billion and yet outside the MTEF it increased from UGX 238 billion to UGX 351 billion. Funds allocated outside the MTEF do not necessarily address sector priorities and affect overall allocation of funds by government. One problem that has also been observed is that the delivery of services has been hampered by late disbursement of funds from MoFPED to Local Governments. Even the Local Governments to some extent themselves do not use standard guidelines to efficiently allocate funds to lower units.

The question is whether available resources are being used efficiently and the people of Uganda are deriving maximum health care benefits from the investments in the Health Sector. The Fiscal Space study noted that development assistance was a major source of funding but mainly off budget[32]. On the other hand, the PER highlighted challenges with off budget development assistance namely poor alignment resulting in expenditure on inputs not included in the HSSP, weak capacity of MoH to manage these funds and poor reporting[33]. The World Bank (2009) noted that distortions from management of development assistance were the second most important source of waste[34]. Government spending is largely on salaries in light of a stagnant and/or reducing recurrent non-wage allocation. Absenteeism resulting in a loss of UGX 26 billions annually has been documented as the largest source of waste and this may be as a result of lack of basic inputs to enable health workers provide services. Procurement and logistics management in regard to medicines and infrastructure is the third area of waste[35]. HSSP III will aim is to improve the efficiency of health service delivery through health sector reforms, donor coordination, improved allocation of resources and better reporting. The HSSP III will also aim at ensuring equity in benefiting from use of health care services[36].

The World Bank study also noted that Uganda can create significant fiscal space by improving efficiency and effectiveness of health spending through:

- Improving management and performance of health workers.
- Improving the procurement and logistics management system
- Linking funding to results and avoiding resource wastage.
- Revising the health financing strategy
- Better programming and management of development assistance for health.

[32] World Bank, MoH, MoFPED; 2009, Fiscal space for health in Uganda
[33] MoH, Public expenditure review, 2007, 2004/05 – 2006/07
[34] World Bank, MoH, MoFPED; 2009, Fiscal space for health in Uganda
[35] World Bank, MoH, MoFPED; 2009, Fiscal space for health in Uganda
[36] Equity in receiving benefits means beneficiaries receive health services according to their need for health care. A benefit in this case refers to access and the quality of health care.

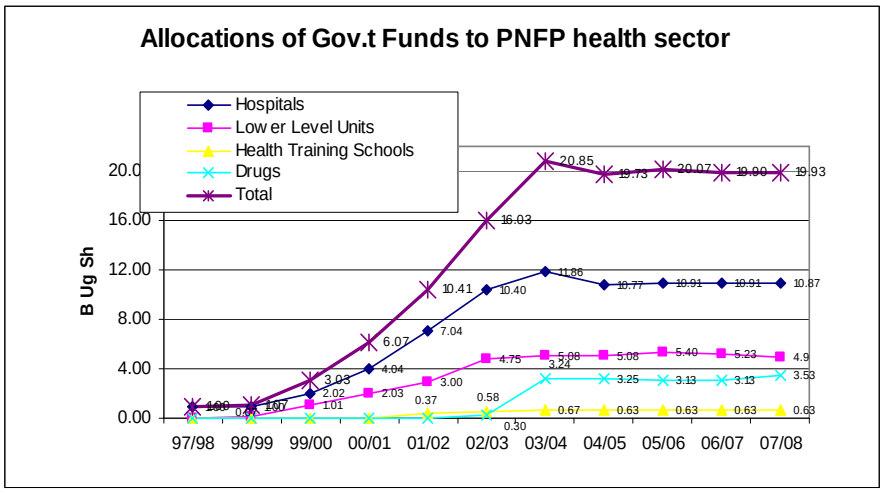
The Government of Uganda is committed to improve the health status of its people through formulation of sound health financing policies that can create significant fiscal space in the health sector in the medium term. GoU subsidizes the PNFPs and its training institutions and a few private hospitals but the level of subsidies for PNFPs remains low at 20%. The allocation to PNFP facilities is disproportionately low with the volume of services delivered, and takes little account of changing needs in terms of workload. In order to effectively sustain financing to the health sector, there is a need for improving allocative and operational efficiency, increasing Government contribution to the health sector budget and mobilizing community contributions through implementation of the national health insurance scheme.

### 3.7. Partnerships

The Public and Private sectors, other Ministries and Departments, HDPs, Civil Society Organizations (CSOs), and the community they play an important role in health. The MoH acknowledges the importance of each partner and considers partnership an important guiding principle of the NHP. In particular, the private sector provides a relevant financial contribution to the overall health sector, improving at the same time governance, management and quality of care. Furthermore, the private sector is considered as complementary to the public health sector in terms of increasing geographical access to health services and the scope and scale of services provided. This section discusses the progress that has been made towards the functionality of these partnerships.

### 3.7.1 Public Private Partnerships in Health (PPPH)

The GoU acknowledges the private sector as a major partner in national health development, service delivery and training. The private sector includes 3 subsectors: PNFPs, PHPs and TCMPs. The contribution of each sub-sector varies widely. While coordination structures between MoH and the private sector have been established at national l level, these are absent at the district and lower levels. The PNFP subsector is well organised and a functional collaborative framework exists with the MoH. The regulatory structures for PHP are not as effective as required and are lacking in respect of TCMPs. With decentralisation, the establishment of district structures is important. Even though the private health providers provide a significant proportion of health services in Uganda especially in urban areas, the operations of the sub-sector is not properly integrated with the public sector. The major challenge in strengthening of the public private partnership is the fact that the PPPH policy is still in draft form and once this ia passed it will facilitate coordination and integration with the public health sector. Guidelines have been developed in readiness for implementation once the policy is approved.



Government also encourages the private sector investment as it does not charge duty on importation of machinery and raw materials for production of pharmaceuticals.

The GoU subsidises PNFP health facilities and training institutions, however, the level of subsidies for the PFNP facilities has stagnated at about 20% of the total PNFP expenditures in the past few years (Fig 3.3) and it was reduced in real terms. At the same time, there is a general insensitivity by some sector of the government to current PNFP problems and the rising funding gap, due to lack of awareness on the overall benefits of the partnership and the relevant contribution of PNFP structures to the overall HSSP. The GoU subsidy to the PNFP subsector needs urgent revision. Additional sources of revenue for the sub-sector are donors (mostly foreign, but also local) and user fees from clients. In recent years, external resources from donors have increased, although the greater proportion of the external donor's funds are earmarked for HIV/AIDS. This creates pressure on the entire system, especially on human resources, due to increase in activities.

Although technical and consumer assessed quality of care is considered better in the private sector, rising cost of services delivery, against constant or decreasing income, is impacting negatively on quality of care. There are decreasing resources for all inputs and poor incentive structures compared to other sub-sector. Recently, growing disparities in remuneration and incentives, such as training opportunities between public and private health workers, havehave created a net outflow of health workers from the PNFP mostly to the public sector. In 2007/08 the attrition rate for hospital doctors was 35% and 32% for nurses and midwifes. Attrition is even worse for lower level units and rates are uniformly on the increase. Emigration of health workers to developed countries is also a major problem. The contribution of NFB-PNFPs has for long not been properly harnessed.

There has been a policy shift in the national medicines supply system. Previously, government and partners put funds for procurement of medicines in one basket, the Essential Medicines Account. In here, allocations were made to approximately 4:1 in respect of government and PNFP facilities. With the change, all government funds for procurement are to be sent to NMS under vote 116. The implication of this is that the government subsidy to PNFP to support procurement of medicines and other health supplies will no longer happen. This may have consequences for the PNFP sub-sector including JMS that had qualified as the second national supplier of medicines and health supplies.

In addition to these challenges, the private sector experiences difficulties in accessing soft loans and taxation has also not been favourable for the explansion of the private sector. This has led to the recently growing effort aimed at harmonizing and improving on the collaborative framework of the sub-sector within the health sector and developing a model structure of organization. This effort has been spearheaded by CSO representatives on the Health Policy Advisory committee including MACIS (Malaria and Childhood Illness NGO Secretariat), AMREF and Uganda National Health Consumers Organisation (UNHCO), AIC and TASO. Representatives of this sub-sector are currently active members of key forum specifically the national Health Policy Advisory Committee and the respective technical working groups. As one of the results there has been a strong coordinated CSO voice to advocate for addressing bottlenecks for example for resources coming from the Global Fund to ensure that communities can receive timely appropriate services. Continued support to this sub-sector therefore remains essential through effective partnership at the national and district level that will enhance capacity to provide health promotion and disease prevention directly to the communities.

In recent years there has been an expansion of private health providers, which has not been adequately regulated, although existing legislation provides for licensing and regulation of health professionals who

engage in private practice. According to a national survey conducted in 2005, an estimated 30% of the PHPs subscribe to a voluntary health professional association. Those structures are affiliated mainly to UPMPA (73%), UPMA (23%), UPHUA (4%). During the implementation of HSSP III, the PHPs have been involved in national immunization days (Central Region) and, at national level, in capacity building for malaria control. In addition, following the principles of partnership, professional associations are now represented in HPAC.

### 3.7.2 Intersectoral and inter-ministerial partnership

The PEAP (2004) recognizes that improving health outcomes will be the achievement of several sectors and performance on any health PEAP and MDG indicator will depend on activities in more than one sector. The NDP stresses the central role of the MoH, and its stewardship functions at the different levels, as crucial in harnessing the contribution of the health related sectors. To this end, the HSSP II envisaged a consolidation and expansion of partnerships with a number of different ministries (MoFPED, MoLWE, MoAAIF, MoGLSD, MoWHC, MoES, MoPS, MoLG and MoTI) strengthening their roles and responsibilities in promoting people's health. In order to foster effective linkages with other sectors, a framework for operationalisation of multi-sectoral linkages for health was discussed at the 2007 NHA and this formed the basis for a cabinet paper which proposes a sub-committee of cabinet referred to as Inter-Ministerial Committee on the Delivery of Health and at technical level a Technical Coordinating Committee, composed of permanent secretaries from the same sectors. There are other institutions that have been set up to spearhead implementation of specific programme that among other things call for interministerial involvement for example UAC is a government body charged with the responsibility of developing and monitoring the National HIV/AIDS Strategic Plan while the Partnership Committee oversees the management and coordination of the national HIV/AIDS response. At implementation level there was a proposal for a Technical Implementation Committeecomprised of heads of departments and line managers. While such attempts have been made the major challenges include the lack of awareness of the different players of their responsibilities and for some failure to implement including lack of activities and budgets in their work -plans.

### 3.7.3 Health development partners

Health Development Partners (HDPs) are playing an important role in Sector Wide Approach (SWAp) developed as a mechanism to address the health sector as a whole in planning, management, resource mobilization and allocation. The MoU between government and HDPs, which covers the HSSP period, spells out the obligations of each party and describes the structures and procedures established to facilitate the functioning of the partnership. The Government of Uganda established several fora for interacting with the HPDs. During the implementation of the HSSP I and II, the Health SWap was established as a tool that addresses health sector planning, management, resource mobilisation and allocation and guides the partnership with the HDPs. The MoU between GoU and HDPs which covers the HSSP period, spells out the obligations of each party and describes the structures and procedures established to facilitate the functioning of the partnership. One of the most significant achievements of the SWAp during HSSP II was the successful conclusion of negotiations with both GAVI and GFATM towards increased alignment of their support with the Health SWAp and agreeing common working arrangements, the so called Long Term Institutional Arrangements (LTIA). This included integrating the health component of the GFATM CCM into an expanded HPAC, integrating the AIDS CCM into the AIDS Partnership Committee (PC) and rationalising the composition of HPAC, which has undergone restructuring as part of LTIA. HPAC has met regularly and consistentlyand it is perceived by most people to be the most effective forum for consultation with stakeholders. It is however reported to be at

risk of being overwhelmed by GFATM related issues to an extent that some members have described it having been subsumed by CCM rather than *vice versa*. The scheduled stakeholder meetings at the annual TRM, JRM and NHA have been held regularly, discussions have been lively, and informative. The Auditor General's reports provide a component of accountability. Prior to the JRM field visits composed of MoH and other stakeholders are undertaken and findings reported in the NHA. Variation in district performance is discussed with the aid of the District league Table in the AHSPR.

In spite of these achievements there is an emerging view that the earlier dynamism and effectiveness of the Uganda SWAp has begun to wane. Progress towards meeting the Paris commitments on aid effectiveness is slow. Compliance with the provisions of the HSSP II MoU has been variable on the part of GoU as much as with the HDPs. The important function of stewardship of the SWAp rests broadly on HPAC and especially on the MoH but there is a lack of consistency in attendance and participation in the SWAp structures, including HPAC. Unsupportive approach to aspects of the partnership is reflected by lukewarm approach to PPPH related undertakings and budget allocation. There is emergence of pockets of resentment of what is seen to be undue partner interference and an attempt to take over responsibilities of the MoH. There is evidence that this attitude is already affecting the willingness of some of the health partners (HDP and PNFP) to participate more actively in HPAC, the various TWGs and other partnership activities. The evident decline in the level of importance and therefore urgency that used to be accorded to meeting JRM undertakings and the lack of follow-up on undertaking of previous years is yet another sign of decline in functioning of the structures. Many items remain on the agenda review – a good case in point is the matter of resolving the disparities in salaries between public and PNFP health workers. The intended linkages between units, programs, divisions, departments, TWGs, SMC, HPAC, and TMC still remain tenuous. Another strong disincentive for active participation of partners is the increasingly common practice of late coming and/or absence of key MoH officials from meetings convened by MOH itself. The sector review processes utilising the Area Teams, AHSPR, TRM, JRM and NHA are said not to be sufficiently critical and rigorous in the assessment of performance at sector level including gaps in highlighting fundamental reasons for poor performance and being silent on how effectively and efficiently available resources are being used. There is poor participation of other ministries and CSOs at the JRM. There have been concerns about data quality and the current local government indicators.

The TWGs have been revitalised focussing especially around the process and the drafting of the NHP II and HSSP III. The terms of reference and membership of the TWGs were revised and approved by HPAC. Various technical programme Inter-agency Coordinating Committees (ICCs) have been absorbed into the respective Technical Working Groups (TWGs). The Sector Budget Working Group was established for the purpose of facilitating the development of high quality Budget Framework papers and Annual Sector Budget proposals, in line with MFPED guidelines and consistent with Government policies and priorities; it was to also ensure that projects and proposals were consistent with sector priorities and that all recurrent cost implications were to be identified, quantified and provided for. Formulation of the MOH Headquarters Annual Work Plan and budget is now routine practice with the plan showing activities under respective objectives by program area, with implementation scheduled by quarter and budgets by source.

On their side, the HDPs have continued to reorganise in a bid to improve alignment and harmonization in line with the HSSP II MoU and the Paris Declaration on Aid Effectiveness. A permanent HDP Secretariat was established, and HDPs interaction with GoU is now mostly through the Chairperson of the HDP Group or a designated lead in any specific area. HSSP remains the framework for the support of the HDPs to Uganda health sector. However, the GoU initiative to rationalise the pattern of

distribution of HDPs among the different sectors (through the Division of Labour), has not been concluded. The strategy for sharing responsibility of various thematic areas more rationally among the HDP member agencies in accordance their respective areas of interest and comparative advantage, has not progressed much either. Only 3 out of 7 of the HDPs allocate the greater part (85% to 100%) of their support through Budget Support, while the rest use a combination of budget support and project support. Only 20% of the support to PPP is on-budget though much of is included in the MTEF. Even more alarming is the estimation that over 73% of all donor contribution goes to non-HSSP priorities and to support the administration of the projects under the respective HDPs.

The International Health Partnerships and other Initiatives (IHP+) is therefore an attempt to improve the alignment and coherence of aid for health development including more accountability. IHP+ therefore aims for health development that is country-led, country-owned, and fully aligned with national priorities and capacities. At the centre of this effort is a costed and validated national health plan which guides the commitment of donors, through either budgetary support or support to technical programmes. The IHP+ therefore provides a framework for holding all partners accountable for producing tangible and measurable results.

The reported decline in the quality of the Budget Framework Papers, the lack of adequate consultation in its development and lack of transparency in the allocation of the approved budget all contribute to the declining level of trust within the partnership. It has also been suggested that this trend may account for the retention of varying proportions of donor funds in projects, and the health budget being heavily earmarked at MFPED level before it reaches MOH, leaving little room for internal reallocations. Many of the funding partners have expressed unease over the apparent unwillingness of MoH to make the admittedly difficult choices of re-prioritising among the many priorities of the UNMHCP and targeting available resources towards those core interventions that have been proven to contribute most to the reduction of morbidity and mortality.

### 3.7.4 Partnership with communities

Both the HSSP I and II promoted community participation and empowerment as an important strategy for enabling communities to take responsibility for their own health and well-being through active participation in the management of local health services. Community participation as a strategy in health service delivery is important as it ensures the availability of appropriate community based services and addresses barriers to accessing care. Two structures were established: the village health team (VHT) and the health unit management committee (HUMC). HUMC have since been established in all health facilities in Uganda. The target was that by the end of the HSSP II VHTs would have been formed in all the villages in Uganda. This has however not been achieved as to date only 50% of the districts have functional VHTs. Studies have demonstrated that where VHTs are functional they have led to decongestion of health facilities as treatment of minor illnesses are effectively managed by these VHTs. The lack of funding is a major constraint in the rolling out of VHTs.

The HSSP II noted that the responsibility for health primarily lies with individuals and emphasizes involvement of individuals and communities in attainment and maintenance of good health status. The relevant HSSP II objective was the establishment of dynamic interactions between health care providers and consumers of health care with the view of improving the quality and responsiveness of health services. The health sector has continued to work with political and administrative leaders at various levels for improvements in health service delivery and health outcomes. This collaboration extends to the district level including such fora as National Health Assembly, Regional and District Planning

meetings. Partnerships have been built and continue to be nurtured with civil society organisations (CSOs) as an entity that is working directly with and among communities and therefore strategically positioned to represent the voices of these communities. Through the LTIA agreed with GFATM, more representatives of CSOs have been brought on board the SWAp structures like the Technical Working Groups, HPAC and the JRM.

User satisfaction has come to be accepted as one of the major indicators of good quality services. Even if other technical aspects of quality of care are important, user satisfaction is a major determinant of effective use of services. The proportion of the surveyed population expressing satisfaction with the health services was one of the monitoring indicators of the HSSP II (and even the HSSP I). A WB/MOH/MUK survey, conducted in 2007, found that three quarters of those responding to exit polls in Uganda were happy with the quality of care they receive. Although levels of satisfaction were significantly lower among respondents interviewed at public facilities, with the exception that patients prefer public-facility prices to those charged by other providers. A number of patients and households report paying for care received in public-sector health facilities, even though these services are supposed to be free. The capacity to receive feedback from the community on the quality of health services remain a major challenge for the next HSSP. This makes it even more essential to strengthen the role of CSO networks and closely work with them to monitor and report back to MOH using robust mechanisms.

## 4. CONTEXTUAL ANALYSIS

### 4.1 The external factors

This section describes some of the external factors that might affect the implementation of the HSSP III.

#### 4.1.1 Population growth and distribution

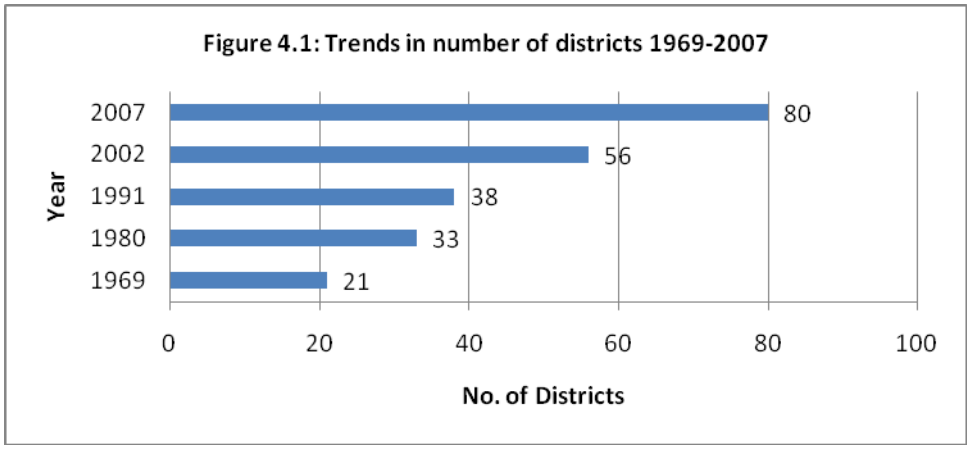
Uganda has an area of 240,038 $km^2$ of which 197,323 $km^2$ is covered by land. In 2002 the population of Uganda was estimated at 24.2 million: 48.5% were male while 51.5% were female; and 88% are resident in rural areas. The population growth rate is estimated at 3.2% per annum which means an increment of more than 1 million people annually. The Uganda Bureau of Statistics (UBOS) estimates the population in 2009 at 30.7 million and by the end of the HSSP III in 2014/15 Uganda's population will be approximately 37.9 million. This implies that the health sector in Uganda should be prepared to provide quality healthcare to an extra 7 million people. The budgetary allocation to the health sector over the last 5 years has not grown much as a % of GoU's total discretionary expenditure (it has been stagnant at around 9%). It has however increased from UGX 242.62 billion in 2006/07 to UGX375.38 in 2008/09. In order for the health sector in Uganda to provide services to an extra 7 million people in 2014/15 the budgetary allocation to the health sector has to increase considerably. If Uganda's population growth is not checked such an increase in the number of people will cause a big strain in health service delivery and the quality of services and coverage will significantly be affected.

It is estimated that 49% of Uganda's population constitutes of persons under the age of 15. Over the next 5 years of the HSSP III Uganda will have to cover new specific age-related health needs. Whilst the Ugandan population will remain a young population with 18.5% of the total population being under-five (down from 19.5% now), the population structure will start showing signs of aging, with the elderly (65+) slowly increasing from about 2.1% to 2.3% of the total population. Small as this percentage may

seem, it does explain nevertheless that there will be close to 1 million 'senior citizens'. The very considerable increase in the number of females in reproductive years (from 7 million now to 8.3 million in 2014) will put considerable strain on all aspects of reproductive health services.

### 4.1.2 Political, administrative and legal factors.

Administratively, Uganda is divided into 80 districts which are further sub-divided into lower administrative units namely counties, sub-counties and parishes. Overtime, the numbers of districts and lower level administrative units have continuously increased with the aim of making administration and delivery of social services easier. Figure 4.1 below shows the increase in the number of districts over the period 1969-2007.




In 1969 there were only 21 districts; by 2002 the number had more than doubled to 56; by 2007, there were 80 f districts. Currently, it is estimated that there are 90 districts in Uganda and at this rate it is likely that by the end of the HSSP III there will be more than 100 districts. Each newly created district is supposed to have a new district hospital and this calls for Government to mobilise resources for either the upgrading of existing HC IVs to general hospitals or the construction of new general hospitals that will cater for the districts and ensuring that they are equiped with the required human resource, equipment and other logistics. In a country where budgetary allocation to the health sector has not been growing as expected the creation of new districts will further strain the capacity of the health sector to provide quality health services to the people of Uganda if the policy of 1 general hospital per district is maintained.

As a way of improving the efficiency and effectiveness of service delivery, the GoU has been implementing decentralisation programmes. These programmes are guided by the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997). Both NHP I and II r recommend the decentralisation of services to districts and within districts to HSDs. Each level of the decentralised health delivery system has specific roles and responsibilities. There are some constraints related to decentralisation of health services: roles and responsibilities among district leaders have not been internalised; supervision both from central level to districts and districts to lower levels is inadequate; inadequate logistics frustrates the functioning of the DHOs especially in newly created districts and inadequate funding to districts. Despite these constraints a recent study shows that over the last two decades of implementing a decentralised health delivery system the performance of the health system has improved significantly. Over the period of the HSSP III the delivery of health services shall

continue to be delivered in a decentralised manner but there are suggestions that some aspects of human resource management and development should be recentralised among other recommendations[37] in order to improve service delivery.

### 4.1.3 The National Development Plan and International Health Initiatives

The National Development Plan (NDP), a new development framework for the GoU for the period 2009/10-2013/14, highlights the strategic agenda for development and further details priority interventions in all sectors of the economy including health nutrition. The overall goal of the NDP is to accelerate economic growth to reduce poverty. The NDP seeks to achieve 7 development objectives as follows:

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

The NDP therefore acknowledges that social and human development is a critical component of economic development. Over the period of the NDP 2009/10 GoU will increase availability and access to quality social services including health services delivery. The chapter on health and nutrition in the NDP prioritises the implementation of the UNMHCP. While the NDP, the Constitution of the Republic of Uganda and the NHP II avail the right to good quality of health care for all people in Uganda there are constraints such as shortage of HRH and inadequate funding for the health sector that will make this unattainable. In addition to the UNMHCP, the NDP over the next 5 years will give priority to the promotion of health and prevention of disease, strengthening of health systems and it will also focus on programs of national interest namely reproductive health and child survival, HIV, AIDS and tuberculosis, malaria and nutrition. The delivery of health services will, if not addressed urgently, greatly be affected by shortage of HRH, inadequate funding to the health sector, poor infrastructure, unavailability of medicines in the facilities, and inadequate planning, management and leadership.

### 4.1.3 Social determinants of health

The growth of Uganda's economy has mainly been boosted by macroeconomic and political stability resulting from the macroeconomic reforms. For almost a decade now, Uganda has experienced robust economic growth rates averaging 7% in real terms. A stronger export sector; increased foreign direct investment into various sectors; growing fixed private investment, driven by construction; large concessional inflows from donors; and a stable macroeconomic environment have contributed to the steady growth of the Uganda's economy. Even though this is the case, further economic growth has also been constrained by inadequate infrastructure, limited capacity in the energy sector, high interest rates and extreme weather conditions (drought, flooding etc). With a GDP of US$430 per capita[38] Uganda

[37] Lukwago, J.C., D.K. Musoke, G. Nantume, S. Kamba. (2009). *Ministry of Health special study on effects of decentralisation on health services delivery in Uganda.* Kampala: HealthConsult.
[38] UBOS Statistical abstract 2008.

remains among the poorest countries in the world. Poverty is still wide spread in the country especially in rural areas. In 2005/06 31.1% of Ugandans were estimated to be poor, 34.2% were from rural areas while 13.7% were in urban areas with northern Uganda having the highest proportion of people classified as poor.

The GoU budget allocation to the health sector has remained static. In 2004/5 this was at 11.2% but in 2006/7 and 2007/8 it went down to 9.6% still falling short of the 15 % Abuja target of 2000. Achieving acceptable safe hygiene and sanitation remains a challenge for Uganda with a significant proportion of the population of up to 32.5 percent with no latrines. The Sanitation MDG of 72 % has been achieved by 40 % of the districts, with 25 % on course to meet the goal. According to the 2006 UDHS, 77% of the population has access to safe water. Addressing social determinants of health will help improve the health status of the people of Uganda. Continued security, economic growth and stability are assumed necessary conditions for the successful implementation of the NDP, NHP II and the HSSP III.

Gender plays an important role in seeking health care. In most cases married women may not make decisions on their own regarding how resources in the home can be spent. The UDHS shows that about 55 percent of the women mainly decide by themselves how their earnings are to be spent, 32% report that they make the decision jointly with their husband/partner while 13 percent report that the decision is mainly made by their husband/partner. There are variations in the proportion of women who make independent decisions about their earnings ranging from 24% in Eastern region to 79% in Kampala. This shows that women in urban areas are more likely to make independent decisions conpared to those in rural areas. Decision making is an important determinant of health care seeking behaviour and in contexts where decisions are made by men this may delay seeking appropriate health care.

### 4.1.4 Education

Education is also one of the major determinants of health: the 2006 DHS generally shows that level of education attained constitutes one of the major determinants of health; e.g. prevalence of diarrhoea, ARIs and fever among under-five children decreases the higher the educational level of the mother. Education constitutes one of the major components of human capital quality essential for sustainable economic growth. The NDP acknowledges that education is a tool to fight poverty and increase peoples' incomes. In order to increase access to education the GoU introduced Universal Primary Education (UPE) programme in 1997 to offer free education at the primary level while Universal Secondary Education (USE) was introduced in 2007. Since the introduction of UPE, enrolment in primary schools in Uganda increased to 7.6 million in 2005/06 compared to 3 million in 1997.

Although the net enrolment ratio in primary education is high and virtually the same for girls as boys (approx. 82%), the literacy rate among 15-24 year old girls (58%) is substantially lower than among boys (70%) and ensuring that children remain in school is a major challenge as the school dropout rate is high: only 49% reach Grade 5. This difference in literacy levels between males and females is also seen in other age categories, resulting in an overall literacy rate among males of 76% compared to females at 63% (UNHS); it is also higher among urban residents at 86% compared to rural residents at 66%. In 2005/2006, Northern Uganda had the lowest literacy rates at 59%. Improving the level of education would therefore help to address these diseases. In terms of seeking health care educated persons are more likely to seek health services from the formal health care system than the TCMPs. Access to health services over the five year period of the HSSP will also be largely determined by literacy levels.

### 4.1.5 Changing food habits, sedentary life styles and changing climates

Uganda, as is the case with other countries, is experiencing important changes in disease patterns. For example, NCDs are an emerging problem and their increase is due to multiple factors such as adoption of unhealthy lifestyles, increasing aging population and metabolic side effects resulting from life long antiretroviral treatment. The GoU acknowledges this as a problem and that during the period of implementing HSSP III effective interventions need to be put in place in order to contain these diseases. The treatment of NCDs is very expensive and if they are not effectively prevented they will constitute a major expenditure in Uganda's health budget.

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

### 4.2 SWOT analysis

In order to adequately implement the HSSP III, there are some opportunities and strengths that the MoH, HDPs and other health service providers should build on as they implement this plan. At the same time there are weaknesses and threats that need to be contained or addressed if the HSSP III is to be implemented successfully. This section discusses the strength and weaknesses and opportunities and threats that will impact on the implementation of the HSSP III.

### 4.2.1 Strengths

The MTR of the HSSP II has identified the following strengths in the MoH and the wider health sector that need to be built on as the HSSP III is being implemented.

- *Leadership and stewardship*:

  Despite major bottlenecks in the health sector, the HSSP II was implemented successfully under the leadership and stewardship of the MoH.

  - A number of health sector reforms were successfully implemented during this period including the introduction and operationalisation of the Sector Wide Approach in health (SWAp) as required by the HDPs.

  - The delivery of health services in Uganda has been fully decentralised**.** This enables communities to participate in health planning and management, especially in those areas where the VHTs have been trained and are fully functional.

  - The availability of appropriate health structures at all levels for the delivery of key health interventions is a major strength for Uganda's health sector.

- ***Policies, strategies and guidelines:***

  Over the years, with leadership of the MoH, the NHP I and II and HSSP I, II and III have been developed. Other health strategic plans, policies and guidelines have also been developed, are available and are reviewed periodically as need arises. The MoH and stakeholders have also defined a set of health services that should be delivered at each level of health care. In the context of a limited resource envelope, the sector strategic plans define a minimum health care package that should be delivered to all Ugandans and the indicators and targets in the health sector have since been aligned with the NDP and the MDGs.

  The existence of policies, strategies and guidelines for the health sector informed by international agreements such as the RBM, IMCI and the Stop TB Strategy and Global TB Plan (community DOTS) among others constitutes a major strength that MoH and other stakeholders should build on during implementation of the HSSP III.

- ***Resource mobilisation:***

  Uganda is a signatory to the IHP+. The donors, both bilateral and multilateral, are committed to funding the health sector in Uganda. Over the years, the MoH and stakeholders in Uganda have demonstrated strength in mobilising external resources for the sector.

- ***Partnerships:***

  The MoH further recognises that it cannot implement the NHP II and HSSP III on its own. The NHP II describes the partnerships and other structures that have since been created in order to ensure the successful implementation of the HSSP III.

  - The operationalisation of the Health SWAp, seen as a vehicle through which the UNMHCP is being delivered, is an important partnership through which HDPs are supporting MoH and other providers of health services in mobilising and managing resources for the health sector. The establishment of structures such as HPAC, Health Sector Budget Working Group (HSBWG), the National Health Assembly (NHA), TRM and JRM are all aimed at ensuring the effective delivery of the UNMHCP. The NHP II spells out the functions and responsibilities of these different structures and such structures further constitute the strengths upon which the implementation of the HSSP III can build upon.

  - The NHP II also emphasises on the importance of the public private partnership for health in which the private sector is seen as a major partner in national health development.

### 4.2.2 Weaknesses

There are a number of weaknesses within the health sector that may affect the effective delivery of the UNMHCP. These weaknesses have been identified through the MTR of the HSSP II, AHSPR and other studies.

- ***Unsatisfactory implementation of sectoral policies and strategies and weak enforcement of existing legislation:***

  While health sector policies and strategic plans exist, implementation is a major challenge. The lack of implementation and enforcement might be due to:

  - The critical shortage of HRH.
  - Inadequate funding to the health sector makes it difficult to effectively deliver the UNMHCP; and train, recruit, deploy and maintain and adequately motivate health care workers.
  - Redundancy or limited impact/interest for the policy.

- ***Weak referral system:***

  While the number of health facilities has increased significantly over the years, nearly a third of the people in Uganda still live more than 5 kilometres from the nearest health facility; and the referral system is weak and this, combined with staff shortage and lack of medicines, forces many Ugandans to seek treatment from TCMPs.

- ***Weak partnersship between MoH and PHPs:***

  Even though the PHPs provide a significant proportion of health care the partnership with MoH is rather weak and it is non-existent at district and lower levels.

- ***A weak Supervision, M and E system:***

  A system for supervision, monitoring and evaluation exists but it is weak. The late release of funds for supervision, insufficient funds, inadequate transport arrangements and lack of supervision skills affect the frequency of supervision and this impacts negatively on quality of services rendered. The operations of the HMIS are affected by inadequate human and financial resources as well as excessive volumes of data collection that may not be relevant to the different levels of care and programme. Timeliness of reporting is currently estimated at 68%. The existence of parallel data collection systems for vertical programs such as HIV/AIDS puts a strain on HRH. Data analysis and utilisation for planning purposes is low and the private sector's contribution to the HMIS is modest. The capacity of the HMIS is still inadequate.

- Many facilities still lack basic utilities such as water and electricity.

- Financial management, accountability and transparency are still weak; and there is limited absorption capacity for donor funds e.g. GFATM.

- Limited coordination of donor efforts, in particular in malaria and HV programmes.

### 4.2.3 Opportunities

While these weaknesses exist, there are also opportunities within the health sector that can be used by all stakeholders to successfully implement the NHP II and HSSP III:

- The GoU has just developed the NDP whose overall goal is to accelerate economic growth to reduce poverty. The NDP is an overall development plan for Uganda and it is a guiding document for sector investments: it has prioritised the delivery of the UNMHCP which in turn focuses on poverty related diseases affecting the majority of the people in Uganda. The NDP details the GoU's *commitment* to improve health service delivery including quality of care. The NDP is also an opportunity because of synergies can be expected for health due to prominence given to other sectors.

- While financial resources are limited, an opportunity exists for Uganda: it is a signatory to the IHP + and global initiatives such as the Global Fund and GAVI and bilateral donors are *committed to funding the health sector* and supporting GoU efforts to achieve MDGs. The availability of such funding will reduce the funding gap for implementation of the HSSP III.

- Other opportunities that need to be fully exploited include: growing involvement of the private sector; decentralisation of services to allow full participation of the communities in service delivery and management; and harmonisation of funding from different sources.

- The academia in Uganda with their external alliances of reputable and experienced universities and other academic institutions- can –if properly harnessed and guided- support the sector as a real 'think thank'

- The continued development of the East African Economic Community and Uganda's active participation.

### 4.2.4 Threats

There are also threats to the implementation of the HSSP III.

- Uganda is classified as a poor country: about 31% of the people live below the poverty line and poverty is one of the major determinants of health status; hence a major threat to the implementation of HSSP III and achievement of its related targets. While Uganda's economy has been growing steadily at 7% over the last few years, government allocation to the health sector has been stable at around 9.6%. The unfavourable macroeconomic environment, exacerbated by adverse climatic conditions and food crises, threaten government contribution to the health sector. heavy reliance on donor funding, high transaction costs

- Uganda is one of the countries that have been heavily affected by the HIV and AIDS epidemic. The disease claims the lives of young and economically productive Ugandans. The disease threatens the availability of HRH and contribution to the economic development of Uganda. The continued HRH crisis in the health sector if not addressed will threaten the implementation of the HSSP III.

- While a SWAp mechanism has been established in Uganda and is relatively functioning well and most donors have aligned their support to SWAp, there still exist some HPDs who resist such a funding arrangement and this is a threat to successful implementation of the HSSP III.

- High population growth.

- Poor health seeking behaviour.

## 5. VISION, MISSION, GOAL, VALUES, PRIORITIES AND MAIN ASSUMPTIONS.

### 5.1 Goal

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

### 5.2 Vision

- To have a healthy and productive population that contributes to economic growth and national development.

### 5.3. Mission

- To provide the highest possible level of health to all people in Uganda through promotion, prevention, curative and rehabilitative health services at all levels.

### 5.4 Social values of the HSSP III

The HSSP puts the client and community in the forefront and adopts a 'client centered' approach and it looks at both the supply and demand side of health care. The following social values, as detailed in the Uganda's Patients' Charter, the Constitution of the Republic of Uganda (1995 as amended)and international human rights standards that Uganda is party to, will guide the implementation of the HSSP III.

#### 5.4.1 The right to highest attainable level of health (right to health)

The HSSP will be implemented in the context that health is a fundamental human right. Health as a human right is enshrined in several legal instruments that Uganda has ratified. The instruments declare health as a fundamental human right to be enjoyed by all without discrimination and these include the WHO constitution; International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC), International Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the African Charter on People's Rights (ACHPR) and several others.

- The 1995 Uganda Constitution (as amended) guarantees rights of access for all people in Uganda to basic health care services as well as the right to food and nutrition security. The right to health therefore is not only a right to quality health care but also a right to other determinants of health such as safe and adequate water supply, sanitation, education, food and a right to a safe environment among others.

- The right to health entitles individuals to information about their health including diagnosis, treatment, costs and prognosis. It also requires that individuals make informed decisions regarding their health including making informed consent prior to undergoing any procedures.

- The public and private health providers are obliged to ensure patients' safety and privacy and observe the required professional standards in the course of their duties. This has implications on treatment protocols, and quality of medicines, medical supplies, medical equipment and infrastructure.

### 5.4.2 Solidarity

- Government will give due consideration to pursuit of national solidarity in a common concern for health-for-all, with special consideration for social protection of the poor, the most vulnerable and the disadvantaged.

### 5.4.3 Equity

- Government shall ensure equal access to quality care according to needs for individuals with the same health conditions.

### 5.4.3 Respect of cultures and traditions of the people of Uganda

- All stakeholders shall respect the cultures and traditions of the peoples of Uganda that promote health. At the same time, negative practices, attitudes and behaviours shall be discouraged.

### 5.4.5 Professionalism, Integrity and ethics

- Health, health-allied and other professionals working in the sector (including managers, accountants, engineers etc) shall perform their work with the highest level of professionalism, integrity and trust as contained and detailed in the ethics guidelines enforced by professional bodies to which they are affiliated.

### 5.4.6 Participation

- Individuals are ultimately responsible for the lifestyle decisions they adopt. Patients have the responsibility of seeking care and adhering to treatment as prescribed for their benefit and that for the community. Communities will be empowered to participate in the implementation of the HSSP through their VHTs and HUMC.

### 5.4.7 Accountability

- At all times and at all levels, a high level of efficiency and accountability shall be maintained in the development and management of the national health system.

- The health sector will be accountable for its performance, including its financial management performance, not only to the political and administrative system, but, above all, to its client communities.

### 5.5 Guiding principles

The implementation of the HSSP III shall be guided by the following principles:

#### 5.5.1 Evidence-based and forward looking

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

#### 5.5.2 Pro-poor and sustainability

- The HSSP III shall be pro-poor and shall provide a framework to support sustainable development. In order to address the burden of disease in a cost effective way. The GoU, PHPs and PFNPs shall provide services included in the UNMHCP with special attention to underserved parts of the country.

- GoU shall explore alternative, equitable and sustainable options for health financing and health service organisation targeting vulnerable groups.

#### 5.5.3 Partnerships

- Government considers partnership with other institutions, ministries, CSOs and the private sector as a cornerstone of all its undertakings. With regard to service delivery, the private sector shall be seen as complimentary to the public sector in terms of increasing geographical access to health services and in terms of the scope and scale of services provided.

#### 5.5.4 Primary Health Care

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

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

#### 5.5.5 The Uganda National Minimum Health Care Package

- In order to address the burden of disease in a cost-effective way, public and private providers shall offer services that are included in the UNMHCP.

### 5.5.6 Integrated health care delivery

- Curative, preventive and promotive services shall be provided in an integrated manner.

### 5.5.7 Gender-sensitive and responsive health care

- A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.

### 5.5.8 Mainstreaming of health in all policies

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

### 5.5.9 Uganda in the international context

- In order to minimize health risks, the GoU shall play a pro-active role in initiating cross border initiatives in health and health- related issues.
- The HSSP III shall follow the principles of the Paris Declaration and the Accra Agenda for action through the IHP+ in the interaction and collaboration with national and international development partners.

### 5.5.10 Decentralisation

Health services shall be delivered within the framework of decentralisation.

## 5.6 Priorities in the HSSP III

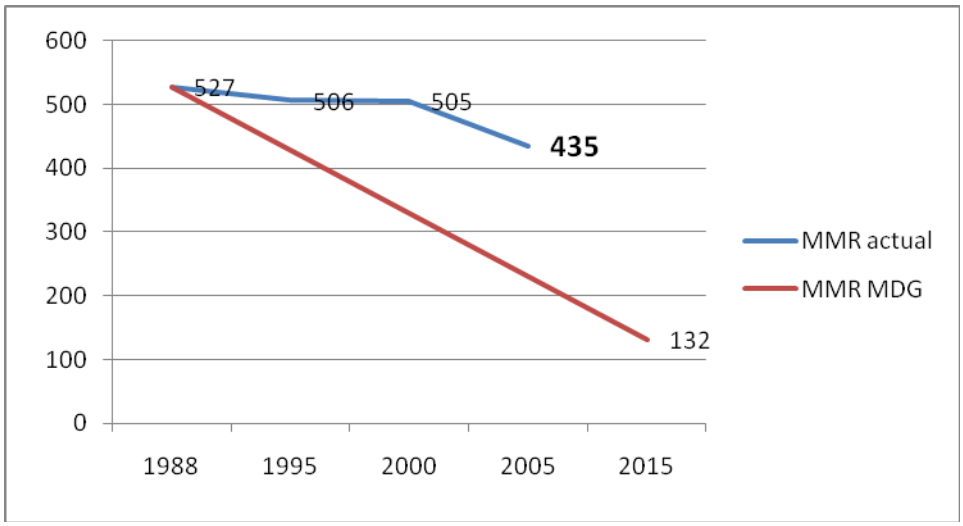
Chapter 6 defines the major strategies and interventions that will be implemented during the period of the HSSP III. While it is necessary that all these interventions should be implemented it is important that priorities of the HSSP III be identified and budgetary allocation will also reflect prioritised interventions. As the projected resource envelope for service delivery will be insufficient to cover all interventions and services to all people in Uganda in the foreseeable future, strategic decisions on investing in health have to be made. There are four priorities in this HSSP III and these are Sexual and Reproductive Health, Child Health, Health Education and the Control and Prevention of Communicable Diseases (HIV/AIDS, Malaria and Tuberculosis).

### 5.6.1 Sexual and reproductive health

Uganda, as a signatory of the Millennium Declaration, is committed to achieving the targets of the MDGs. However, not much progress has been made with respect to MDG 5 which is to improve maternal health. As can be seen from Figure 5.1 MMR remains high and it is unlikely that the target for 2015 will be achieved unless deliberate or strategic investments are made to accelerate progress. There was very little decline in MMR between 1988 and 2006 when the last UDHS was conducted in Uganda. This implies that at current rates, 6,000 women dies each year due to pregancy and related factors. The

of pregnant women who deliver using skilled personnel and contracepotive prevalence rate have remained low and the unmet need for family planning has remained high as discussed earlier.

**Figure 5.1: Maternal Mortality Rates in Uganda (1988-2006)**

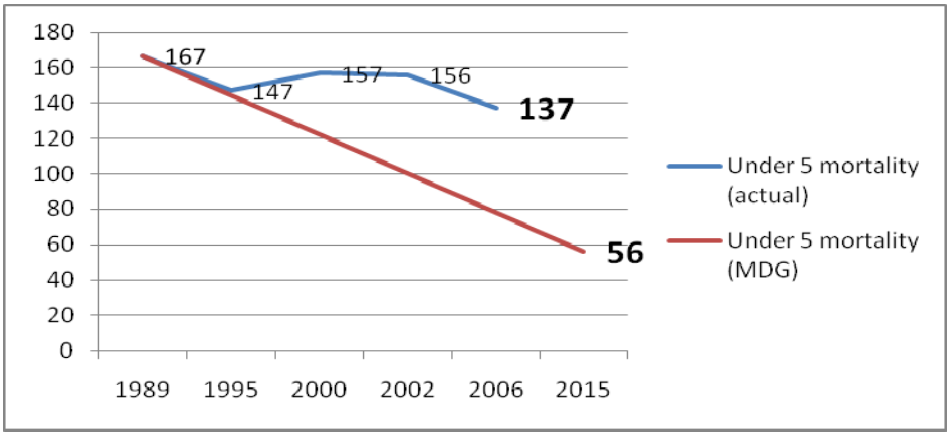



It is therefore important that in this HSSP III priority be given to sexual and reproductive health as it will help accelerate progress towards achieving MDG 5 and save the lives of women who die during pregnancy and child birth. At the same time addressing the unmet need for family planning will also reduce population growth and relieve pressure on health services.

### 5.6.2 Child Health

As is the case with child mortality, limited progress has beenmade in achieving targets of MDG 4 which is to reduce child mortality. Figure 5.1 below shows trends in child mortality:

**Figure 1: Under-5 Mortality rate in Uganda (1988-2006)**




The target for MDG 4 for Uganda is 56 deaths per 1000 live births but with current trends this is unlikely to be achieved. During the HSSP III priority will therefore also be given to child health

interventions in order to ensure that Uganda achieves the target of MDG 4. A costed Child Survival Strategy has been developed for Uganda and emphasis will be on implementation of the interventions that have been spelt out in this strategy.

### 5.6.3 Health Education and Promotion

The situation analysis identified a number of challenges that need to be urgently addressed during the HSSP III. More than 75% of the overall burden of diseases, either CDs or NCDs, is preventable, including malnutrition. Access to safe water, sanitation, hygiene, nutrition and living conditions are still poor, especially in rural areas and urban slums, resulting in poor health, especially in women and under-five children. Urbanisation and unhealthy lifestyles have led to an increase in NCDs. Health promotion and education is one of the most cost-effective approaches to contain the burden of communicable and non-communicable diseases, injuries, disabilities and mental health problems. HPE shall address major known health risk factors and health determinants and shall be delivered through specifically targeted, population-based programmes involving different sectors (e.g. other ministries, schools, media, political leaders, CSOs, etc). Implementing health education and promotion will ensure that 75% of the overall burden of diseases are prevented.

### 5.6.4 Control and Prevention of HIV/AIDS, malaria and tuberculosis

HIV/AIDS, malaria and tuberculosis are still important public health problems in Uganda and are important causes of mortality among women, children and the general population; hence the need to invest resources in the control and prevention of these diseases.

### 5.6.5 Health systems strengthening

As has been mentioned earlier, the focus of this HSSP III will be on sexual and reproductive health, child health, health education and promotion and control and prevention of HIV/AIDS, malaria and tuberculosis. In order to implement the interventions for these priorities it is important to strengthen the health system; hence priority will also be given to systems strengthening. The focus for health systems strengthening shall be on:

- Strengthening district health systems in line with decentralisation through training, technical assistance and financial support.

- Reconceptualising and organising supervision and monitoring, including the clinical supervision, of health workers at all levels of the government health system.

- Improving the collection and utilization of data for evidence-based decision making at all levels.

- Establishing a functional integration between the public and private sectors in health care delivery, training and research.

- Addressing the human resource crisis and redefining the institutional framework for training of health workers, including the mandate of all actors, leadership and coordination mechanisms, with the aim of improving both the quantity and quality of health workers production.

- Availability of essential medicines and health supplies is central to the delivery of UNMHCP. There is therefore need to strengthen the commodity supply chain system to ensure that medicines are available and accessible to the population at all times.

While a wide range of interventions have been spelt out in Chapter 6, priority will be given to the interventions discussed in this section. The allocation of resources including HRH shall reflect these priorities.

### 5.7 Main assumptions

During the implementation of strategic plans things may happen that can affect the successful implementation of the plan itself. Assumptions therefore have to be made. The review of literature and discussions with various TWGs and other stakeholders a number of assumptions were identified as follows:

- Contniued political stability.

- Continued political support at both national and district level.

- Uganda's economy will continue to grow and that consequently Government allocation to the health budget including allocation to PNFPs will also increase and that consequently during the implementation of the HSSP III the target of 15% as recommended in the Abuja Declaration will be reached.

- Even if Government expenditure on health reaches 15%, the resources will not be adequate to fully implement the HSSP III. The assumption therefore is that the HPDs shall continue providing additional resources to compliment government funding to the health sector through the SWAp mechanism.

- Prudent financial management, accountability and transparency shall be key in order to attract financial and other resources into the health sector.

- The focus in the health sector shall continue to be the delivery of the UNMHCP free of charge to all people in Uganda which shall be reviewed depending on epidemiolocal data and other new evidence.

- Availability of an effective legal and policy environment conducive for delivery of health services.

- The MoH with support from HDP shall train, recruit, deploy and retain HRH for effective delivery of the minimum package.

These assumptions will be part of the implementation process and will be monitored and evaluated to see the rate of progress towards achieving the targets set in the HSSP III.

## 6. OBJECTIVES, STRATEGIES AND TARGETS FOR THE HSSP III

The HSSP III is guided by objectives of the NHP II and these are the basis for the broad priority areas within this plan.

### 6.1 Organisation and management of the NHS

#### (a) Issues

In accordance with the 1995 Constitution of the GoU and the 1997 Local Government Act, the MoH has been implementing a decentralised system of health service delivery over the last 10 years. Evidence exists that the decentralisation of health service provision has improved health care. A number of challenges however have been identified in the way health services are organised and managed in Uganda namely: the prevailing weak management systems at all levels; inadequate funding; lack of *adequate* coordination among different sectors involved in the delivery of health services; limited knowledge about decentralisation especially at district level; the limited planning and supervisory skills especially at district and lower levels; the lack of ICT infrastructure and software; and the unsatifactory performance of the HMIS as it does not provide timely and reliable data for decision making. The development of the HSSP III acknowledged that these issues have affected the delivery and utilisation of health services in Uganda. The proposed strategies and interventions in this plan are aimed at improving health care delivery services and systems through institution of efficient and effective health management systems. The plan will also ensure equitable delivery of health services with deliberate attempts to develop, pilot and implement service delivery models for vulnerable groups for example pastoral communities and other population groups living in hard to reach areas.

While the MoH headquarters shall continue to formulate policies and monitor the overall sectoral performance among other responsibilities, certain functions shall also continue to be delegated to autonomous national institutions such as NRHs, RRHs, UHI, UCI, UAC, UBTS and other tertiary care institutions. Regulation shall be enforced through professional councils and the National Drug Authority whose role shall be expanded to include food items and its name changed to National Food and Drug Authority; and other authorised bodies. The Food Safety and Hygiene Act and the Public Health Act shall be enforced by local governments. Research shall be coordinated by the UNHRO and implemented by various institutions, both public and private.

#### (b) Objective

- To strengthen the organisation and management of the national health system.

#### (c) Strategies and key interventions

- *Ensuring that the MoH central level and other appropriate national level autonomous institutions carry out their core functions effectively and efficiently.*
    - Train managers at all levels in leadership, planning and management including financial management.

- Recruit and sustain an optimum number of health workers to effectively deliver the minimum health care package as defined in the NHP II.
- Allocate adequate resources at all levels of health care with a special focus on the districts.
- Design, pilot and implement appropriate service delivery models for hard to reach areas and disadvantaged population groups such as the rolling out of mobile clinics in such places for mobile populations.
- Establish, operationalise and sustain a regional tier in all the regions in Uganda.
- Establish, train and sustain VHTs in all villages in Uganda.

- *Ensuring that complete, reliable and timely health management information for health care is provided and shared among all stakeholders in the health sector.*

  - Train staff in the health sector at central and district level in data collection and analysis and writing of reports.
  - Recruit and deploy adequate and appropriately trained staff to manage HMIS at all levels.
  - Involve the private sector in HMIS activities.

- *Strengthen the partnership between the private sector and the public sector.*

  - Establish, operationalise and sustain the PPPH at district level.
  - Conduct quarterly PPPH meetings at national and district level.

**(d) Indicators with targets**

- No. of managers trained in leadership, planning and management.
- Vacant positions at district and lower levels reduced from 51% to 20%.
- PPPH established, operationalised and sustained at district level.
- No. of PPPH meetings conducted per annum at district and national level.
- Regional tiers established in all regions and functional.
- No. of service delivery models designed, piloted and established for disadvantaged population groups.
- A fully functional HMIS and data available to all stakeholders every quarter in all the districts.
- The percentage of districts with operational VHTs increased from 31% to 100%.

**(e) Implementation arrangements**

The Department of Planning in the MoH has the overall responsibility of policy formulation, development of overall sector strategic plans and guiding current and future investments in the health sector among other responsibilities. In order to ensure that the above strategies and interventions are implemented, the Department of Planning will liaise with different departments within the MoH and outside. The Department of Planning will work with:

- Department of Human Resource Management and Development in order to build capacity in management, accounting, planning and other requisite skills at different levels of health care. Local governments will have the responsibility to build such capacities at district and HSD and lower levels.

- Resource Centre and the HIDM to make the HMIS *functional* and the installation of ICT infrastructure including the necessary software for management and delivery of care, respectively.
- Local Governments to identify hard to reach areas and other disadvantaged population groups, design specific strategies for reaching such groups and ensure that these are included in their district implementation plans.
- Ministry of Finance to ensure that adequate financial resources are allocated and transferred for district health services and that allocation shall be based on need.

Lastly, communities shall participate in the delivery of health services through VHTs and HUMCs and adequate resources shall be made available in order to ensure that all VHTs have been trained during the implementation of the HSSP III.

### 6.2 Hospitals

#### (a) Issues

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

#### (b) Objectives

- To improve access to equitable and quality hospital services at all levels in both the public and private sectors.

#### (c) Strategies and interventions

- *Strengthen the capacity of hospitals to provide specialised care.*

    - Train managers of hospitals at all levels in leadership, management and planning.
    - Train key workers in emergency response in all hospitals.
    - Recruit adequate personnel inncluding financial managers to effectively manage care in hospitals and lower levels.
    - Allocate adequate financial resources for effective delivery of hospital care.
    - Conduct quarterly supportive supervision to lower level facilities.
    - Provide adequate ambulances (both motorcycle, vehicle and boat where required) for referral of cases from lower level facilities to hospitals.
    - Establish functional accident and emergency units in all RRHs.
    - Install adequate ICT in hospitals and lower level facilities to facilitate referral.

- Develop and sustain standards of best practice in all hospitals.

- *Increase the range of health services provided by hospitals.*

  - Provide basic care for common illnesses including non-communicable diseases and injuries.
  - Provide specialised hospital care.
  - Introduce palliative care in all HCIVs and above.
  - Train health workers in infection prevention and control.
  - Scale up infection prevention and control in hospitals.
  - Procure appropriate equipment for infection prevention and control for all hospitals.
  - Provide public education on prevention and control of common illnesses and injuries
  - Ensure availability of essential medicines and supplies.

- *Improve quality of hospitals in line with BFHI and CFHI.*

  - Conduct baseline assessment to establish quality standards for newborn healthcare.
  - Develop, print and disseminate standard guidelines on minimum standards for newborn care.
  - Conduct peri-natal death audits.
  - Conduct internal and external assessments in order to certify health facility as Baby Friendly.

**(d) Indicators with targets**

- The proportion of public hospitals managed by trained managers increased to 60%.
- The functionality of the HC IVs increased from 5% to 50%.
- A fully functional national referral system.
- Standards for best practice in hospitals established by 2012.
- Infection control committees established and functional in all hospitals.
- The proportion of vacancies in hospitals reduced by 50%.

**(e) Implementation arrangements**

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

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

- Management of hospitals shall work with the Department of Human Resource Managament in the MoH to train hospital managers including Boards and Committees.
- MoH shall work with the respective service commissions to recruit, promote and retain staff to fill existing vacancies in the hospital sub-sector.
- The MoH shall work with the training institutions in order to increase the number of health workers they train so that an adequate number of health workers are available on the market.

- The MoH shall be responsible for ensuring that all lower health facilities have or have access to adequate logistics for referral including vehicles and ICT.
- The Department of Clinical Services will ensure regular technical support supervision and ensure that the minimum set standards are adhered to.
- The Department of Clinical Services shall ensure that infection control practices are established and observed in all health facilities and that up to 50% of health facilities have palliative care services.

### 6.3 Uganda National Minimum Health Care Package (UNMHCP)

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

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

The composition of the package shall be revisited periodically depending on changes in disease burden, availability of new interventions to address these conditions, changes in the cost-effectiveness of interventions and the total resource envelope available for service delivery and shall be based on available evidence. Greater attention shall be paid to ensure equitable access to the minimum package including affirmative action for underserved areas, vulnerable populations and continuum of care. The implementation of the minimum package in the HSSP II was limited by inadequate resources, both human as well as financial, at all levels of health care. The *objective of the minimum package cluster* is to ensure universal access to quality UNMHCP consisting of promotive, preventive, curative and rehabilitative services for all priority diseases and conditions, to all people in Uganda, with emphasis on vulnerable populations. The following strategies shall be used to achieve this objective:

- Priority shall be given to interventions proven effective against diseases targeted for control, elimination or eradication, and in conjunction with the private sectors provide in an integrated manner, promotive, preventative, curative and rehabilitative services that have been proven effective, cost effective and affordable.

- Ensuring that all people in Uganda, both users and providers of health services, understand their health rights and responsibilities through implementation of comprehensive advocacy, communication and social mobilisation programs.

- Improving people's awareness about health and related issues in order to bring about desired changes in knowledge, attitudes, practices and behaviours regarding the prevention and control of major health and nutrition problems in Uganda. In order to achieve this, government will promote the use of social marketing and establish a clear marketing plan that will be pro-active

in targeting groups with the greatest need and use varying media according to the target audience.

- Strengthening responsible self-care, especially at primary care level, for selected health problems and patient categories through carefully planned and evaluated- pilot phases.

- Strengthening community health services.

- Prevention, management and control of communicable diseases.

The objective and strategies detailed above apply to all the clusters of the minimum package. The following sections describe in detail the issues, objectives, strategies, interventions, targets and the implementation arrangements for each of the clusters.

### 6.3.1 Health promotion, disease prevention and community health initiatives

Over 75% of Uganda's disease burden is considered preventable as it is caused by poor hygiene and sanitation. Malaria, ARIs, diarrhoeal diseases, AIDS and vaccine preventable diseases can all be prevented as effective preventive measures exist. This cluster supports other clusters through creating awareness about diseases and health in general, strengthening community capacity for health promotion and improving service delivery and promotion of community participation in the delivery and management of health services.

There are 4 elements of the health promotion and disease prevention cluster namely: HPE, environmental health, school health and epidemic and disaster prevention, preparedness and response. This section presents the objectives, strategies, targets and implementation arrangements for each of these elements.

#### (i) Health promotion and education

#### (a) Issues

Prevailing cultural beliefs constitute one of the major determinants of health seeking behaviour in most African countries. Uganda is no exception: 60% of the people seek care from TCMPs before presenting to modern health facilities. People might be ignorant about the aetiogy of disease and how to prevent ill health. HPE helps to address these issues and should therefore be a component of all health programmes as it promotes behavioural change. The major thrust in health promotion and disease prevention has been the establishment of VHTs at community level to facilitate creation of awareness, community participation and delivery of efficient and effective health interventions at community level. Only 31% out of the districts so far have functional VHTs. Inadequate funding has led to delayed implementation of the VHT strategy.

At district level there is also inadequate capacity for planning and implementation of HPE activities mainly due to shortage of health educators. While demand for information has been created at community level, the need for IEC materials is not being met because of the lack of funding. During HSSP III these shortfalls shall be addressed through mobilisation of adequate resources for rolling out the VHT strategy to all districts in Uganda.

**(b) Objective**

- To promote individual and community responsibility for better health and to advocate for HSSP III.

**(c) Strategies and interventions**

- *Strengthen IEC initiatives to bring about changes in health and related behaviours among people in Uganda.*
    - Set standards and guidelines for the production and delivery of IEC messages among institutions that are responsible for such activities.
    - With involvement of VHTs, increase community awareness on safe water and sanitation practices, garbage disposal and other disease prevention approaches.
    - Incoporate health education in primary school curricula.

- *Mobilising adequate resources for rolling out the VHT strategy in all the districts.*
    - Complete the establishment and training of VHTs in all the districts in Uganda.
    - Provide adequate tools (e.g. registers, IEC materials) to make the VHTs operational.
    - Provide the necessary incentives to VHTs as detailed in the NHP II.
    - Pool resources from programs for the common functions of VHT which cut across programs.

- *Initiate and implement advocacy programmes to influence provision of effective preventive health services.*
    - Advocate for enforcement of protective legislation e.g. seatbelt use, policing drunk driving, pollution control, restricted smoking, fiscal policy for tobacco and alcohol.
    - Promote the development and enforcement of byelaws by district local governments.

- *Strengthen intersectoral linkages for health promotion.*
    - Identify the roles of different government ministries and departments in health promotion and ensure they do their part.
    - Ensure participation of different ministries and departments during the NHA and JRM.

**(d) Indicators with targets**

- Standards and guidelines for the production and delivery of IEC messages developed and disseminated among institutions.
- Health education incorporated in primary school.
- The proportion of districts with trained VHTs increased from 31%to 100%.
- The proportion of health facilities with IEC materials at 100%.
- The proportion of people seeking health services according to national standards from 71% to 100% (seeking treatment within 24 hours).

**(c) Implementation arrangements**

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

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

At district level the District Director of Health Services (DDHS) shall be responsible for planning, management, monitoring and coordinating IEC activities and will work with all agencies including the District Information Office. Operational plans will also be developed for HPE with the leadership of the DDHS. At health centre level HPE activities will be carried out by available health professionals and VHTs and this will be based on need and health problems most prevalent at household and community level. The effective implementation of this component of the health promotion and disease prevention cluster will depend on effective coordination and a multisectoral approach to programming of HPE activities.

**(ii) Environmental health**

**(a) Issues**

Environmental health factors such as availability of safe water, safe human excreta, solid and liquid waste disposal facilities, health care waste management, practicing good personal, domestic and food hygiene, occupational health and safety including disease vector control and at the same time promoting behavioural change and practices to improve hygiene and sanitation are major determinants of health outcomes. The Environmental Health, Health Promotion and Disease Prevention Cluster therefore focuses on improving the above environmental health factors. Poor hygiene and other environmental health factors which are often linked to disease and poverty are the major causes of ill health in Uganda. The 2006 UDHS shows that 59% of the households have pit latrines; 77% have access to safe water sources; 75% live in houses made of temporary material; and 14% of persons wash hands with soap. Only 25% of the districts are implementing water quality surveillance.

There are a number of factors that are responsible for this situation: inadequate allocation of resources for environmental health activities; inadequate human resource; high levels of poverty; and inadequate facilitation especially transport. Climate change which is related to global warming has significant impact on human health, environment and health service delivery. The increase in temperatures has an influence on the geographical range of diseases e.g malaria and diarrhoeal related illnesses. Climate patterns such as El Nino result into flooding which exacerbates the spread of waterborne diseases like cholera, typhoid and dysentery. Uganda has experienced some of these impacts of climate change; hence the need to pay attention to climate change and related issues.

During the implementation of HSSP III priority shall be given to provision of adequate resources for environmental health programmes and the private sector in particular shall be mobilised to be involved in these activities. Special attention shall be given to addressing poor sanitation and hygiene to move households up the sanitation ladder from slums to facilities that can be cleaned and having hand washing facilities next to them, water quality surveillance, food hygiene and safety, occupational health and safety and increasing awareness about climate change and its impacts.

**(b) Objective**

- To contribute to the attainment of a significant reduction of morbidity and mortality due to environmental health and unhygienic practices and other environmental health related conditions.

**(c) Strategies and key interventions**

- *Advocate and promote improved sanitation and hygiene as detailed in the Kampala Declaration on Sanitation.*

    - Conduct home improvement campaigns and establish model villages in all districts in Uganda.
    - Sensitize political, religious and cultural leaders on the importance of sanitation and hygiene promotion.
    - Implement Participatory Hygiene and Sanitation Transformations (PHAST) and Community Led Total Sanitation (CLTS).
    - Train staff in the Environmental Health Division and the private sector on emerging technologies dealing with the promotion of sanitation and hygiene.

- *Support and encourage Local Governments to formulate ordinances and bye-laws on environmental health and ensure that they are enforced.*

    - Sensitize local governments on formulation and implementation of environmental health bye laws and ordinances.
    - Train local governments in the development and implementation of environmental health bye laws and ordinances.
    - Train law enforcers on new bye laws and ordinances.

- *Strengthen the capacity of public and private health care providers in health care waste management.*

    - Develop guidelines for health care waste management.
    - Sensitize health workers and private health care providers in health care waste management.
    - Provide facilities at all health facilities for health care waste management.

- *Support and advocate for food hygiene and safety, safe water chain and hand washing with soap and mass hand washing campaigns.*

    - Disseminate the food hygiene and safety, safe water chain and hand washing guidelines.
    - Support local governments to enforce food hygiene and safety, safe water chain and hand washing standards

- *Streamline climate change and improve adaptation within the health sector.*

- Develop guidelines on streamlining climate change in the health sector to improve adaptation to climate change impacts.
- Sensitize staff at the MoH and local governments on climate change and adaptation.
- Develop early warning systems and disseminate weather forecasts to health managers to improve preparedness and response.
- Coordinate climate change response interventions in health sector and collaborate with relevant line ministries and agencies.

**(d) Indicators with targets**

- The proportion of households in Uganda with pit latrines increased from the current 67.5% to 72%.
- The proportion of districts implementing water quality surveillance and promotion of safe water chain/consumption increased from 30% to 50% by the year 2015.
- The proportion of households with hand washing facilities with soap increased from 22% to 50%.
- The proportion of health care workers and private health care providers trained in health care management and occupational health and safety increased.
- The proportion of health workers in the formal and informal sector sensitised on occupational health and safety increased to 30%.

**(e) Implementation arrangements**

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

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

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

### (iii) School health programmes

#### (a) Issues

These programmes were introduced in HSSP I to provide comprehensive preventive and promotive health services to school going children and instil healthy habits and practices in children. The full implementation of the school health programmes in HSSP II were hampered by the lack of a school health policy and an MoU between the MoE and MoH, understaffing at MoH and local government level and the poor enforcement of available guidelines in local governments. During the implementation of the HSSP III focus for school health programmes will be on primary and secondary schools and teachers training institutions. The MoU will be instituted and the School Health Policy will be in place. It is expected that the school health programmes will improve the health of school children, reduce dropout rates and increase school perfomance.

#### (b) Objectives

- To improve the health status of the school children, their families and teachers and to inculcate health seeking behaviour among this population.

#### (c) Strategies and interventions

- *Advocate for the review and enforcement of the school health policy and school health service standards.*
    - Finalise the School Health Policy.
    - Sign the MoU with the MoES to govern the implementation of school health programmes.
    - Develop and operationalise school health and health services standards.

- *Strengthen the capacity of districts to implement school health programmes.*
    - Allocate adequate resources for implementation of school health pogrammes at district level.
    - Orient district level staff including teachers on school health programmes.
    - Recruit adequate personnel for implementation of school health programmes at district level.

- *Expand the provision of clean water and improved sanitation to schools.*
    - Install clean and safe water sources in both primary and secondary schools including the distribution of water treatment chemicals to control outbreaks of waterbourne diseases.
    - Support the construction of safe latrines in both primary and secondary schools.

#### (d) Indicators with targets

- School health policy finalised and implemented.
- A memorandum of understanding between MoE and MoH developed, signed and implemented.
- The proportion of schools in Uganda that provide basic health and nutrition services increased from 50% to 100%.

- The proportion of primary and secondary schools with safe water source within 0.5 km radius of the school increased from 60% to 80%.
- The proportion of primary and secondary schools with pupil per latrine stance ration of 40:1 or better increased from 57% to 80%.

**(e) Implementation arrangements**

The implementation of school health programmes will be a joint responsibility of the MoES and MoH but it will also involve other school health stakeholders. These will be responsible for the development and implementation of the school health programmes.

- The MoH will provide guidelines and technical supervision to all districts while monitoring shall be a joint excercise between MoH and MoE.

The MoH, MoE and stakeholders shall ensure that all schools are properly equipped to provide health education and health promotional activities. The DHO will coordinate school health programmes at district level but will also work with District Education Office to ensure that these programmes are implemented.

### 6.3.2 Epidemic and disaster prevention, preparedness and response

**(a) Issues**

Over the years Uganda has been prone and has also experienced disasters such as floods, drought, famine and epidemics such as Ebola, Marburg, meningitis and cholera among others which have far reaching social and economic implications including decreased tourism, trade and opportunities for investment both from within and outside of Uganda. The environmental degradation, global warming and climate change are further exacerbating the vulnerability of the population. During the HSSP II mechanisms for disaster preparedness and response in all the districts were established but inadequate resources and logistics, weaknesses in planning for emergencies, understaffing and lack of skills especially at lower levels and the fact that epidemic and disaster prepadness is not given priority at district level hampered the country's response system. The GoU will therefore target to improve its preparedness and response to disasters and epidemics to reduce morbidity and mortality from these events.

**(b) Objectives**

- To prevent, detect early and promptly respond to health emergencies and other diseases of public health importance.

**(c) Strategies and key interventions**

- *Strengthen epidemic, disaster prevention, preparedness, response and management at all levels.*
    - Train health workers (including VHTs) at district level on early detection of epidemics, preparedness, respeonse and management.

- Establish appropriate coordination mechanisms within the country and with the neighbouring countries on management of epidemics.
- Develop emergency preparedness and response plans including contingency planning at all levels.
- Conduct vulnerability and risk mapping exercise to guide policy and strategy development.
- Produce and make available Standard Operating Procedures (SOPs), formats and tools at all levels.
- Ensure contingency stock piling at strategic sites for priority diseases.
- Advocate for allocation of adequate resources for disaster prevention, preparedness and management.

- *Strengthen integrated disease surveillance, with particular emphasis on the early warning system and linkage with meteorological forecasts.*

  - Establish and sustain a reliable and functioning early warning system.
  - Expand coverage of the IDSR Strategy.

**(c) Indicators with targets**

- The proportion of suspected disease outbreaks responded to within 48 hours of notification increased from 52% to 80%.
- The proportion of districts with functional epidemic preparedness and response committees increased from 76% to 100%.
- The proportion of districts with epidemic preparedness plans increased to 100%.
- A fully functional integrated disease surveillance system.
- The timeliness and completeness of weekly and monthly reports maintained at greater than 80%.
- CFR rates maintained within the acceptable ranges for the various outbreaks.

**(e) Implementation arrangements**

At national level the Department of National Disease Control (NDC) has the responsibility for the development of the national strategy for prevention and control of epidemics, carrying out national disease surveillance and training of DHMTs in disease control. A new IDSR/EPR/IHR strategic plan corresponding to the HSSP III period has been developed and will be the basis for implementation of interventions/activities to strengthen epidemic and disaster prevention, preparedness and response. International Health Regulations (2005) shall be adhered to in the course of EPR. This NDC department shall be responsible for coordination of these interventions. The Department of National Disease Control:

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

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

### 6.3.3 Nutrition

#### (a) Issues

The nutritional situation of the population is generally poor especially among under fives, children of school going age, women of reproductive age, the elderly, the displaced and those with communicable and non-communicable diseases. Data from the previous three Demographic Health Surveys (DHS) in Uganda report high levels of child and maternal under nutrition that have not changed much over the past 15 years. For example, the latest UDHS of 2006 shows that 38 % of children under five years in Uganda are stunted, 16% are underweight, and 6% are wasted. Child under nutrition in Uganda reflects poor maternal nutritional status: over 12% of women of reproductive age have chronic energy deficiency (low body mass index) while 17% are overweight. There is a wide spread micronutrient deficiency: 50% of women and 73% of children under 5 years are anaemic, 20% of children under 5 years and 19% of women are vitamin A deficient (UDHS 2006). Sub-optimal child care and inappropriate feeding practices, impact on the health and nutrition of children. Only 60% of infants 0-6 months are exclusively breastfed and at 4-5 months only 35% of infants receive breast milk only and this has been complicated by the HIV infection. Malnutrition start early in foetal life and this includes foetal retardation, iodine deficiency and anaemia, however most irreversible stunting takes place between one and two years. Although there is widespread consumption of iodized salt, goitre is still commonly seen in the population. There is evidence from the field that other micronutrient deficiencies such as zinc and folate exist. Malnutrition makes the population vulnerable to infections and other diseases and contributes to 60% of under five deaths. Despite the variety of interventions by the government and other stakeholders to address nutrition issues, malnutrition levels remain unacceptably high.

#### (b) Objectives

- To reduce the incidence and prevalence of macro- and micro-nutrient deficiencies and associated mortality among vulnerable groups.
- To improve access and quality of nutrition services at facility and community levels.
- To review, formulate and enforce nutrition related regulations and standards in consultation with other relevant stakeholders.
- To strengthen advocacy, social mobilization for behavioural change.
- Strengthen nutrition information management systems for monitoring and evaluating nutrition interventions programs.

#### (c) Strategies and interventions

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

- ***S****trengthen maternal nutrition interventions to ensure adequate pregnancy outcomes and healthy infancy.*

- Provide micronutrient supplements, iron and folic acid tablets to adolescents in and out of school and to pregnant and lactating mothers.
- Provide post-partum supplementation with vitamin A, iron and folate.
- Encourage and support antenatal care services through health and nutrition education.
- Promote the consumption of high nutrient density local foods during the reproductive age especially during pregnancy and lactation

- *Integrate infant and young child nutrition interventions into maternal, infant and young child services to ensure growth and development.*

  - Provide counselling during ante-natal and post-natal care to promote and support exclusive breastfeeding.
  - Provide continued and intensified growth monitoring and promotion with intensive counselling to address needed behavioural change, and referral as necessary for facility-based attention.
  - Support infant and young child feeding in the context of HIV.
  - Promote and support exclusive breastfeeding for six months, timely introduction of adequate complementary feeding, and continued breastfeeding to at least 24 months.
  - Provide semi-annual Vitamin A supplementation and deworming to targeted groups.

- *Scale up micronutrient supplementation of vitamin A, iron and folic acid.*

  - Develop a comprehensive policy framework for micronutrient deficiency control.
  - Provide support for implementation of a consolidated policy on micronutrient deficiency control.
  - Advocate for the control and prevention of micronutrient deficiencies.
  - Control iodine deficiency disorders.
  - Provide Vitamin A supplementation for children and post partum women.
  - Deworm young children, school children and pregnant women.
  - Promote food fortification, particularly of complementary foods with vitamin A, iron, zinc and other micronutrients.
  - Control of zinc deficiency through food fortification and supplementation as part of diarrhoea management.

- *Promote good quality diets through diet diversification.*

  - Conduct nutrition education and counselling at facility, family and community levels.
  - Promote consumption of locally produced fortified foods.
  - Encourage the production and preparation of a variety of locally available nutritious foods.

- *Integrate the management of malnutrition into the health delivery system.*

  - Identify, screen, refer and manage cases of acute malnutrition at community and facility level.
  - Support nutrition management and support of sick children following IMCI protocols.
  - Support institutional feeding.
  - Promote local production of commercial and therapeutic diets.
  - Procure anthropometric nutrition equipment, demonstration and food preparation equipment.

- *Integrate nutrition into the treatment and management of HIV/AIDS, TB, malaria, etc.*

    - Incorporate nutrition support into the management and treatment of HIV/AIDS, TB and malaria interventions.
    - Establish coordination mechanisms among partners involved in food and nutrition and HIV, TB and malaria interventions.
    - Support community involvement in provision of nutrition support to HIV/AIDS and TB patients.

- *Strengthen nutrition information management system for monitoring and evaluating nutrition programs.*

    - Routinely monitor service delivery, evaluate impacts, and surveillance sites to assess trends.
    - Conduct basic and operational nutrition research.

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

- *Build the infrastructure and human resource capacity at central, district and lower levels and communities for improvement of nutrition.*

    - Procure equipment for nutrition management like weighing scales, MUAC tapes, and height meters.
    - Conduct pre- and in-service training for service providers to promote nutrition interventions.
    - Develop curricula and training manuals for nutrition training.
    - Determine the human resource needs for nutrition services.
    - Train trainers and equip the VHTs, community resource persons and other community based organizations with nutrition knowledge and skills.
    - Provide technical support supervision and mentoring of health workers.

**Objective 3: To review, formulate and enforce nutrition related regulations and standards in consultation with other relevant stakeholders**

- *Develop and disseminate nutrition policy and implementation guidelines.*

    - Initiate the review and up-date of the Uganda National Food and Nutrition Policy (2002)
    - Develop implementation guidelines for the reviewed Uganda National Food and Nutrition Policy and other related nutrition policies.
    - Orient stakeholders on the revised Uganda National Food and Nutrition Policy.

- *Strengthen nutrition related standards and regulations.*

    - Review the regulations on salt iodization.
    - Support the development of the Codex on complementary foods.
    - Develop a regulatory framework for food fortification.

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

- *Strengthen advocacy, social mobilization and communication at all levels.*

    - Develop and disseminate nutrition IEC materials using mass media including print, audio, visual and print media.
    - Develop a comprehensive nutrition communication strategy.
    - Mark the World Food Day and the World Breastfeeding Week.

- *Strengthening inter-sectoral collaboration and public-private partnership in the design and implementation of nutrition programs*

    - Operationalise the National Food and Nutrition Council and its secretariat.
    - Conduct National, regional and district coordination and planning meetings.

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

- *Strengthen the regular collection of nutrition indicators on underweight, vitamin A, iron and folic acid supplementation in the HMIS.*

    - Establish nutrition sentinel sites to assess trends.
    - Conduct basic and operational nutrition research.
    - Collaborating with UBOS in collection of nutrition indicators during annual food consumption surveys.
    - Conduct periodic nutrition surveys.

**(d) Indicators with targets**

- The proportion of underweight in under five year children reduced from 16% to 10%.
- Vitamin A deficiency among children 6-59 months reduced from 20% to 10% and women of reproductive age from 19% to 9%.
- The proportion of stunted children below 5 years reduced from 38% to 32%.
- Vitamin A supplementation coverage increased for children aged 6-59 months from 60% to 80%.
- Deworming coverage for children 1-14 years increased from 60% to 80%.
- Iodine deficiency eliminated.
- The proportion of the households consuming iodised salt increased from 95% to 100%.
- The prevalence of anaemia among children decreased from 73% to 60%, women from 49% to 30% and men from 28% to 15%.
- The proportion of underweight women of reproductive age decreased from 12% to 6%.
- Exclusive breastfeeding at 6 months increased from 60% to 80%.
- Accessibility to nutrition information and knowledge increased to 100%.
- Nutrition services to health units and the community scaled up to 100%.

**(e) Implementation arrangements**

In order to address the problem of malnutrition in Uganda a multi-sectoral approach is required. While the MoH and Ministry of Agriculture are the line ministries dealing with food and nutrition security it is

necessary that other government ministries and departments, CSOs and the private sector should participate in the fight against malnutrition. The implementation of nutrition activities in Uganda shall be guided by the UFNP and the policy guidelines on infant and young child feeding developed in 2009[39].

At national level the Nutrition Unit at the MoH headquarters shall be responsible for coordinating nutrition activities and lead the process of formulating policies and guidelines relating to nutrition. In order to do this it shall work with other departments within the MoH, other government ministries and departments, the UNFNC and other stakeholders. The Unit shall provide technical support to the DHO including supervision. At district level the DHOs shall be responsible for coordination of nutrition activities. VHTs at community level shall be capacitated to provide the necessary nutrition education and other nutrition related interventions to members of the community and build capacity of the community to become active participants in nutrition programs. Annex 5 shows the logframe for nutrition.

### 6.3.4 Control of Communicable Diseases

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

#### (i) Prevention and Control of STIs/HIV/AIDS

#### (a) Issues

Inside a quarter of a decade, HIV/AIDS remains a major health concern. Uganda has made great progress in HIV/AIDS service delivery and prevention since the advent of the epidemic in 1982. By 2008, HIV testing and counselling services were provided in more than 50% of health facilities. More than 830,000 pregnant women were tested and received their HIV status results in 2008. PMTCT and ART services were provided in 66% and 83% of the health facilities respectively that are supposed to provide such services, according to the ACP annual report 2008/09. By the end of September 2009, there were 200,213 receiving ARVs, 8.5% of them being children. The need to integrate these successful HIV services with others especially TB, RH and MCH is now a glaring issue.

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

[39] Ministry of Health.MoH. (2009). Policy guidelines on infant and young child feeding. Kampala: Ministry of Health.MoH.

prevalence rates among these populations (CRANE Study 2009). There are also challenges in programme management and coordination of the national response to HIV and AIDS. The multi-sectoral approach brought in very many actors which created parallel systems for service delivery. This phenomenon weakens the existing health support systems. The best example is the Health Management Information System (HMIS) of the MoH that has been made more or less dysfunctional by partners setting up their own separate systems for monitoring and evaluation of their programs. This affects data availability and accuracy useful for planning, programme reporting and improvement which subsequently renders it difficult for MoH to ensure equitable and, and cost-effective delivery of HIV services in the country. In addition, in this era of the global recession, financial resources for the HIV response seem to have peaked and flattened. This calls for review of the health sector interventions to ensure "value for money" and the GoU needs to allocate more funds for control of the HIV and AIDS epidemic.

**(b) Objectives**

- To contribute to attainment of a good standard of health of the population through prevention of STI/HIV/TB transmission and mitigation of the medical and personal effects of the epidemic.

**(c) Strategies and key interventions**

- *Strengthen all aspects of HIV prevention namely reduction of sexual transmission of HIV, prevention of MTCT of HIV and prevention of HIV transmission through blood and blood products.*

    - Increase the distribution of free condoms targetting among others discordant couples and people in stable relationships.
    - Scale up social marketing of condoms to general and high risk populations.
    - Review and harmonise all curricula and materials relevant for HIV and AIDS trainings.
    - Provide life skills education targetting both youth in and out of school.
    - Provide HCT services in all HC III and higher level facilities and community HCT especially in high prevalence communities.
    - Promote the practice of male circumcission.
    - Extend the provision of PMTCT services to all HC IIIs and make it an integral component of antenatal services.
    - Screen all blood for transfusion for HIV and other blood transmissible infections befor transmission.
    - Provide PEP to health workers and other populations in need.
    - Train health workers in management of STIs.
    - Increase and sustain the distribution of free male and female condoms.

- *Improve access to quality HIV treatment and care services at all levels including treatment for opportunistic infections.*

    - Provide ART including paediatric ART to all those who are eligible.
    - Monitor and improve ART treatment protocols and train health workers accordingly.
    - Scale up supportive home based care to ensure that PLHIVs are treated and counselled at home.
    - Review, update and disseminate therapeutic feeding guidelines and protocols for PLHIVs.
    - Ensure that essential, efficacious, safe, and quality HIV related medicines are available and rationally used.

- *Strengthen coordination and management of HIV programs at all levels.*

    - Facilitate the functionality of the national and decentralised coordination structures.
    - Establish and operationalise a comprehensive National HIV/AIDS monitoring and evaluation framework for proper monitoring and reporting.
    - Put in place a partnership framework to guide private sector participation in delivery of HIV/AIDS services.
    - Mainstream HIV/AIDS in planning and budgeting at national and local government level.

- *Strengthen the policy and legal environment for the national HIV/AIDS response.*

    - Finalise the National HIV/AIDS Policy.
    - Promote the development and implementation of the sectoral HIV/AIDS policies.
    - Enact the HIV/AIDS Bill.
    - Print and disseminate the HIV/AIDS Policy and the HIV/AIDS Bill.
    - Train law enforcers on HIV/AIDS legislation and policy.

- *Strengthen IEC and community mobilisation initiatives with emphasis on the ABC principle.*

    - Develop and print IEC materials on HIV prevention, treatment and management targetting most at risk populations.
    - Produce and broadcast HIV/AIDS programmes on major radio and television channels.

**(d) Indicators with targets**

- HIV prevalence among pregnant women 19-24 yrs attending antenatal clinics reduced from 7% to 4%.
- The proportion of people who know their HIV status increased from 38% to 70%.
- The proportion of people who are on ARVs increased from 53% in 2009 to 75% by 2015 among adults and from 10% to 50% in children less that 15 years of age.
- The proportion of children exposed to HIV from their mothers access EID program increased to 75%.
- Th eproportion of pregnant women accessing HCT in ANC increased to 100%.
- HCT services available in all health facilities up to HC III.
- PMTCT services available in all health facilities up to HC III.
- ART services available in all health facilities up to HC IV and 20% of HC III by 2015.
- The proportion of males circumcised increased from 25% to 50%.
- HIV Prevalence remains at 6% in the general adult population.

**(ii) Tuberculosis**

**(a) Issues**

The burden of Tuberculosis is still high with annual notifications at about 50,000 cases. The community TB DOTS has been expanded to all districts. Challenges however remain: only 50% of cases nationwide

are notified for various reasons; under staffing; lack of laboratory equipment; weaknesses surrounding community mobilisation; and that even though the cure rate target is at 85% globally in Uganda this has not been achieved – it is still at 73%.

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

**(b) Objectives**

- To reduce the morbidity, mortality and transmission of tuberculosis.

**(c) Strategies and interventions**

- *Expand and consolidate high-quality DOTS services in all districts by 2010.*

    - Conduct case detection through quality-assured bacteriology.
    - Provide standardised treatment, with supervision.
    - Carry out contact tracing and tracing treatment interrupters.
    - Ensure uninterrupted drug supply and management system.
    - Sustain EQA coverage at all Diagnostic and Treatment Units (DTUs) in the districts.
    - Mobilise communities to participate in CB-DOTS in all districts with involvement of VHTs.
    - Provide TB preventive, diagnosis and treatment services among children in line with international standards (ISTC) and guidelines.
    - Operationalise the TB Infection Control plans at all DTUs nation wide.
    - Provide adequate resources for TB control.

- *Expand and strengthen TB/HIV collaborative activities, address MDR-TB and other challenges in special settings and populations.*

    - Consolidate implementation of TB/HIV services nationwide.
    - Operationalise programmatic management of Drug Resistant TB (DR-TB).
    - Develop a policy and legislation for drug resistance TB management.
    - Conduct drug sensitivity testing (DST) on all category II (Retreatment) TB cases reported by 2015.

- *Contribute to the Strengthening of health systems.*

    - Actively participate in efforts to improve sector-wide policy, service delivery, medicines and supplies management, information systems, health workforce, financing, Leadership & Governance at all levels of the NTLP
    - Strengthen systems for monitoring and evaluation of NTLP prevention and control
    - Adapt innovations from other fields: - integration within community, PHC outreach, social mobilization like HIV/AIDS, regulatory actions and financing schemes, PIA

- *Engage all care providers in TB care.*

- Enhance public-public and public-private mix in TB control.
- Maintain Village Health Teams (VHTs) participation and involvement in implementing DOTS as informal care providers in TB care.
- Re-invigorate ACSM activities so as to increase Central and Local Government commitment, community awareness and demand for TB services.
- Promote the application of International Standards of TB Care (ISTC).
- Strengthen the Uganda Stop TB Partnership.

- *Empower people with TB and the communities to participate in TB care.*

  - Advocate at national and district level for increased resources allocation (dedicated budget) for TB control.
  - Mobilise communities to participate in CB-DOTS in all districts
  - Improve ACSM activities for TB using VHTs, CBOs, patient organisations, communities – allocate roles for each beyond formal health sector.
  - Develop patients' Charter for Tuberculosis care.

- *Enable and promote operational and other research.*

  - Train NTLP staff to perform and oversee OR.
  - Conduct research to develop new diagnostics, drugs and vaccines.
  - Promote evidence based interventions as well as the practice of turning evidence into action.

- *Build capacity for TB control.*

  - Carry out a training needs assessment on DOTS management for laboratory staff, clinicians and SCHWs at DTUs.
  - Train general health workers in performance improvement approach and quality in the eyes of the clients for TB control activities.
  - Train microscopists in peripheral laboratories.

**(d) Indicators with targets**

- TB case detection rate increased from 57.3 to 70%.
- TB cure rate increased from 75 to 85%.
- TB associated death rate reduced from 4.7 to 2.5%
- The proportion of TB cases on supervised DOT increased to 80%.
- DST uptake among smear positive Relapse cases (CAT II) increased to 75%.
- High False Negative (HFN) prevalence at DTUs reduced to less than 5% in all districts.

**(iii) Leprosy**

**(a) Issues**

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

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

**(b) Objectives**

- To sustain the elimination of leprosy in all the districts.

**(c) Strategies and key interventions**

- *Strengthen the capacity of health workers to diagnose and treat leprosy cases.*
    - Train health workers in diagnosis, treatment and referral of leprosy cases.
    - Equip program officers and managers with skills for advocacy, resource mobilisation and leadership.
    - Create awareness among community members to identify and refer cases of leprosy to health facilities.
    - Promote self care among persons affected by leprosy.

- *Conduct a sustained leprosy elimination and treatment campaign.*
    - Conduct active case finding in high burden areas.
    - Carry out systematic surveillance of contacts of new leprosy cases.
    - Build synergies with CBR teams at district and sub-county levels to address the rehabilitation needs of people with rehabilitation needs after completion of leprosy treatment.
    - Procure and distribute MDT and rehabilitative appliances.
    - Conduct monitoring and evaluation of progress in leprosy control and quality of care.
    - Conduct surveillance for drug resistance.
    - Conduct periodic examination of school children

**(d) Indicators with targets**

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

### (iv) Malaria

### (a) Issues

Malaria remains one of the major causes of morbidity and mortality in Uganda. During HSSP II progress was made in terms of seeking treatment within 24 hours after the onset of fever as well as coverage of IRS, ITNs and availability of antimalarials in health facilities at all levels. These modest gains were underpinned by several challenges and constraints such as**:** poor coordination and harmonization of partners to embrace the "three ones" principle; Inadequate procurement and delayed delivery of malaria commodities especially ACTs (Coartem); inadequate trained health workers in health facilities; and weak laboratory infrastructure for malaria diagnosis among other issues. In the current strategic plan, the sector will focus on a rapid scale up for impact, providing an enabling environment for implementation of key Malaria interventions. There will also be deliberate efforts to implement a comprehensive policy on malaria diagnostics and treatment, strengthen the procurement and delivery of malaria commodities, and strengthen RBM coordination mechanisms as well as M&E and general health systems. The goal for this component is to halt by 2015 and begin to reverse the incidence of malaria and thereby minimise the social effects and economic losses attributable to malaria in Uganda.

### (b) Objectives

- To reduce the mortality rate due to malaria in all age groups and in under-fives

### (c) Strategies and interventions

- *Strengthen measures to control malaria transmission.*
    - Procure and distribute LLINs and contribute to achieving universal coverage.
    - Expand coverage of indoor residual spraying to all endemic districts.
    - Disseminate and operationalise the comprehenmsive malaria prevention and control policy.
    - Ensure malaria epidemic preparedness and response.

- *Strengthen the implementation of a comprehensive policy on malaria diagnostics and treatment.*
    - Promote effective case management of malaria in pregnant women and underf-five children.
    - Ensure that all pregnant women access IPT.
    - Provide antimalarial drugs to VHTs for management of cases at community level.
    - Monitor drug supply chain to ensure availability of antimalarial drugs at community level.
    - Strengthen the RBM partrnership.

- *Strengthen IEC/BCC for malaria prevention and control*
    - Design and print IEC/BCC materials for malaria control and prevention.
    - Distribute IEC/BCC materials for malaria prevention.
    - Provide small grants to NGOs and CBOs to promote uptake of LLINs and IRS.
    - Training of DHT in planning, M&E, negotiation, advocacy, communication and social mobilization

- *Building national and sub-national capacity for Monitoring and Evaluation of malaria interventions.*

    - Train malaria officers in monitoring and evaluation at central and district level.
    - Orient VHTs on their role in monitoring and evaluation for malaria control.
    - Conduct periodic malaria indicator surveys to provide up todate information on coverage.

- *Build the capacity of health workers for malaria control, prevention and treatment.*

    - Scale up refresher training and supervision of diagnostic testing.
    - Procure supplies and equipment for diagnotic testing.
    - Training of health workers in the management of malaria.
    - Advocate for better resource allocation and mobilisation.

**(d) Indicators with targets**

- Incidence rate of malaria reduced in all age groups.
- Mortality rate associated with malaria in all age groups and in under-fives reduced.
- The proportion of under-fives with fever who receive malaria treatment within 24 hours from a community drug distributor increased from 70% to 85% by 2015
- The proportion of pregnant women who have completed IPT2 increased from 42% to 80% by 2015.
- The percentage of under-fives and pregnant women having slept under an ITN the previous night increased.
- The percentage of mothers and care takers knowledgeable bout malaria prevention measures increased.
- The percentage of mothers and caretakers of under-fives with appropriate recognition of signs and symptoms of malaria increased.
- The percentage of targeted structures for indoor residual spraying (IRS) in epidemic areas actually sprayed increased to 80% by 2015.
- The case fatality rate among malaria in-patients under five reduced from 4% to 2% by 2015.
- The percentage of households having at least one insecticide treated net (ITN) increased from 42% to 100% in 2015.
- The percentage of public and PNFP health facilities without any stock outs of first line anti-malarial medicines increased to 100% throughout the strategic plan period.
- The percentage of government health centres II and III and PNFP health centres without stockout of rapid diagnostic tests.
- All quarterly RBM partnership review meetings held.

**(e) Implementation arrangements for communicable diseases**

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

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

These disease programmes will take the lead in the coordination and implementation of their respective diseases. At district level the responsibility for coordinating and implementing communicable disease control programmes will be with the DDHS who will in turn support and provide guidance to HSDs to develop their annual operational plans and budgets. At community level the VHTs will play an important role in the mobilisation of their respective communities for the prevention and control of communicable diseases. Annex 6 is a logframe for the prevention and control of communicable diseases.

### 6.3.5 Diseases targetted for elimination

There are a number of diseases that have been targeted for elimination or eradication by the international community. Uganda as a signatory to the treaties and conventions for the elimination of certain diseases is committed to these processes. The diseases targeted for elimination and/or eradication are as follows: poliomyelitis, guinea worm, onchocerciasis, measles, leprosy, trachomalymphatic filariasis, trypanosomiasis and schistosomiasis. During the HSSP III emphasis will also be to strengthen crossborder disease control initiatives if Uganda will be on track to eliminate these diseases. The overall objective for this cluster of diseases is to achieve national and global targets for elimination or eradication of targetted diseases. This section gives details on objectives, strategies, targets and implementation arrangements for the control and prevention of diseases targetted for elimination.

#### (i) Guinea Worm

#### (a) Issues

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

#### (b) Objectives

- To maintain the Guinea Worm free status of the country through maintenance of high quality post-certification surveillance.

#### (c) Strategies and key interventions

- *Strengthen the existing surveillance systems for elimination of guinea worm*

- Conduct and maintain high quality community-based surveillance through village health teams and sub-county supervisors.
- Carry out prompt and in-depth investigation of all rumors of suspected cases and containment of any imported cases.
- Implement an enhanced and nation-wide reward scheme for the improvement of sensitivity of surveillance.
- Work with neighbouring countries to ensure eradication of guinea worm.

- *Expamd the treatment and control of guinea worm in Uganda*

  - Manage and contain all cases of guinea worm.
  - Work with other stakeholders such as the Ministry responsible for water and CSOs to increase access to safe water supply in endemic districts and repair of broken down boreholes.
  - Advocate for more financial resources for the control and prevention of guinea work.
  - Control vectors through application of Abate to ponds and other water bodies.

- *Build the capacity of health workers for control and prevention of guinea worm.*

  - Provide refresher training for health workers involved in the treatment, control and prevention of guinea worm.
  - Conduct regular training of VHTs and community members.

**(d) Indicators with targets**

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

**(ii) Onchocerciasis**

**(a) Issues**

Onchocerciasis is endemic in 29 districts of Uganda mainly those bordering the Democratic Republic of Congo, where more than 2. 5 million people are at risk of acquiring the disease. During HSSP II 100% of all affected communities were treated with more than 75% of all eligible individual receiving the drug. In addition, 90% of endemic districts integrated CDTI activities within their district health plans. In spite of these successes, challenges remain for the control of onchocerciasis: districts have only continued to contribute minimally to CDTI activities due to inadequate funds at this level; as the burden of onchocerciasis is progressively reduced, policy makers and health service managers reduce the financial and other logistical inputs for CDTI support; inadequate motivation and the presence of many community development and health interventions constrain community medicine distributors (CMDs). As a result, the CMDS fail to do adequate community mobilization. There is therefore a need for sustained advocacy for CDTI implementation at all levels and to integrate implementation and supervision of all community interventions.

**(b) Objectives**

- To eradicate onchocerciasis and its vector in 14 districts.

**(c) Strategies and interventions**

- *Strengthen IEC activities for the control and elimination of onchocerciasis at all levels.*
    - Conduct advocacy campaigns for CDTI support at all levels.
    - Develop and print IEC materials on onchocerciasis prevention and treatment and distribute them in 14 target districts.

- *Conduct capacity building at district and community levels and in schools for prevention and management of Onchocerciasis.*
    - Train health workers and teachers at district and lower levels on onchocerciasis prevention and treatment.
    - Orient VHTs on onchocersiasis control and prevention in all the 14 districts.

- *Expand treatment and vector elimination in 14 targetted districts.*
    - Implement integrated control with other neglected tropical diseases and other health interventions such as LLIN and IRS.
    - Conduct biannual treatment and vector control in 14 targetted districts.
    - Promote CDTI for the control of onchocerciasis.

**(c) Indicators with targets**

- S. nivae eliminated in 14 endemic districts in Uganda.
- At least 75% therapeutic coverage in all affected communities and 100% geographic coverage achieved in endemic districts.
- CDTI activities integrated within their district health plans in all the 14 districts to sustain integration.

**(iii) Trachoma**

**(a) Issues**

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

During HSSP II a survey was done to quantify the burden of trachoma in 19 districts. The prevalence of active and non-active Trachoma in all the surveyed districts was more than 20% and more than 4%, respectively, which are above the threshold set by WHO for massive antibiotic distribution, with three

being hyperendemic (TF>65%)[40]. The control of trachoma is hindered by shortage of HRH, low funding levels and low priorities accorded to the disability sector in general at all levels. As a signatory to GET Uganda is committed to eliminate trachoma through the SAFE strategy[41] as developed and recommended by WHO.

**(b) Objectives**

- To achieve the global target for the elimination of trachoma.

**Strategies**

- *Build the capaity of health workers to provide services to patients suffering from trachoma.*
    - Train lid rotation surgeons to increase access to trachoma treatment.
    - Provide requisite equipment for performing surgery.
    - Link people who are already blind to existing rehabilitation programmes.

- *Work with schools and communities to build capacity for prevention and control of trachoma.*
    - Train teachers and VHTs on the prevention, control and treatment of trachoma.
    - Teach children in school about facial hygiene practices to prevent spread of infection.
    - Promote family sanitation and improved water supply through the school health programs to sustain prevention of trachoma.

- *Improve access to treatment for trachoma.*
    - Implement mass community distribution of tetracycline and azithromycin in all endemic districts to reduce prevalence.

**(c) Indicators with targets**

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

[40] Bubikire et al. (2006). Fred please provide the full reference here.
[41] SAFE is an acronym for a comprehensive strategy which combines treatment with public health education and environmental health improvements: S: Surgery; A: Antibiotics; F: Face washing; and E: Environmental change.

### (iv) Lymphatic Filariasis

#### (a) Issues

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

#### (b) Objective

- To reduce and ultimately interrupt transmission of the disease in all endemic communities through the use of chemotherapy with Ivermectin and albendazole.

#### (c) Strategies and key interventions

- *Improve access to chemotherapy, disability management programmes and control measures in 44 endemic districts.*
    - Procure and distribute ivermectin and albendazole in 44 districts through integrated NTD control.
    - Conduct mapping of areas for lymphatic filariasis in districts where it has not been done.
    - Develop and implement a comprehensive disability management programme.
    - Link control activities for lymphatic filariasis into district workplans and with other control strategies such as LLINs.

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

#### (d) Indicators with targets

- Therapeutic coverage for the affected people with single annual dose of Ivermectin and Albendazole achieved by 2015.
- Morbidity and disability associated with lymphatic filariasis reduced by 25% by 2015.
- Mapping of areas with lymphatic filariasis completed in all endemic districts.

### (v) Trypanosomiasis (Sleeping Sickness)

#### (a) Issues

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

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

#### (b) Objective

- To eliminate sleeping sickness as a public health problem in Uganda.

#### (c) Strategies and key interventions

- *Strengthen the capacity of health institutions to control and prevent sleeping sickness.*
    - Train health workers in control and prevention of sleeping sickness.
    - Set up surveillance systems for sleeping sickness.

- *Improve access to drugs for the control and treatment of sleeping sickness.*
    - Procure drugs for the control of sleeping sickness.
    - Conduct mass chemoprophylaxis of human populations.
    - Conduct active screening of communities at risk to identify patients at an early stage.
    - Procure adequate quantities of NECT for effective management of sleeping sickness.

- *Strengthen advocacy and social mobilisation at all levels.*
    - Develop and disseminate IEC materials using different media channels.
    - Advocate for an increase in resources allocated for the control and prevention of sleeping sickness.
    - Create awareness about sleeping sickness at community level using VHTs.

#### (c) Indicators with targets

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

- All people in endemic areas are knowledgeable about sleeping sickness.

**(vi) Schistosomiasis and Soil Transmitted Helminths**

**(a) Issues**

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

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

**(b) Objectives**

- To reduce morbidity caused by the worms by decreasing the worm burden among communities.

**(c) Strategies and interventions**

- *Strengthen advocacy and social mobilisation at all levels.*
    - Develop and disseminate IEC materials on schistosomiasis.
    - Advocate for improved water supply and sanitation in all endemic communities.
    - Integrate schistosomiasis control with child plus days.

- *Improve access to treatment and control of schistosomiasis.*
    - Implement periodic mass chemotherapy.
    - Conducting systematic regular treatment in school-age children at risk of morbidity.
    - Conduct selective vector (snail) control.

- *Capacity building in communities and schools to address the prevention and control of Schistosomiasis.*
    - Train VHTs and teachers in the prevention and control of schistosomiasis.
    - Provide IEC materials to VHTs and schools on prevention and control of schistosomiasis.

**(d) Indicators with targets**

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

**(e) Implementation arrangements for diseases targeted for elimination**

The Department of National Disease Control in the MoH shall coordinate this programme and shall work with other departments within the MoH to develop policies and guidelines for the diseases targetted for elimination or eradication. It will have responsibility as well to provide technical support and supervise the DHOs which will in turn supervise nd support lower level efforts. The VHTs at community level will be capacitated to educate members of the community about the control and prevention of diseases targeted for elimination.

### 6.3.6 Non-communicable diseases/conditions cluster

Uganda is experiencing dual epidemics of communicable and non-communicable diseases. The Cluster on Prevention and Control of Non-Communicable Diseases/Conditions include the following elements: Non-communicable Diseases; Injuries, Disabilities and Rehabilitative Health; Gender-Based Violence, Mental Health and Control of Substance Abuse; Integrated Essential Clinical Care; Oral Health and Palliative Care. This section examines each of these diseases and conditions.

**(i) Prevention and Control of Non-Communicable Diseases**

**(a) Issues**

Non-communicable diseases (NCDs) and their risk factors are increasing in low income countries including Uganda. During HSSP II, the MoH established a Programme for the Prevention and Control of Non-Communicable Diseases in 2006 and in collaboration with stakeholders initiated the process of conducting a baseline study on risk factors and magnitude of non-communicable diseases in the country. The survey is yet to be done. A major challenge of controlling NCDs in the country is lack of local data, inadequate capacity of the health system to address chronic conditions and the high cost of medicines/supplies for treatment.

Cancer of the cervix contributes to over 50% of gynaecological admissions in Mulago Hospital and many patients are coming in very late only fit for palliation. There is high prevalence of the Human Papilloma Virus in Uganda yet very limited information on the factors responsible for this deadly condition many of which could both be primarily prevented or respond to early screening. Clearly most of the hospitals in Uganda do not offer cancer cervix screening services, yet evidence exists in the region that this can be a very effective method of addressing the problem.

**(b) Objective**

- To reduce the morbidity and mortality attributable to Non-communicable diseases through appropriate health interventions targeting the entire population of Uganda.

**(c) Strategies and interventions**

- *Strengthen the policy environment for the control and prevention of NCDs.*

    - Formulate the national policy and medium term strategic plan for the NCD (end of 2011).
    - Develop stanfdards and guidelines for treatment of NCDs.
    - Disseminate the national policy and strategic plan to all stakeholders.

- *Increase and sustain people's awareness about NCDs.*

    - Develop and implement an information and advocacy strategy on the public health importance of NCDs.
    - Create community awareness on prevention and control of NCDs using a multisectoral approach.

- *Strengthen the capacity of health workers to manage NCDs effectively.*

    - Train health workers at all HC IVs and hospitals to correctly manage NCDs so as to prevent avoidable complications.
    - Coordinate the different players in NCD control to ensure a comprehensive approach to NCD prevention and control.
    - Carry out to determine the burden of disease and main risk factors for NCDs in Uganda.

**(c) Indicators with targets**

- The burden of disease and main risk factors for non-communicable disease condition in Uganda established by 2012.
- Community awareness on NCDs/conditions increased to 80%.
- All districts implementing social mobilization for the prevention and control of NCD/conditions by 2015.
- NCD prevention and management integrated in the functions of all HC IVs.
- Cervical cancer screening services and activities using VIA and Cryotherapy established in all the Regional Hospitals by 2015.
- The proportion of HC IV with functional NCD clinics increased to 70% by end 2015.
- A comprehensive and integrated work-plan for NCD prevention, control and surveillance developed by 2012.
- A National NCD policy developed by 2012.
- Standards and guidelines for NCD prevention and control set by 2012.

**(ii) Injuries, disabilities and rehabilitative Health**

**(a) Issues**

Injuries, disabilities and rehabilitative health encompass conditions that result in an individual's deprivation or loss of the needed competency. This can be due to damage or harm done to or suffered by a person before or after birth. Such deprivation or loss of competency includes conditions like:

deafness, blindness, physical disability and learning disability. Some challenges exist that deter the effective prevention and control of injuries, disabilities and rehabilitative health: understaffing, inadequate support to orthopaedic workshops, low priority accorded to disability at all levels and challenges of coordination of many different stakeholders with varying interests. There is need to address these issues.

**(b) Objective**

- To decrease the morbidity and mortality due to injuries and common emergencies.

**(c) Strategies and key interventions**

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

    - Produce various types of assistive devices for people with disabilities.
    - Advocate for enforcement of protective legislation e.g. use of seat belts, policing drunken driving, restricted smoking among others.
    - Develop and disseminate guidelines on handling of trauma, disabilities and rehabilitation.
    - Conduct intensive mobilization of communities for early detection and proper treatment of disorders of sight and hearing in order to minimize complications.
    - Enhance collaborations with the Social Development sector with respect to the Community based rehabilitation initiative.
    - Conduct studies aimed at determining the burden of disability in Uganda.
    - Create awareness about the causes, prevention and treatment of disabilities at community level through VHTs.

- *Improve access to health services by people with disabilities.*

    - Rehabilitate health facilities to make them accessible to people with various forms of disabilities.
    - Develop and disseminate a protocol for provision of services to people with disabilities.
    - Train health workers on control, prevention and treatment of injuries and disabilities.

**(c) Indicators with targets**

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

**(iii) Gender based Violence (GBV)**

**(a) Issues**

Gender based violence is rampant in Uganda as reported in the 2006 UDHS 2006. While programmes are being implemented to address GBV challenges exist: lack of resources and equipment including

transport and requisite skills among health workers to deal with such issues. In addition there is poor coordination and collaboration amongst different stakeholders in Uganda and this tends to weaken the national response to sexual and gender based violence. There is need to enhance awareness creation to all health workers and all other stakeholders; roll-out training of health workers on management of SGBV both in-service and pre-service; develop, translate and disseminate IEC materials on SGBV, empower and support male change agents for SGBV and to Educate school pupils, students and communities on health consequences and response of SGBV.

**(b) Objective**

- To prevent morbidity and mortality due to gender based violence.

**(c) Strategies and key interventions**

- *Build the capacity of health workers, their respective institutions and communities to manage cases of SGBV.*

    - Create awareness about SGBV among all health workers, teachers, VHTs and all other stakeholders.
    - Provide both inservice and preservice training to health workers on management of SGBV.
    - Educate school pupils, students and communities on health consequences of SGBV.
    - Develop user friendly manuals to facilitate the implementattion of gender mainstreaming in the health sector.
    - Provide PEP to victims of rape.

- *Strengthen IEC activities on the effects of SGBV.*

    - Develop, translate and disseminate IEC materials on the negative health and development effects of SGBV.
    - Empower and support male change agents for SGBV.
    - Develop a strategy to address SGBV in the health sector.
    - Create awareness about the effects of SGBV among communities using VHTs.
    - Conduct a mapping exercise to determine the organisations dealing with SGBV in Uganda and work with them to create awareness about the effects of SGBV.

- *Strengthen the capacity of the health sector to conduct SGBV related M and E activities.*

    - Compile and analyse information available to establish the prevalence of GBV in Uganda and formulate strategic interventions for the health sector.
    - Work with UBOS to incorporate SGBV issues in national surveys such as the UDHS.

**(c) Indicators with targets**

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

### (iv) Mental Health and Control of Substance Abuse

#### (a) Issues

Mental health problems and substance abuse disorders contribute 12.5% of the global burden of disease. The burden is likely to be higher in Uganda due to effects of civil strife, the consequences of HIV/AIDS and increase in alcohol and drug abuse due to an inefficient and poorly enforced substance use control law. During HSSP II, resources necessary to achieve increase the percentage of RRHs with Mental Health Units from 50% to 100% were identified under SHSPP II; community access to mental health services increased from 20% to more than 50% and the proportion of HC IVs with at least one antipsychotic, one antidepressant and one anti epileptic medicine increased from 10% to 30%. There is a need to keep this momentum through increasing PHC wage budget and by allocating credit line budget for purchase of essential drugs. The mental health program also coordinates management of neurological disorders such as epilepsy which affects about 3% of the general population. The implementation of mental health programmes is impeded by underfunding, stockouts of mental health and epilepsy medicines, delayed repeal of mental health law and negative attitudes of some managers which hinder integration with other programmes.

#### (b) Objective

- To ensure increased access to primary and referral services for mental health, prevention and management of substance use problems, psychosocial disorders and common neurological disorders such as epilepsy.

#### (c) Strategies and interventions

- *Strengthen the legal and policy environment for provision of mental health services in Uganda.*
    - Repeal the Mental Treatment Act which is outdated.
    - Develop and enact a new Mental Health Law.
    - Develop mental health policy.
    - Promote the rights of the mental ill.
    - Develop a community strategy for control and prevention of mental health problems.

- *Improve access to mental health services.*
    - Develop and disseminate standards and guidelines for the integration of mental health into primary health care.
    - Integrate mental health services into primary health care.
    - Provide care for neurological disorders at primary care level.
    - Provide food for all unaccompanied mental health patients.
    - Provide essential mental health drugs.
    - Ensure the availability of functional mental health units in all RRHs.
    - Provide a psychiatrist for each RRH.

- *Build the capacity of health workers in provision of health services to the mentally ill.*

- Orient health workers in mental health in order to address the negative attitudes of some managers.
- Increased the number of psychiatric nurse and psychiatrists being trained in health training institutions.
- Provide basic training to general practitioners and health officers.

- *Strengthen IEC messages create awareness about mental health including destigmatisation of the mentally ill.*

  - Develop and disseminate appropriate messages for improving community mental health.
  - Promote services for demand reduction for alcohol and drug abuse.
  - Train VHTs to provide IEC activities at community level.

**(d) Specific targets**

- Mental Health Law enacted.
- Mental Health Policy developed.
- Mental health fully integrated into primary health care.
- Functional mental health units established in all RRHs.
- Community access to mental health services increased by 50%.
- A community strategy for prevention of mental health problems developed.

**(v) Oral Health**

**(a) Issues**

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

**(b) Objectives**

- To improve the oral health of the people of Uganda by promoting oral health and preventing, appropriately treating, monitoring and evaluating oral diseases.

**(c) Strategies and interventions**

- *Strengthen the policy environment for implementation of oral health interventions.*

- Operationalise the oral health policy.
- Develop, disseminate and implement oral health policy implementation guidelines.

- *Strengthen IEC activities on oral health.*

  - Operationalise the oral health policy.
  - Train VHTs to be involved in creating awareness about oral health.
  - Develop and disseminate IEC materials on oral health to raise awareness about oral health risk factors and appropriate means of oral health care.

- *Develop capacity for the delivery and management of oral/dental health conditions.*

  - Conduct in-service training for dentists and other technicians.
  - Organise preventive examination in primary schools.
  - Ensure fully operational oral health infrastructure at HC IVs.
  - Develop a national water fluoridisation programme.
  - Implementing oral health research to inform development of oral health interventions.
  - Integrate oral health into other health programmes.
  - Identify and develop collaborative approaches to initiatives that address oral disease common risk factors such as tobacco, sugar, alcohol, unsafe sex, chronic medication, violence and vehicle accidents.

**(d) Specific targets**

- Number of IEC materials distributed.
- Number of health workers trained.
- Oral health policy implementation guidelines developed and disseminated by 2012.
- National water fluoridisation programme developed.
- Oral health integrated into other health programmes.
- The proportion of HCIVs with well equipped and functional dental units increased from 8% to 80%.
- The proportion of the population aware about the risk factors and prevention of oral diseases/conditions increased to 80%.
- The proportion of the population with access to primary oral health care from increased from 20% to 80%.

**(vi) Palliative Care**

**(a) Issues**

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

**(b) Objective**

- To improve the quality of life of terminally ill patients and their families.

**(c) Strategies**

- *Build the capacity for palliative care in collaboration with other stakeholders.*

    - Develop guidelines and standards for palliative care.
    - Train health workers and male and female volunteers in palliative care.
    - Establish partnerships with community based palliative care providers.
    - Establish outreach palliative care services.
    - Integrate palliative care into the curricular of health training institutions.
    - Intensify public education on palliative care.

- *Improvce access to palliative care.*

    - Provide palliative care in all hospitals and HC IVs.

.

**(d) Indicators with targets**

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

**(e) Implementation strategy**

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

**6.4 Sexual and reproductive health**

**(a) Issues**

Maternal and child mortality rates in Uganda are quite high: MMR stands at 435/100,000 and IMR at 76/1,000. The proportion of deliveries by skilled personnel is still low at 34% and the provision of Emergency and Basic Obstetric and Newborn Care (EmONC) is limited. The CPR is low at 24% and the unmet need of FP is 41%. Total fertility rate has remaned high at 6.5. While a significant proportion of Uganda's population constists of adolescents, adolescent sexual and reproductive health services are limited and they do not address the needs of adolescents. Teenage pregnancy stands at 23% (UDHS 2006). Maternal malnutrition, due to both macro and micro deficiencies, still contribute prominently to still births, maternal and child morbidity and mortality. Sexual and Gender-Based Violence is a major concern that impacts on maternal morbidity and mortality. The right to Sexual and Reproductive Health and Rights is important as it aims at reducing the MMR, U5MR and TFR.

**(b) Objectives**

- To reduce, perinatal, neonatal, infant and maternal mortality and morbidity.

**(c) Strategies and interventions**

- *Strengthen IEC activities on sexual and reproductive health*

  - Develop, print and disseminate evidence based IEC materials.
  - Through VHTs, create awareness about sexual and reproductive health including family planning among community members.
  - Sensitise communities about sexual and reproductive health rights.
  - Advocate for increased funding for SRH activities.
  - Promote deliveries by skilled attendants.

- *Build institutional and technical capacity at national, district and community levels for RH*

  - Train health workers in the provision of SRH services including management of obstetric emergencies.
  - Strengthen referral systems for SRH services.
  - Provide quarterly technical support supervision to districts and lower level

- *Expand the provision of SRH services.*

  - Procure and distribute contraceptives with minimal side effects to men and women of reproductive age group including adolescents.
  - Conduct outreach SRH services from health facilities.
  - Introduce deliveries in HC IIs.
  - Provide emergency obstetric care.
  - Improving inter and intra-sectoral co-ordination and collaboration between actors in reproductive health.
  - Conduct operational research aimed at improving the uptake of SRH services.
  - Design programmes to encourage men to support women in using family planning services.

- *Strengthen adolescent sexual and reproductive health services.*

  - Integrate and implement adolescent sexual and reproductive health in school health programmes.
  - Increase the number of facilities providing adolescent friendly sexual and reproductive health services.

- *Strengthen the legal and policy environment to promote delivery of SRH services.*

  - Review SRH and related policies and address institutional barriers to quality SRH services.
  - Review SRH policies, standards, guidelines and strategies as need arises.

**(d) Indicators with targets**

- The proportion of pregnant women attending ANC 4 times increased from 47% to 60%.
- The proportion of women who deliver in health facilities increased from 34% to 90%.
- The proportion of health facilities with no stock-outs of essential RH medicines and health supplies increased from 35% to 70%.
- Contraceptive Prevalence Rate increased from 24% to 35%.
- The proportion of health facilities that are adolescent-friendly increased from 10% to 75%.
- The unmet need for family planning reduced from 41% to 20%.
- To increase the proportion of deliveries attended by skilled health workers from 40% to 60%.
- The unmet need for emergency obstetric care reduced from 50% to 20%.

**(e) Implementation arrangements**

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

**6.5 Child health**

**(a) Issues**

The survival of children under-five years of age is a major public health concern in Uganda and over the past two decades there have been modest gains in child survival mainly due to public health interventions and improving economic and social performance. More than 200,000 children under-five years still die every year mainly due to preventable conditions including malaria, pneumonia, diarrhoea, vaccine-preventable diseases (e.g. measles), HIV/AIDS, and neonatal conditions. With the current levels of under five mortality and infant mortality rates, it is unlikely that Uganda will achieve the targets of MDG 4 namely to reduce by two-thirds the mortality rate among children under-five is to be achieved by 2015. The major constraints to child survival include critical shortage of HRH to provide services, shortage of child survival commodities such as LLINs, ACTs, ORS, delivery kits etc and even when these are available uptake is low. In order to make rapid progress towards achieving targets of MDG 4, the GoU has developed a Child Survival Strategy to address the main bottlenecks of child health interventions at household and community level. The goal of the stragey is to reduce the under five mortality rate from 137 per 1,000 live births to 56 per 1,000 live births by 2015.

**(b) Objective**

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

**(c) Strategies and interventions**

- *Increase community access to child survival commodities.*

  - Procure and distribute commodities for child survival (LLINs, ACT/RGTs, ORS/Zinc and antibiotics).
  - Make available build buffer stocks of for child survival commodities at community level.
  - Improve food fortification in infant food products.
  - Ensure continuous availability of medicines and supplies in public and private health facilities and communities for control of diarrhoeal diseases and other childhood illnesses.

- *Raise awareness and demand among community members and families about child survival.*

  - Develop/update and disseminate IEC materials on child survival interventions.
  - Conduct orientation workshops for community leaders, VHT members, and teachers on promotion of child survival interventions
  - Conduct mass media campaigns on diarrhoeal management and revised health interventions as required.
  - Develop IEC materials for community mobilization for PMTCT, EPI, micronutrients deficiency disorders

- *Increase utilisation of community and population health services through provision of incentives and linkages to outreach activity.*

  - Provide performance incentives for ante- and post-natal home visits to encourage attendance at ANC/EPI and facility based delivery.
  - Support mothers of children with severe acute malnutrition with RUTF.

- *Strengthen and maintain vaccine/ micro-nutrient/PMTCT supply chain*

  - Design, implement and maintain logistics management information system (LMIS) at all levels for vaccines and related supplies, including complete inventory of EPI equipment and gas tracking system.
  - Train health workers in logistics management.
  - Expand cold storage space at the national and district levels and maintain existing cold chain system.
  - Procure, and distribute adequate vaccines in a timely manner as well as micro-nutrients, HIV test kits, and de-worming tablets.

- *Integrate and expand routine outreach services to cover all interventions*

  - Update guidelines for micro-planning/mapping to ensure that all children/women visiting health facilities are screened for immunization services to avoid missed opportunities
  - Conduct joint/integrated micro-planning for EPI services with involvement of the community

- *Expand coverage using campaigns and innovations to ensure "missed-outs" and "drop-outs" from routine services are identified, particularly in remote, underserviced areas.*

- Carry out immunization (static and outreach) according to micro-plans by ensuring timely provision of funds for mobility
- Integrate biannual vitamin A supplementation and de-worming integrated with other mother and child health activities.
- Provide incentives for registration and defaulter tracing of target children for EPI.
- Carry out pulse (mop-up) immunization in poorly performing sub-counties.
- Implement the RED approach.
- Conduct child health days

- *Strengthen health worker capacities for quality provision and monitoring of child survival strategies*

  - Develop and disseminate job aides to facility activities during integrated outreach sessions.
  - Revise training guidelines and curricula to include PMTCT/EID information.
  - Train operational level health workers engaged in EPI/ANC/PMTCT.
  - Conduct quarterly support supervision to districts, health sub-districts and health facilities.
  - Training of service providers in public and PNFP health facilities and VHTs for management and prevention of diarrhoeal diseases.
  - Conduct diarrhoeal diseases surveillance, epidemic preparedness and response.

- *Increase availability of essential commodities for management of child illness and EmONC.*

  - Revise essential drug list to include newborn medicines and supplies (e.g. antibiotics for premature rupture of membranes)
  - Improve supply chain management for HIV/AIDS commodities (SCMS – Supply Chain Management System)
  - Procurement and distribution of essential medicines and commodities, in particular: ARV; newborn care supplies (including referral drugs at lower facilities; first and second line antimalarials; antibiotics
  - Supervise facilities to ensure compliance with procurement procedures / schedules, especially for ACT/SP
  - Conduct a study to quantify safe blood and blood products to all HCIV and hospitals
  - Conduct community mobilization and sensitization for blood donation.
  - Procure and distribute blood transfusion sets.

- *Improve and expand capacity to manage normal deliveries, EmONC, and malnutrition.*

  - Establish newborn care corners/intensive care units at HC-III, HC-IV and hospitals.
  - Rehabilitate and/or construct nutrition rehabilitation units throughout country (regional and district hospitals)
  - On case-by-case basis recognise and support delivery services within HC-II where capacity can be easily upgraded and distances to alternative facilities is large.
  - Provide additional midwife position and equipment in HC-II recognised for normal delivery services.

- *Increase capacity of facility-based health workers to manage common childhood illnesses and newborn illness.*

- Revise curricula to include newborn health care (routine postnatal care for newborns and extra care for sick and vulnerable children)
- In- and pre-service training of staff for newborn health care skills (health-worker orientation on revised IMCI protocols to including sick newborns, malaria case management (with RDTs), and IYCF and malnutrition
- In-service training for improved management and processes (triage) of severe disease at HC III, IV and hospitals
- Training and follow-up support supervision of health workers to manage PMTCT and Paediatric HIV care services at health facilities including appropriate data management
- Training of OPL health workers on diarrhoeal management

- *Build knowledge base on critical areas of child survival.*

  - Conduct operational research to strengthen evidence base for VHTs, including community-based case management of common illnesses, PMTCT and diarrhoeal management.
  - Conduct national documentation of polio free status.
  - Support disease-specific surveillance efforts (e.g. Hib, pneumococcus, yellow fever, hepatitis B ,and rotavirus) to inform future policy in these areas

**(d) Indicators with targets**

- Under five mortality ratio decreased from 137 per 1,000 live births to 56 per 1,000 live births.
- The percentage of households with at least 1 ITN increased from 42% to 90%.
- The percentage of children under five having slept under an ITN the previous night increased from 10% to 80%.
- The proportion of children under five getting correct treatment for malaria within 24 hours of onset of symptoms increased from 25% to 85%.
- The proportion of children under five with fever, diarrhoea and pneumonia seeking care within 24 hours of illness increased from 30% to 80%.
- The proportion of sick children under five seen by a health worker according to IMCI guidelines increased from 60% to 100%.
- The proportion of children under 5with acute diarrhoea receiving ORT increased from 37% to 80%.
- The coverage of DPT III among children aged 12-23 increased from 74% to 85%.
- The proportion of mothers delivering in hospital increased from 42% to 90%.
- Th eproportion of mothers who have completed IPT II increased form 18% to 80%.
- The proportion of facilities providing BemoNC increased from 14% to 75%.
- The proportion of pregnant women accessing comprehensive PMTCT package increased from 25% to 80%.
- Vitamin A supplementation uptake for children aged 6-59 months increased from 36% to 80%.
- The cholera incidence rate reduced from 3/100,000 to 1.5/100,000.
- The percentage of rural and urban population who wash their hands after visiting the toilet increased from 21% and 27% respespectively.
- The cholera case fatality rate among in-patients reduced from 1.2`% to <1.0% and the acute watery diarrhoea case fatality rate from 0.9% to 0.5%.

### (e) Implementation arrangements

The Ministry of Health and Ministry of Local Government will be responsible for implementation of the child survival strategy and their roles will be:

- Ensure adequate representation of child survival in national and district plans with technically sound interventions as outlined in the Child Survival Strategy;
- Formulation of technical policy, standards and implementation guidelines;
- Set priorities based on the availability of financial, human, and physical resources;
- Coordinate efforts of implementation as well as M&E with other partners;
- Provide technical support and supervision;
- At field level, delivery of quality preventive and curative services;

Other ministries such as Ministry of Water and Environment, Ministry of Education and Sports, Ministry of Gender and Social Affairs, Ministry of Agriculture and Fisheries, Ministry of Works, Ministry of Finance, Planning and Economic Development, Ministry of Internal Affairs, and Ministry of Defence will integrate child survival interventions into their workplans.

The Ministry of Finance and HDPs will play an important role in mobilising resources for child survival interventions. At community level the VHTs will play an important role in promoting child survival interventions.

## 6.6 Supervision and mentoring

### (a) Issues

Supervision and mentoring (S&M) in the health sector in Uganda is based on supervisory visits, coaching, periodic reviews and the health management information system. S&M aims at informing policy makers and implementers about progress towards achieving targets as set out in the annual health sector plans and the HSSP and to help managers in making appropriate decisions. It also aims at continuous quality improvement of health services as well as ensuring the safety of health providers and the clients. Supervision and mentoring also assures that the environment or conditions under which services are provided are conducive, appropriate and safe; and that the people who provide the service have the right skills, information and knowledge. However, there are un coordinated multiple initiatives, gaps in reporting and feedback, lack of clarity on roles and responsibilities of the different stakeholders as well as inadequate implementation of supervision and mentoring activities. These problems affect the consistency and effectiveness of supervisory and mentoring efforts and the MoH will address these issues as a matter of urgency. Supervision will respond to the Monitoring and Evaluation reports as well as routine quarterly and annual reports to track performance in the sector and guide continuous quality improvement initiatives.

### (b) Objective

- To ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being.

**(c) Strategies and interventions**

- *Build capacity for supervision and mentoring at all levels for improvement of system performance for both private and public sector.*

    - Develop a training programme on supervision and mentoring targetting senior and middle level managers at central and district levels.
    - Train senior and middle level managers in supervision and mentoring.
    - Provide adequate logistics (transport, fuel, allowances, and supervision checklists) to facilitate supervision and mentoring.

- *Implement supervision and monitoring at all levels.*

    - Develop a comprehensive supervision and mentoring framework for the sector.
    - Institutionalize and implement supervision and mentoring as scheduled (quaterly).

**(d) Indicators with targets**

- Proportion of supervisory reports shared by supervisees increased to 100%.
- Proportion of planned visits that are carried out increased to 100%.

**(e) Implementation arrangements**

The Ministry of Health and other central level departments/agencies have the mandate to supervise and inspect the entire health sector. In line with the decentralization policy districts have the responsibility of supervising the district health system. The Ministry of Health through the Directorate of Planning and Development and Department of Quality Assurance will be responsible for the overall coordination and guidance of supervision, mentoring and inspection during the implementation of HSSPIII. As was the case over the HSSPII, Area Teams will be responsible for conducting integrated support supervision, mentoring and inspection to Local Governments/Districts during the HSSPIII. The Area Teams shall be composed of Technical officers of the Ministry of Health, Health Development Partners (HDPs), Civil Society Organizations (CSOs), Health Service Commission (HSC), Central Level Institutions such as National Medical Stores (NMS), and other MDAs such as Ministry of Public Service and Office of the President. The Area Teams shall carry out the supervisory visits to districts quarterly and they will produce written reports that will be discussed by SMC and TMC and feedback given to the districts. During the HSSPIII, there shall be Political Supervision/inspection of Local Governments by the sector Ministers and Members of Parliament. TMC shall also carry out support supervision, mentoring and inspection visits to Districts at least twice a year. In addition there will be other forms of supervision such as Technical support supervision by technical programmes and emergency support supervision like in case of epidemics and disasters.

**6.7 Quality of care**

**(a) Issues:**

Quality of care was an important component of HSSP I and HSSP II. However, during their implementation emphasis was focused on access to health services, both geographical and financial, and

less on the quality of services. This was because of the poor access to services at the start of the HSSP I. The current quality management system is not well developed and needs to be reviewed and improved. The current standards are inadequate for different levels of health care and services. The present mechanisms and standards are unable to provide effective and appropriate quality assurance. The HSSP III will build on accomplishments of both the HSSP I and HSSP II with emphasis on scaling up and improvements in quality of services.

**(b) Objective**

- To ensure good quality health services with efficient utilization of available resources.

**(c) Strategies and interventions**

- *Improve the quality of care at all levels of the health system including the private sector.*
    - Develop and disseminate standards of quality health services to all health service delivery points.
    - Enforce the use the standards and guidelines by health service providers through the establishment and strengthening of a regular supervision system using agreed checklists.
    - Facilitate establishment of internal quality assurance capacity at all levels of health services.
    - Institutionalize quality of care in the health services delivery system.
    - Involve the community in quality of care.
    - Involve professional associations and other stakeholders in improvement of quality of care.
    - Provide an incentive scheme for health facilities that conform to standards of quality of care.

- *Build capacity at all levels to ensure provision of good quality of care*
    - Integrate quality of care in training curricula for health workers including laboratory technicians.
    - Provide in-service training for health workers on quality of care.

**(d) Indicators with targets**

- Sector wide quality management system established and operational
- Professional associations and interested stakeholders are involved in quality of care improvement.
- Appropriate quality of care standards and gudelines developed and being used.

**6.8 Responsiveness, accountability and client satisfaction**

**(a) Issues**

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 utilization of health services is a combination of the supply side and the demand side. The improving utilization of health services during the HSSP I (as shown by improvements in OPD utilization, immunization) is a sign that supply

and demand has been moving in the same direction. The supply side issues include: 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 or household. However, utilization of in-patient services and especially maternity services is well below desired levels to produce improvements in health status especially to make much needed decrease in maternal and child morbidity and mortality. This low utilisation shows that the maternal health services supply 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 HSSP III will therefore attempt to address these issues.

**(b) Objective**

- To 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.

**(c) Strategies and interventions**

- *Strengthen coordination initiaves among different institutions to improve quality and responsiveness of health services.*
    - Reactivate and build capacity of Health Unit Management Committees in government and PNFP health units throughout the country.
    - Work with political and administrative leaders at all levels of government in health services delivery.
    - Work with civil society organizations, especially those working in the area of health consumer rights such as Uganda National Health Consumers' Organization to build awareness among individuals and communities about their rights and obligations.

- *Strengthen initiatives to improve client satisfaction with health services.*
    - Carry out and/or participate in surveys (National Service Delivery Surveys, Participatory Poverty Appraisals, etc.) and other studies that can provide more information about client satisfaction and gender responsiveness.
    - Step-up/Institutionalize other ways and means of receiving feed-back from communities.
    - Conduct a client satisfaction survey at the beginning of implementation of the HSSP III which will provide baseline information that can in future be used to determine trend of performance.

**6.9 Monitoring and Evaluation**

**(a) Issues**

Monitoring and evaluation (M&E) in the health sector in Uganda is based on supervisory visits, periodic reviews and the health management information system. M&E aims at informing policy makers about progress towards achieving targets as set in the annual health sector plans and the HSSP and to help provide managers with a basis in making decisions. The current challenges in teh health sector regarding M&E include lack of a comprehensive M&E plan to which all partners subscribe, routine information systems wanting in quality and lack of wide consensus on tools and mechanisms to measure quality of

both facility and community based services. There is also lack of analytical capacity at the country level to generate strategic information to support new initiatives, coupled with poor dissemination and use of information is weak at both national and sub national levels, means a lot will have to be done to improve recording and reporting, and use of data at all levels and all stakeholders, public, private and community to effectively monitor and later evaluate our HSSP III implementation, including the M&E plan itself.

**(b) Objective**

- To enable evidence-based decision making, sector learning and improvement.

**(c) Strategies and interventions**

- *Build capacity for effective data management dissemination at all levels.*

    - Develop and implement a comprehensive M&E plan for the health sector.
    - Provide the necessary tools (computers and software, data collection forms etc) for data collection, analysis and reporting.
    - Train health workers at all levels in data collection, analysis and report writing.
    - Conduct inservice training for health workers on monitoring and evaluation.
    - Fill the vacancies in the resource centre at MoH headquarters and at district level.
    - Increase the training, recruitment and deployment of required human resource for effective data management and dissemination at all levels.

- *Strengthen the monitoring and evaluation system.*

    - Extend the HMIS to the private sector.
    - A set of indicators, tools and the Monitoring and Evaluation system adapted to monitor the quality of service delivery, both at the health facility and community levels.
    - Facilitate the establishment and operation of a community based health information system linked to HMIS.
    - Ensuring utilization at all levels and dissemination of information to other stakeholders for purposes of improving management, sharing experiences, upholding transparency and accountability.
    - Generate through periodic surveys, appropriate data for effective planning, management and delivery of health services.
    - Ensure continuity of care, design appropriate medical records and improve their utilisation at community and facility level.

**(d) Indicator and Targets**

- The proportion of implementing partners (NGOs, CSOs, Private sector) contributing to periodic reports increased to 90%.
- Community based HIS established and linked to HMIS by 2015.
- The proportion of planned periodic review that are carried out increased to 100% by 2015.
- HMIS reporting timeliness, completeness and proportion of validation exercise carried out.

- The proportion of sub national entities (districts, health facilities) that have reported on the key indicators as planned increased to 100% by 2015.

**(e) Implementation arrangements**

At the MoH headquarters the MoH through the Directorate of Planning and Department will be responsible for providing overall coordination and guidance with regard to monitoring and evaluation of the progress made in the implementation of the HSSP III. All stakeholders will participate in the ME processes (JAF). At the same time there will be quarterly District Health Teams (DHTs) Monitoring and Evaluation reports and HSD monthly monitoring and evaluation reports. The responsibilities of each level are clearly spelt out.

At the same time there will be quarterly District Health Teams (DHTs) supervision reports, technical and support program specific reports and HSD monthly supervision reports. The responsibilities of each level are clearly spelt outArea Teams consist of officials from various departments in the MoH and other central and regional institutions have responsibility to provide integrated technical support and supervision to a group of districts. DHTs and HSDs supervise service delivery at government and PNFP facilities at different levels, except the national and RRHs.

**6.10 Research**

**(a) Issues**

Research is a tool that supports evidence-based policy and intervention formulation and is therefore an important component of the HSSP III. During HSSP III emphasis will be given to how research can be used to guide the development and implementation of policy, health promotion, disease prevention and early diagnosis and treatment. The UNHRO shall be responsible for coordinating all the health related research in Uganda.

**(b) Objective**

- To create a culture in which health research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Uganda.

**(c) Strategies and key intervention**

- *Strengthen the policy and legal environment that supports the conduct of research.*
    - Develop a policy and legal framework to ensure effective coordination, alignment and harmonisation of research activities.

- *Strengthen health research capacity in institutions at all levels and develop quality human resource and infrastructure.*
    - Develop and implement, under the coordination of UNHRO, a prioritised national health research agenda in a consultative manner and undertake effective dissemination of research findings.

- Conduct a mapping and capacity assessment of institutions that conduct health sciences research in Uganda.
- Develop an inventory of institutions involved in health related research
- In collaboration with institutions of higher learning, train health workers at central and district level in the development of research proposals and the principles of conducting research.
- Facilitate collaboration and coordination of health research through UNHRO.
- Develop an ethical code of conduct for health research in Uganda, promoting the safety and rights of research participants, as well as the researchers as per the UNHRO Act.

**(d) Indicators with targets**

- A policy and legal framework for effective coordination, alignment and harmonisation of research activities developed by 2012.
- A prioritised national research agenda developed by 2012.
- Institutions involved in conducting research identified by 2011.

**(e) Implementation arrangements**

The Bill for the establishment of UNHRO was passed by parliament in 2009 and it will take a leading and coordinating role in the conduct of health research in Uganda. The Secretariat will be responsible for mobilsing resources, setting health sciences research agenda, commissioning and organising health research in collaboration with other research and academic institutions, NGOs. The DHO will promote and coordinate research at district and lower levels.

**6.11 Legal and Regulatory Framework**

**(a) Issues**

Appropriate legislation and its enforcement provide an enabling environment for operationalization of the policy and the HSSP III and are essential for an effective health service delivery system. The review and enactment of the legislation is slow and that enforcement is a major problem. During HSSP III priority will be given to fast tracking the review and enactment of relevant health legislation that will provide an enabling environment for the provision of quality UNMHCP and the provision of adequate resources for policy and legislation up-dates and reviews.

**(b) Objective**

- To review and develop relevant Policies, Acts and regulations governing health in Uganda and to ensure their enforcement.

**(c) Strategies and key interventions**

- *Strengthen the legal and policy environment conducive for the delivery of the minimum health care package.*

    - Initiate the review of health related policies and legislation as need arises.
    - Identify emerging health issues, conditions and therapeutic interventions that require new legislation and policies.

- Facilitate coordination of policy development in Ministry of Health and other related sectors to ensure harmonisation and mainstreaming of health issues.
- Enforce existing legislation and policies, including inspections by regulatory bodies, and ensure that high quality services are provided by public and private sector.
- Develop an effective regulatory environment and mechanisms for clients who seek redress for poor service provision

- *Build capacity of institutions to develop and enforce health and related legislations.*

  - Recruit additional staff in the Policy Analysis Unit of the Ministry of Health.
  - Train staff from MoH, NDA and professional bodies in the review and development of health and related policies.
  - Train law enforcers on new legislation and policies to ensure implementation of legislation and policies.
  - Train local governments in the development and implementation of byelaws that can directly impact on social determinants of health.

**(d) Indicators with targets**

- Number of policies reviewed and developed.
- Number of laws reviewed and developed.
- Number of law enforcers trained.
- An effective regulatory environment and mechanism developed.

**(e) Implementation**

The MoH will continuously identify emerging health issues, conditions and interventions that require legislation and policy guidance and shall work with the Ministry of Justicce and other relevant law enforcement institutions to draft laws and policies. The MoH will lobby for the allocation of more resources from the MoF for the review and development of legislation. The MoH shall work with appropriate health professional associations to inspect health care and related services. The local governments at district level shall be responsible for implementing the legislation as well as developing their respective bylaws relating to health and health care.

**6.12 Human resources for health**

**(a) Issues**

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

**(b) Objective**

- To supply and maintain an adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce matched to the changing population needs and demands, health care technology and financing.

**(c) Strategies and key interventions**

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

    - Introduce mechanisms/incentives for attraction, recruitment and retention of health workers especially in hard to reach areas.
    - Review staffing norms in the sector.
    - Develop and implement a safe working environment to minimize health risk for the human resources and patients.
    - Provide appropriate remuneration of health workers.
    - Provide decent accommodation for health workers at health facilities especially in hard to reach areas.
    - Develop and promote other incentive schemes for deployment and retention of health workers, especially in hard-to-reach areas.

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

    - Plan, design and install HRHIS ICT infrastructure and software for HRH management and development.
    - Ensure that complete, reliable, timely, efficient and effective HRH development and management information for health care is provided and shared among all stakeholders in the sector.
    - Train, recruit and deploy required human resource for effective data management and dissemination at all levels.

- *Strengthen capacities for HRH policy formulation and implementation.*

    - Develop and implement a practical course in HRH policy and planning in partnership with Health Training Institutions.
    - Develop and disseminate guidelines for districts HRH planning processes.
    - Train a critical mass of health managers with capacity in HRH policy Planning and Development

- *To build capacity for HRH training and development to ensure constant supply of adequate, relevant, well mixed and competent community focused health workforce.*

    - Increase the production of health workers to cope with existing emerging health problems, approaches and challenges.
    - Redefine the institutional framework of health workers' training institutions including the mandate, leadership and coordination mechanisms among all stakeholders.

- Support the training of locals in hard to reach areas such as Karamoja to address the long term HR problem in such areas.
- Strengthen CPD Centres including HMDC to promote Distance learning and e-learning

- *Strengthen HRH Systems and Practices.*

  - Review and streamline the recruitment system for health workers.
  - Streamline the deployment and placement of health workers.
  - Develop and promote HRH succession and exit planning.
  - Develop and implement an internal system of career development in the health sector.
  - Review and establish appropriate management structures at different levels.
  - Review job descriptions for health workers at RRH, NRH and central level Institutions.
  - Review curricula and training strategies to enable health workers cope with emerging health problems, approaches and challenges.
  - Develop and operationalise the HRH Monitoring and evaluation plan

- *Promote enforcement, observance and adherence to professional standards, codes of conduct and ethics.*

  - Enforce professional standards.
  - Develop effective ways of increasing health workers' accountability towards client communities.
  - Establish and operationalize a Joint Professional Council with decentralized supervisory authorities.
  - Review guidelines for establishing and operating private clinics and health training institutions.
  - Review and streamline staffing levels of the Professional Councils.
  - Increase logistical and financial support to the Professional Councils.

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

  - Strengthening management and leadership skills at all levels in public and private health sectors to ensure clear roles and responsibility for HRH resources.
  - Alocate HRH to critical areas of staff shortage.
  - Conduct supportive supervision and performance management for health workers.
  - Ensure that all financial resources to the HRH are administered according to the GoU financial regulations.

**(d) Indicators with targets**

- The proportion of districts with the minimum staffing norms increased from 49% to 65%.
- The proportion of approved posts filled with health professionals increased from 51% to 75%.
- HRHIS information management capacity built at national, RRHs and District levels by end of FY 2011/2012
- Core HRHIS subsystems integrated, linked and functional by end of FY 2012/2013
- HRH Policy and planning practical course developed and rolled by December 2010
- HRH Policy and Planning capacity built for 150 health managers annually for five years.
- Evaluation of the ECN/RCN course and their products carried out within FY 2010/2011
- Two selected curricula reviewed over the next five years.

- Schemes of service and Job Descriptions of health workers reviewed by end of FY 2010/2011
- Appropriate management structures at different levels reviewed and developed by the end of FY 2011/2012
- Career development and HRH succession and exit planning developed and promoted.
- An adequate and functional staffing structure of Professional councils established over the next five years.
- A Joint Professional Council with decentralized supervisory authorities established and operationalised over the next five years.
- The functionality of Health Unit Management Committees and Village Health Teams at all levels through training revitalised over the next five years.
- At least 480 HRH managers oriented in Leadership and Management by the end of the next five years

**(e) Implementation arrangements.**

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

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

The MoH has established staffing norms for each level of health care. It will be important at the beginning of the HSSP III for the MoH in conjunction with the private sector to identify gaps in the existing health workforce including their training. Once these gaps have been identified, the MoH will work collaboratively with the MoE to effectively plan for the development of the needed numbers and competences of health workers. In addition to this, the Human Resource and Management Directorate in the MoH will work with the HSC in order to fill the existing vacancies in the health sector. The MoH shall further recentralise the recruitment and depolyment of staff at district level.

### 6.13 Medicines and health supplies

### (a) Issues

Over the period of the HSSP III priority will be given to increasing access to *medicines* and health supplies required for the effective delivery of the UNMHCP. The implementation of this component of the HSSP III will be guided by the National Pharmaceutical Sector Strategic Plan (NPSSP II). In order to achieve this, government shall continue to consolidate, strengthen and ensure an effective and harmonized procurement and supplies management system is in place. The National Medical Stores shall be further strengthened and required resources (human and financial) allocated and deployed. The health sector will also work with the MoE in order to increase the outputs for pharmacists and pharmacy technicians from training institutions such as Makerere, Mbarara and paramedical training schools.

### (b) Objectives

- To increase access to essential, efficacious, safe, good quality and affordable medicines at all times.
- To increase compliance of patients with prescribed medicines.
- To increase knowledge among patients about correct handling and use of medicines

### (c)Strategies and key interventions

- *Strengthen the policy and legal environmental governing the production, procurement and distribution of pharmaceuticals in Uganda.*
    - Develop pharmaceutical policies based on research and evidence.
    - Develop and enforce laws and regulations in the pharmaceutical sector.
    - Orient health workers and law enforcers on new pharmaceutical laws and policies.
    - Work with the MoES and PNFPs to increase the number of pharmacists graduating from training institutions.

- *Strengthen coordination among different stakeholders in the pharmaceutical sector.*
    - Promote regional and international collaboration on medicine regulation and bulk purchasing.
    - Work with local companies and encourage them to produce medicines local in compliance with Standards of Current Good Manufacturing Practices.
    - Facilitate the National Drug Authority to ensure safety and efficacy of medicines and health care products
    - Promote and support good and relevant aspects of traditional and complementary medicines.

- *Financing an adequate volume of pharmaceuticals and medical supplies in both the public and private sectors.*
    - Procure adequate pharmaceutical, medical and laboratory supplies for the UNMHCP at all levels of health care.
    - Advocate for adequate financing of essential medicines and health supplies in the national budget and gradually move towards reliance on sustainable sources of funds

- Promote, support and sustain interventions that ensure rational prescribing, dispensing, use and patient safety.

- *Strengthen the delivery and storage of pharmaceutical and medical supplies at all levels.*

  - Provide safe and adequate storage and distribution costs at all levels.

**(d) Indicators with targets**

- The percentage of health units with monthly stockouts of any indicator medicines decreased from 72% to 20%.
- The funds in the MOH budget for procurement of EMHS increased from meeting 30% to 80% of need
- The service level of NMS for all EMHS increased to 80%.
- The % of NDA budget directly financed by GOU (consolidated funds) increased to 25%).

**6.14 Health infrastructure**

**(a) Issues**

Over the years the proportion of households living within walking distance to health facilities has improved: it was 49% at the beginning of HSSP I and currently it is estimated at 72%. This is because the number of health facilities for both the public and private sectors has increased. The target for both HSSP I and II was that by the end of these plans 80% of the population of Uganda should live within 5 km of thehealth centre. This however has not been achieved. While new facilities will be constructed during the implementation of the HSSP III priority will be given to consolidation of existing facilities: most facilities are in a state of disrepair, do not have the required facilities for them to function effectively (e.g. staff housing, water and energy, theatres, equipment, stores etc) and required ICT and related infrastructure. These tend to compromise the efficiency, quality and access of these services. The consolidation of facilities will also include the upgrading of facilities to higher level facilities. As was the case in HSSP I the link between health infrastructure and HR availability will be a key determinant of the pace of new construction.

**(b) Objectives**

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

**(c) Strategies and key interventions**

- *Increase access to health services through development of health facilities.*

  - Conduct an inventory of health facilities in Uganda including those belonging to the private sector and determine their status.
  - Renovate and maintain existing health infrastructure to support the delivery of the minimum package.

- Equip priority health facilities with basic utility systems such as water, electricity and ICT.
- Construct new facilities (where necessary) in order to increase the proportion of the population living within 5 km of a health facility.
- Support private sector in health infrastructure.
- Provide an adequate infrusture maintenance budget at all levels of health care.

- *Finance the purchase and maintenance of essential medical equipment for both the private and public sectors.*

  - Provide an adequate budget for the maintenance of essential medical equipment including vehicles.
  - Procure and distribute essential medical equipment according to level of facility.
  - Provide all health facilities with 2 way communication systems and where possible telephones.
  - Procure appropriate equipment for the management of solid medical waste.

**(d) Indicators with targets**

- The proportion of the population of Uganda living within 5 km of a health facility increased from 72% to 90%.
- A functional referral system countrywide.
- The number of health facilities increased by 30% by 2015.

**(e)Implementation strategy**

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

**6.15 Health financing**

(a) Issues

Government budgetary allocation to the health sector has been on average about 9.6% over the last few years. While the donor community contributes significantly to the health sector, the overall resource envelope for the health sector is inadequate to finance the delivery of the minimum health care package for Uganda. During the implementation of the HSSP III GoU with support from HDPs shall mobilise and provide adequate resources to the health sector. The donor community shall continue to provide budgetary support to the health sector. Priority will also be given to the broadening of the resource base for funding the UNMHCP including implementation of the social health insurance which shall be universally accessible to all people in Uganda in the long term. The HSSP II shall also focus on building

the capacity of both finance and non-finance managers to ensure efficiency and transparency in themanagement of finances.

**(b) Objective.**

- To mobilize sufficient financial resources to fund the health sector programmes whilst ensuring equity, efficiency, transparency and accountability.

**(c) Strategies**

- *Broaden the resource base for funding the UNMHCP.*
    - Develop a comprehensive Health Financing Strategy addressing resource mobilisation, pooling of resources, efficiency and equity.
    - Implement social health protection through insurance and other mechanisms such cash transfers and voucher systems.
    - Increase government per capita expenditure on health.
    - Implement contracting mechanisms with the private sector to improve efficiency in resource use and service delivery.
    - Improve harmonisation and alignment of external funding to the health sector.

- *Strengthen financial management systems to ensure efficiency, transparency and accountability.*
    - Train both finance and non-finance managers in finance management.
    - Recruit qualified and competent accounting and finance personnel to manage accounts at all levels.
    - Administer financial resources according to GoU financial regulations.

**(d) Indicators with targets**

- A comprehensive health financing strategy by June 2011
- Donor project and GHI funding amounting to 70% included in the MTEF by 2014/2015
- Timely quarterly financial reports including donor projects and GHI expenditure produced and circulated.
- Social health protection implemented by 2011.

**(e) Implementation arrangements**

The Department of Planning will take the lead in terms of providing advice to the Minister of Health on the allocation of resources depending on priorities as detailed in the NHP II and the HSSP III. It will lobby for an increase in government and external funding to the health sector. The Department will also have overall responsibility with support from other departments of developing a sustainabile and comprehensive health financing strategy including the national social health insurance. The costed 5 year HSSP III will be funded within a comprehensive expenditure framework projecting revenues from all possible sources. The resource allocation formular will be revised to ensure that priority interventions are funded, allocation to non state actors (PNFPs) are transparent and equity concerns taken into consideration.

The GoU shall continue providing the basic package at no fee but will continue exercising user fees in some wards of tertiary institutions. In all financial transactions, government procedures shall be adhered to and accountability and transparency shall be the norm. The DHO shall implement the health financing mechanism at district level. A sector investment plan will be developed which will streamline the procurements in the health sector, in line with the Government of Uganda PPDA regulations. Financial management and audit procedures and financial reporting will be based on appropriate international accounting standards, the GoU financial and accounting regulations and reforms and the audit manuals. Efforts would be made that reports are provided in a timely manner and bottlenecks to resource flows are addressed.

### 6.16 Partnerships in health

The implementation of the HSSP III and the NHP II and hence effective provision of the UNMHCP is not only the responsibility of the MoH. There are other stakeholders who pay equally an important role in the delivery of health care services. Partnerships are therefore a critical determinant of the successful implementation of the HSSP III and the NHP II. Strategic partnerships include those with the private sector, other ministries and government departments and with the Health Development Partners. Over the next 5 years of the HSSP III GoU will strengthen partnerships with all stakeholders in order to achieve targets as detailed in this health sector plan.

#### 6.16.1 Public Private Partnerships in Health (PPPH)

**(a) Issues**

While structures to make the PPPH fully functional are present to a greater extent at national level, such structures are established to a lesser extent at district and lower levels. Realizing the importance of the private sector in health care the MoH and HSSP III shall encourage and institutionalize the involvement of the private sector in the provision of preventive, promotive and curative health care to all Ugandans.

**(b) Objective**

- To effectively build and utilize the full potential of the public and private partnerships in Uganda's national health development by encouraging and supporting participation of the private sector in all aspect of the NHP II according to the National Policy on PPPH

**(c) Strategies and interventions**

- *Strenthen the policy and legal environment conducive for the PPPH*
    - Finalise and approve the National Policy on PPPH.
    - Establish appropriate legislative frameworks and guidelines to facilitate and regulate the private sector in line with existing laws and regulations.
    - Disseminate the PPPH Policy and guidelines.

- *Operationalise the public private partnership in health.*

- Establish PPPH structures at district and lower levels necessary to facilitate coordination and consultation among stakeholders.
- Utilise the government subsidies for the private sector to increase access to health services for most vulnerable population and underserved communities
- Encourage and promote the role of Civil Society Organizations.
- Develop and implement incentive mechanisms that would attract legally accepted private health practitioners to the under-served and hard to reach areas.
- Sign and implement a MoU with PNFPs that would link level of subsidies to agreed service outputs.
- Support the adoption of the HMIS by the private sector.
- Facilitate access of the private sector to development capital, essential medicines and supplies for health care developments vital to service expansion to the population.

**(d) Indicators with targets**

- The national policy on PPPH is approved by the Cabinet.
- PPPH structures are established at district and lower and are functional.
- A MoU with the PNFPs is signed that links subsdies to service delivery outputs.
- The PHP sub-sector contributes to the HIMS.

### 6.16.2 Intersectoral and inter-ministerial partnership

**(a) Issues**

Currently, intersectoral collaboration with other government ministries and departments is weak. During the implementation of HSSP III the MoH shall strengthen the collaboration with other ministries and departments whose responsibilities have an impact on the health of people in Uganda. The MoH shall take a leading role in advising, mobilising and collaborating with other government ministries and departments on health matters.

**(b) Objective**

- To strengthen collaboration between the health sector and other government ministries and departments, and various public and private institutions (universities, professional councils, etc.) on health and related issues.

**(c) Strategies and interventions**

- *Strengthen the partnership between Ministry of Health and other government Ministries and Departments*
  - Develop inter-ministerial clusters for cross-cutting thematic areas.
  - Involve other GoU Ministries and departments during the NHA and JRM and any other relevant for a.
  - Conduct Health Impact Assessment (HIA) as a tool for measuring the potential impact of new policies in other sectors.

**(d) Indicators with targets**

- The structures and methods of consultation with other government Ministries and Departments ddefined.
- All government policies assessed using the HIA tool.

### 6.16.3 Health Development Partners

**(a) Issues**

Uganda has implemented the Sector Wide Approach (SWAp) in health for the previous ten years with support from HPDs. The Uganda Health SWAp is a sustained partnership whose goal is achieving improvement in people's health through a collaborative programme of work, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets. The SWAp has generally been working well and GoU intends to strengthen this framework and harmonise the external funding as a signatory of the International Health Partnership and related initiatives (IHP+). The MoH has a MoU with the HPDs and this will be further elaborated and operationalised through a compact arrangement.

**(b) Objectives**

- To implement the national health policy and the Health Sector Strategic Plan within the Sector wide Approach and IHP+ framework, through a single harmonized in country implementation effort, scaled up financial, technical and institutional support for health MDGs and ensuring mutual commitment and accountability.

**(c) Strategies and intrventions**

- *Strengthen the partnership between MoH and HPDs within the spirit of the Paris Declaration and IHP+.*
    - Harmonise and align aid delivery following the spirit of the Paris Declaration (2005) to accelerate progress in implementation.
    - Generate consensus with all HPDs on key development objectives, health priorities and the main strategies for achieving them including a clear resource allocation formula.
    - Institute a joint budget support framework.
    - Integrate on-going donor funded programmes and projects into HSSP III.
    - Conduct joint reviews and monitoring to avoid unnecessary workload and extra burden of logistics on the government.
    - Sign a country compact.

- *Strengthen the capacity at national and district levels for effective co-ordination of all development partners in health, eliminating duplication of efforts and rationalizing HDP activities to make them more cost-effective.*
    - Defining measures and standards of performance, accountability and transparency in financial management, procurement, and program implementation in line with accepted good practices.

- Orient national and district level staff on donor coordinaion and aid effectiveness among other issues.

**(d) Indicators with targets**

- A Country Compact signed by the MoH, HDP, CSOs and the private sector.
- Increased government and donors' funding for the health sector
- A joint budget support framework instituted.
- Annual joint reviews and monitoring conducted.

**(e) Implementation arrangements**

During the implementation of the HSSP III attention will be paid to strengthening partnerships at different levels. This will be achieved at national level, with the approval of the National Policy on PPPH, at district level institutionalizing the structures of partnership and with the formulation of joint district planning involving public and private sector, under the leadership of DHO. The process should be bottom-up and result in the definition of district plan which incorporate all different sub-sectors related to health. The Department of Planning in the Ministry of Health shall be responsible for coordinating the creation and strengthening of partnerships with other Government agencies, the private sector, CSOs and communities. It will also be responsible of the partnership with HDPs, which shall be based on the IHP framework and compact.

The MoH shall maintain ad advisory role toward other sectors ministries, revitalizing and creating inter-ministerial structures of coordination and consultation. At the community level the existing community structures (HUMC, VHT) should be mobilised to ensure community participation and their involvement in the implementation of health activities.

## 7. IMPLEMENTATION ARRANGEMENTS

The development of the HSSP III was led by the Department of Planning in the MoH with support from HDPs and other stakeholders in and outside the health sector. The process was participatory involving all departments at the MoH headquarters, the central level institutions, NRHs, RRHs and the districts; the private sector, both the PNFPs and PHPs; and the HPDs. All these are involved in the delivery of health services; hence the implementation of the HSSP will be a joint responsibility of the MoH and all the stakeholders. It builds on achievements of the HSSP I and II. This section details the implementation arrangements for the HSSP III which do not departure much from HSSP II including the contributions from other major stakeholders as described in the HSSP II.

### 7.1 Roles of different partners

The roles of the MoH have been spelt out in Section 2.1.1 of this strategic plan including those of the RRH, NRH and general hospitals. Section 2.2.2 describes the role of the private sector. Overall the MoH is the line GoU agency responsible for health sector development. In order to achieve the objectives of the HSSP III it is important that the MoH works in partnership with other government agencies and the private sector.

.

#### 7.1.1 Health Services Commission

It was established under the Health Services Act and the 1995 Constitution of the Republic of Uganda. It will cntinue reviewing the terms and conditions of the health workers in Uganda. It is the HR agency for the MoH.

### 7.1.2 Ministry of Finance, Planning and Economic Development

The Ministry of Finance and Economic Development mobilises resources for GoU and has the overall responsibility of allocating resources to different sectors according to priorities set by the GoU. In addition to this, the Ministry oversees national policy development including the development and coordinating the implementation of the National Development Plan, the overall development agenda for Uganda. The implementation of the NHP II and the HSSP III contributes to the achievement of the overall goal of the National Development Plan.

### 7.1.3 Ministry of Local Government

With decentralisation, the Ministry of Local Government is responsible for the management and delivery of health services at district and lower levels including the development and implementation of community health initiatives. It monitors and supervises health services delivery at this level. In addition, the Ministry of Local Government recruits and deploys staff at district and lower levels and mobilises resources at that level. The General Hospitals, HSDs, HC III and HC II should be responsive to the needs of the community and members of the community, through HUMCs and VHTs shall participate actively in the management and delivery of health services.

### 7.1.4 Ministry of Education and Sports

The Ministry of Education and Sports is responsible for the training of health workers in Uganda. This responsibility is however being reviewed and training institutions may revert to the MoH during the implementation of the HSSP III.

The level of education is an important social determinant of health; hence the MoE has the overall responsibility of ensuring that Uganda has an educated population that understands health and how to maintain it. The MoE will also work with the MoH to implement the School Health Policy which will be finalised during Th eimplementation of HSSP III.

### 7.1.5 Ministry of Lands, Water and Environment

The Ministry will ensure that water is available in all health facilities in Uganda. It will work very closely with the MoH to ensure that new facilities are located where water can easily be sourced. It has the overall responsibility of developing water sources and provision of sanitation facilities including communal toilets. It will also be responsible for protection of the environment in general.

### 7.1.6 Ministry of Agriculture, Animal Industry and Fisheries

The Ministry is responsible for food production in Uganda which is essential for normal growth and development and prevention of malnutrition. It is also responsible for preservation and storage of food.

### 7.1.7 Ministry of Gender, Labour and Social Development

The Ministry is responsible for mainstreaming gender in all government policies and plans including advocacy for awareness and prevention of gender based violence which is an important component of this strategic plan. The Ministry also implements safety and health proghrammes in the workplace in order to ensure a healthy workforce.

### 7.1.8 Ministry of Public Service

It maintains the payroll of all civil servants in Uganda including health workers and it has overall responsibility of determining hard to reach allowance and other incentives which is quite crucial for civil servants includng health workers.

### 7.1.9 The Private sector

The private sector, which consists of private for profit and private not for profit sub-sectors, will continue proding services to the people of Uganda. PPPH shall be promoted at all levels.

## 7.2 Consolidating the SWAp arrangements

The GoU adopted the SWAp arrangement during the implementation of the HSSP I. The SWAp provides a framework for collaboration with different stakeholders namely MoH and other GoU ministries and departments, the private sector, CSOs and donors. Despite some concerns, as raised in the MTR of the HSSP II, the health SWAp shall continue to be the approach to health sector management and development. The SWAp is based on the principles of partnership and collaboration with a common goal of achieving the objectives of the NHP II and HSSP III. It further creates a forum for coordinating financing, planning and monitoring mechanisms. As has been the case since HSSP I, all stakholders will contribute to the development of the health sector within the SWAp framework and that the financing of the health interventions shall support the implementation of the NHP II and the HSSP III. The MoH as a line ministry dealing with health and related issues shall take the responsibility of coordinating the SWAp process with support from all stakeholders. HDPs will be expected to support the implementation of the HSSP III through central budget support in line with the GoU policies and guidelines. The MoH shall put in place mechanisms that will ensure transparency in the way finances are managed.

## 7.3 Decentralisation

The Constitution of the Republic of Uganda (1995 as amended) and the Local Government Act (1997) prescribe that central line ministries shall be responsible for policy, setting of standards and guidelines, supervision and monitoring, technical support and resource mobilisation. The Local Governments are responsible for service delivery at district and lower levels. The MoH provides services through a decentralised system in line with the Constitution and the Local Government Act: MoH and central level departments are responsible for development of policies and guidelines as detailed in Section 2 while the local governments have the responsibility of delivering the health services in line with National priorities and taking their peculiarities into consideration. The delivery of health services shall continue to be done by local governments. While the Local Governments were responsible for recruitment of staff at district level, over the implementation of the HSSP III the Ministry of Health Headquarters shall recentralise the recruitment of senior staff such as medical doctors.

### 7.4 Annual operational plans

The HSSP III is a national strategy that guides implementation of priority interventions in the health sector that will lead to the achievement of the targets as set in the NDP and MDGs. The plan does not give details on activities that will be implemented over the 5 year HSSP III period. In order to operationalise the HSSP III the MoH and its various central level departments and institutions will develop strategic and annual worpklans and set targets for each year in line with the HSSP III. RRHs shall also prepare annual workplans. At district level annual district implementation plans will be prepared with input from the HSDs and other lower level health facilities. The central level shall ensure that districts are capacitated adequately to prepare these annual workplans. These annual workplans shall be ready in order to inform the budget for the following year. The development of annual district implementation plans is advantageous because each district has its own needs and priorities. The different annual workplans prepared by the health sector at different levels shall constitute the annual health sector plan.

## 8. Monitoring and evaluation

The main source of data for monitoring and evaluation the health sector shall continue to be the HMIS which is managed by the MoH. It is an integral part of the M and E system and during the implementation of the HSSP III one of the major priorities will be to strengthen the HMIS through filling in of vacancies, inservice training, provision of requisite hard and software. The Resource Centre will be responsible for production of quarterly reports and annual reports using data from a functional HMIS. At the end of each year there will be an AHSPR which will be produced by the Department of Planning. This report, as has been the case since 2001, will highlight progress and challenges in health sector for the year. In order to ensure that the AHSPR is produced in time, the different levels of health delivery system shall compile their reports and submit these reports by August each year for compilation. The report shall be presented at the JRM of each year.The JRM shall be conducted annually and led by the MoH. The PHP, PNFPs and the HDPs shall participate in the JRMs and they will be held in October of each year. In addition to the JRM the NHA will also be held annually in October: Its membership will continue consistiing of representations from all stakeholders from the central level, RRH, NRHs, district, NGOs, Development Partners and civil society. The assembly will review the performance of the sector and identify priorities. In addition, there will be special surveys conducted by the MoH and partners such as UBOS. A list of indicators, which incorporates NDP, MDG and UNGASS, has been agreed upon by the health sector.