Ministry of Health

Health Sector Strategic Plan
2000/01 – 2004/05

TABLE OF CONTENTS Page

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ARI	Acute Respiratory Infections
CDD	Control of Diarrhoeal diseases
CHW	Community Health Worker
DDHS	District Director of Health Services
DFID	Department for International Development
DHMT	District Health Management Team
DHOSP	District Hospital
DQE	Drug Quantification Exercise
DMO	District Medical Officer
DOTS	Directly Observed Therapy
DPT	Diphtheria, Pertussis and Tetanus vaccine
ENT	Ear, Nose and Throat
EPI	Expanded Program on Immunisation
EU	European Union
FP	Family Planning
GDP	Gross Domestic Product
GHOSP	Government Hospital
GNP	Gross National Product
GOU	Government of Uganda
GTZ	German Technical Organisation for Development Co-operation
HC	Health Centre
HIS	Health Information Systems
HIV	Human Immune-Deficiency Virus
HMIS	Health Management Information system
HRD	Human Resources Development
HRH	Human Resources for Health
HSD	Health sub-district
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
KAPB	Knowledge, Attitude, Practices and Behaviour
MOH	Ministry of Health
MOLG	Ministry of Local Government
NGO	Non-government Organisation
PEAP	Poverty Eradication Action Plan
PEM	Protein-Energy Malnutrition
PHC	Primary Health Care
PWDs	People with Disabilities
QA	Quality Assurance
RH	Reproductive Health
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TT	Tetanus Toxoid
TBA	Traditional Birth Attendant
UNEPI	Uganda National Expanded Programme on Immunisation
UNFPA	United Nations Population Fund
UNHRO	Uganda National Health Research Organisation
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

EXECUTIVE SUMMARY

The Health Sector Strategic Plan (HSSP - 2000/1-2004/5) has been developed as a collaborative undertaking of the Ministry of Health, related ministries, the development partners and other stakeholders. The plan has been prepared within the framework of the Poverty Eradication Action Plan and health sector policy. It describes the major technical health programmes and support services and their outputs. The technical health programmes arise from the minimum health care package described in the policy, while the support services include Human Resources, policy and planning, quality assurance, information management system, research and development, health infrastructure, procurement of drugs, equipment, supplies and logistics, health care financing and legal and regulatory framework.

The overall purpose of the Plan is to reduce morbidity and mortality from major causes of ill health in Uganda and the disparities therein, as a contribution to poverty eradication and economic and social development of the people.

Health sector reforms, including decentralisation, have led to administrative and structural changes in the health care delivery system. The district health system will be used to deliver a package of health services to the population of Uganda, while the Ministry of Health will be responsible for policy formulation, standards and guidelines, overall supervision and monitoring. In addition, it will ensure that strategic guidance, technical support and resources are made available to the districts and other health care providers. The referral and other national level health care institutions will provide the necessary back up support to the district health services.

The objectives of the plan are to:

- Relate the ongoing health sector reforms to health development.
- Provide a framework for three year rolling plans at all levels
- Involve all stakeholders in health development.
- Exhibit a health sector strategic framework, with coherent goals, objectives and targets for the next five years.
- Indicate the level of investment in terms of costs required for achieving the policy objectives agreed upon by Government of Uganda and its development partners.
- Articulate the essential linkages between the various levels of the national health care delivery system.

The Strategic Plan is presented in a Logical Framework Matrix in figures I and II. The Overall Programme Goal and the Programme Purpose are presented at the top of the matrix. There are five major outputs of the health Sector Strategic Plan. Below are the Outputs:

- Output 1 defines the minimum package of health services.
- Output 2 describes the health organisation and management system.
- Outputs 3 to 5 describe important support services that are necessary for the successful delivery and implementation of the minimum health package.

Each of these outputs consists of a number of major elements which when considered together will allow the output to be produced. Figure I presents an overview of the plan, which outlines the elements that make up each output. Each of these elements is fully described in narrative form and supported by a Logical Framework Matrix in subsequent chapters. The elements have outputs and represent a broad guide for operational activities. . Within the extensively decentralised service delivery system in the country, and the nature

of the Budget Framework and the Medium Term Expenditure Framework (MTEF) formulation process, it is considered inappropriate to develop a detailed costed five year operational plan for the HSSP.

Cost estimates for the five year plan are presented in Chapter Five. Detailed operational plans and budgets will be developed annually by the central implementing programmes and districts within the MTEF. The Ministry of Health will support the planning and implementation processes to ensure optimal use of resources within the framework of the minimum health care package.

The indicative cost analysis for the Health Sector Strategic Plan shows a total cost figure of US$ 954 million. The annual total costs are US$ 159 million in Year 1, U$ 179 million in Year 2, US$ 207 million in Year 3, US$ 209 million in Year 4, and US$ 201 million in Year 5. The costs for delivering the Uganda Minimum Health Care Package are US$ 110 million in Year 1, US$ 117 million in Year 2, 138 million in Year 3, US$ 140 million in Year 4, and US$ 144 million in Year 5. They represent
between 65% and 73% of annual total costs. The Health Sector Strategic Plan financing framework anticipates an indicative resource envelope of US$ 956 million and government allocation totalling US$ 344 million over the five-year period. Government of Uganda (GOU) resource as a percentage of recurrent cost will range from 42% in Year 1 to 55% in Year 5.

The process of financial planning, programming and management requires commitment of all the stakeholders in the health delivery system namely, the government, the donors, the private sector and the communities. It is envisaged that government will seek support from development partners to redirect spending through a flexible budgetary support procedure. Furthermore, it would explore options for improving efficiency within the public health sector.

The implementation of the Health Sector Strategic Plan will be a dynamic process with constant refinement of the defined needs, modification of the minimum package, cost estimates and provision of financial resources for the health service needs. Following the initial plan design, the next step will include further preliminary technical analysis and preparation of operational plans at all levels. In subsequent years, it is envisaged that the performance of the Health Sector Strategic Plan will be monitored twice yearly through the Joint Missions and will be subjected to mid-term review and re-appraisal.

Overview of programme

Programme Goal
Expanded Economic Growth
Increased Social Development
Poverty Eradication

Programme Development Objective
Reduced Morbidity and Mortality
From major causes of ill health and
reduced disparity therein

Program output 1	**Program output 2**	**Program output 3**	**Program output 4**	**Program output 5**
Minimum Health Care Package implemented,	Health Care Delivery system strengthened	Legal and regulatory framework strengthened and operational	Integrated support systems strengthened and operational	Policy, planning & information management system operational; Research and development implemented
Elements	**Elements**	**Elements**	**Elements**	**Elements**
1. Control of Communicable Diseases - Malaria - STD/HIV/AIDS - TB 2. Integrated Management of Childhood Illness 3. Sexual and Reproductive Health & Rights 4. Immunisation 5. Environmental Health 6. Health Education and Promotion 7. School Health 8. Epidemics and Disaster Preparedness & Response 9. Nutrition 10. Interventions against Diseases Targeted for Elimination or Eradication 11. Mental Health 12. Essential Clinical Care	1 Restructured Ministry of Health and support institutions 2. Decentralised health care delivery system 3. Partnership with private sector. 4. Intersectoral linkages strengthened	1. Health Acts 2. Professional Councils 3. Private sector regulated 4. Traditional practitioners regulated	1. Human Resources for Health 2. Health Care Financing 3. Health Infrastructure 4. Laboratory Services 5. Procurement and management of drugs, medical supplies and logistics	1. Policy & Planning 2. Quality Assurance 3. Health Information System 4. Research and Development

Figure I

Health Sector Strategic Plan 2000/1 - 2004/5

Overall Logical Framework for Sector Programme

Narrative Summary	Performance Indicators	Key Assumptions
Overall Programme Goals ▪ Expanded Economic Growth ▪ Increased Social Development ▪ Poverty eradication	▪ Investment, business growth, production levels, exports, agricultural production, etc ▪ Increased participation of civil society (governance indicators).	Ministry of Finance and economic Development continues to monitor these
Programme Purpose Reduced Morbidity and mortality from major causes of ill-health and reduction in disparity among various groups and regions	1.1 Mortality rates: Reduce IMR from 97 to 68 per 1000 live births Reduce CMR from 147 to 103 per 1000 live births MMR reduced from 506 to 354 per 100000 live births 1.2 Reduce current levels of HIV prevalence by 25% 1.3 TFR reduced: 6.9 to 5.4 & CPR increased: 15% to 30% 1.4 Malnutrition Stunting in under 5s reduced: 38% to 28% 1.5 Reduce present disparities in above indicators between the highest and lowest quartile of districts by 10%.	**Assumptions: Purpose to Goal** 1 Economy continues to grow at 6% p/a; inflation rate remains between 6 and 7% 2 Performance in other sectors achieves poverty eradication objectives. 3 Household incomes increasing as predicted
Programme Output Level **Programme Output 1** 1 Minimum health care package delivered country wide.	1.1 Policy standards, guidelines & promotional program that are gender sensitive established for the integrated minimum package (including: communicable diseases, IMCI/child development, Reproductive Health, EPI, Environmental Health, Emergency & Disaster Preparedness, Nutrition, Eradication targeted diseases, Mental Health, injuries and rehabilitative care and essential clinical care). 1.2 Integrated gender responsive IEC programmes staffed and National/District campaigns implemented in covering the population with mass and multi-media (radio, print, drama,) messages.	**Assumptions: Outputs to Purpose** 1 No new/strange diseases develop internally or from across boarders in next 5 yr. 2 HIV/AIDS and sexual risk behaviour patterns change as anticipated 3 HIV virus strains remain stable 4 No cultural or gender biases 5 Food security improved 6 Water services compliment district health sanitation programs. 7 Political context does not impede delivery or use of Health Services. 8 Investment in Health Sector continues at a minimum of 7 - 8% of total Government Expenditure
Programme Output 2 Health organisation and management system strengthened.	2.1 New Ministry of Health structure in place and appropriately staffed and managed. 2.2 Restructured and autonomous support institutions in place. 2.3 Decentralised District level delivery system provided with trained, gender balanced staff, developing annual plans/budgets, collaborating with Village Health Committees, NGOs, other sectors co-ordinating with MOH programme staff, monitoring implementation and reporting on results. 2.1 District and Sub-District teams implementing the minimum health care package with VHC and NGOs.	
Programme Output 3 Legal and regulatory framework established & operational	4.3.1 Health Sector regulatory mechanism/system established and operational: policy, including guidelines and standards and operational legal and regulatory framework enforced nation-wide.	

Programme Output 4 Integrated support systems strengthened and operational .	4.1 Needs-based, gender sensitive HRD and HRM programme (long term personnel policy & plan, integrating training, motivation, staff performance and development tracking. 4.2 Number and type of accessible health care facilities constructed, upgraded, rehabilitated or renovated, fully equipped, routinely maintained. 4.3 Standardised procurement, distribution, maintenance & storage system established, inventory control system computerised, staff trained and appointed. 4.4 Demand-based drug supply, logistics and inventory system operational providing adequate quantities of essential drugs at all levels of health care delivery, automated in a number of districts. 4.5 Proportion, per capita annual government expenditures allocated to sector, proportion of donor contribution to sector, proportion private expenditure.	9 Community gains confidence in quality and cost of public health services and use them 10 Contribution of health to package costs. 11 Effective legal enforcement compliments health regulatory functions 12 The MOF and MOLG enter into and maintain collaboration on programme planning financing and delivery 13 Conditional Grants secure and maintain commitment to policy and strategy. 14 District Councils commit themselves to participating in planning, making annual and long term commitments and have the capacity to implement. 15 GoU/Donor collaboration remains predictable & assures consistent levels of resource inflows over the next 5 yr.
Programme Output 5 Policy, planning & H/MIS systems operational. Applied Research & Development program co-ordinated and implemented	5.1 National Health Sector Planning System established and operational and providing strategic policy guidelines, operational guidelines, collaborative programme, and M&E supervision system. 5.2 National Health Policy Framework established and consensus maintained and policy on health systems provided (e.g. financial management, evaluation, R&D). 5.3 Comprehensive, multi-level H/MIS automated, installed and operational providing unified surveillance data & implementation information. 5.4 Quality assurance guidelines established, used by trained staff to monitor/supervise the health services 5.5 Applied research system and number of institutions with client centred protocols & standard procedures, staffed and operational , generating usable methods, mechanisms, techniques technologies for programme implementers 5.6 Output Oriented planning, budgeting and monitoring promoted and disseminated.	
Programme Activities See detailed output logframes for description of programme activities	See performance indicators in output logframes and monitoring and evaluation frameworkfor details See budget projections for analysis of inputs and costs	**Assumptions: Activities to Outputs** See detailed assumptions in output logframes

Figure II

Chapter 1

INTRODUCTION

1.1 Background

Prior to the upheavals which beset Uganda for two decades during the 1970s-1980s, the country had the best health indices in the sub-region. The period of decline led to the collapse of the Sector and to a reversal so the Uganda's health indices now, are probably the worst in the sub-region.

The advent of the NRM government in 1986 opened the way to new thinking and to new effort which has culminated in the development of the current National Health Policy and Sector Strategic Plan (2000/01 – 20004/05). The Health Policy Review Commission set up in 1987 led to the development of the Three Year Rolling Plans with priorities identified as consolidation of existing health services and re-orientation of services to Primary Health Care.

While these interventions made over the last 15 years resulted in some tangible progress, there remains much to be accomplished in the development of the health system to acceptable levels. Accessibility to basic health services, measured as population living within five kilometres of a health facility, is estimated to be 49% countrywide and only 42.7% parishes having any type of health facility, with wide variations between rural and urban areas and between different districts (Health Facilities Inventory 2000).

Under the current Government policy on decentralisation and liberalisation, roles both at the centre and at local government level have changed. In addition, the role of the private sector and its interaction with the public sector have become more prominent. There is, therefore, need to review both the management and organisation of the health sector including its regulatory framework.

For development to be sustainable, health and economic growth must be mutually reinforcing. Health is an essential prerequisite as well as an outcome of sound development policies. Without good health, individuals, families, communities and nations cannot hope to achieve their social and economic goals. The 1998 Uganda Participatory Poverty Assessment Project (UPPAP) identified ill health as the most frequent cause and reason for poverty. It is therefore clear that the health sector will play a key role in poverty eradication and overall socio-economic development in Uganda.

1.2 Situational analysis of the health sector

1.2.1 Socio – economic and demographic profile

Uganda's projected population in 2000 is 20.9 million of which 51% are female and 49% are male. The population growth rate is estimated at 2.5% and the fertility rate at 6.9 *(Uganda Demographic and Health Survey, 1995).* The life expectancy in 1991 was 45.7 years (males) and 50.5 years for females, the average being 48 years at birth *(Ministry of Finance and Economic Planning: Population and Housing Census, 1991).* According to the Uganda Demographic and Health Survey of 1995, the overall life expectancy was put at 52

years. Mainly as a result of AIDS Life Expectancy is now projected to be 42 years (World Development Report 1997).

The country has achieved marked economic growth of an average of 6.5% per annum for the last 5 years and inflation rate maintained below 10%. The Gross Domestic Product (GDP) per capita has grown at a rate of 3.4% per annum and per capita income is estimated at US$ 300 over the last 5 years *(Poverty Eradication Action Plan, 1997).* This is attributed to the sound macro – economic policies, liberalisation and privatisation of the economy. The budget deficit has been reduced from 14% to 3% of GDP between 1991/92 – 1996/97 *(PEAP, 1997).*

Government health expenditure was estimated to be 8% of the total government expenditure which represents about 0.8% of GNP *(Ministry of Finance, 1998).* Per capita health expenditure was estimated at US$ 12. Only US$ 3.95 was attributed to government and donor spending, the balance coming from private spending *(Ministry of Finance, Background to the Budget 1998/99; Household Budget Survey, 1996).*

Despite these economic achievements, household incomes have remained low, though there has been a reduction in levels of absolute poverty from 66.3% in 1994/95 to 46% in 1996/97 with the North and East showing lower levels of poverty reduction *(Ministry of Finance: Poverty Monitoring Survey, 1998).* This economic situation has contributed to the poor health status of the population.

A Poverty Eradication Action Plan is being pursued by Government to improve on the above situation. The campaign is aimed at reducing mass poverty in the population of Uganda, by enabling households to earn decent incomes and facilitating an improvement in the quality of their lives. The main pillars of the Poverty Eradication Action Plan stand on a foundation of continued macroeconomic stability. These include the following:

(a) To increase incomes of the poor by providing the necessary infrastructure and enabling environment, and facilitating private and community effort in promoting income generating activities of the poor through:

- provision of roads
- improvement of land laws
- support modernisation of agriculture
- improve rural market infrastructure
- strengthening of rural credit and financial services
- telecommunication and rural electrification

(b) Improving the quality of life of the poor by providing essential services and building human capital through

- provision of primary health care
- water and sanitation
- primary education
- preserving the environment

(c) Strengthening good governance through institutional arrangements which clearly delineate the role of the state vis-à-vis those of the private sector and civil society by ensuring

- transparency
- accountability
- popular participation

1.2.2 General Morbidity and Mortality Situation

1.2.2.1 Health Status Indicators

Uganda has poor health indicators and a heavy burden of disease. Table 1 below shows Uganda's health indicators compared with the regional neighbours.

Table 1: Comparative Regional Health Indicators

Health Indicator	Uganda	Tanzania	Kenya
Life Expectancy (at birth)	52	51	54
Infant Mortality Rate per 1,000	97	82	74
Probability of death before 5 years	14.3%	12%	11%
Total Fertility Rate	6.9	5.8	4.7
Maternal Mortality Ratio	506	529	365

Source: 1. Background to the Budget 1998/99 - Ministry of Finance, Planning and Economic Development, 1998
2. Tanzania Demographic & Health Survey, 1996, 3. Kenya Demographic & Health Survey, 1998
3. Uganda Demographic & Health Survey, 1995 (For IMR, the figure 88 is sometimes referred to. It arises from an indirect Survey).

1.2.2.2 The Burden of Disease

According to *the 1995 Burden of Disease study in Uganda*, 75% of life years lost to premature death are due to ten preventable diseases. These include Perinatal and maternal related conditions (20.4%), malaria (15.4%), Acute Lower Respiratory Infections (10.5%), AIDS (9.1%) and diarrhoea (8.4%). Together these account for over 60% of the total burden. Women and children bear a disproportionate amount of the burden of ill-health. There are also significant variations between regions in Uganda and probably (though less well documented) within regions. Other diseases responsible for a significant proportion of morbidity and mortality include: Tuberculosis, Malnutrition (under-nutrition), Anaemia, Intestinal infestations, Trauma/accidents, Skin infections, Maternal and perinatal conditions, Mental Health and cardiovascular diseases. On top of these, there is an emerging burden of other non-communicable diseases such as hypertension, cancer, diabetes, mental illness and chronic degenerative cardiovascular diseases.

Poor health outcomes are a problem that extends throughout Ugandan society, with for example, mothers in the top expenditure quartile losing almost the same proportion of their children as mothers in the bottom expenditure quartile. More recently however the rate of decline in young child mortality is showing a much more rapid decline in best off families. The major challenge therefore, is to extend basic health care services to the entire population, while at the same time achieving significant reduction in the disparities in health status between the

richest and the poorest segments of the population. This therefore constitutes the main objective of the National Health Policy and the Strategic Plan.

1.2.3 Health Services Infrastructure

Geographical access to health care facilities is so far limited to only 49% of the households. The rural population, where the majority of the poor live, is further constrained in terms of access to health care by distance and geographical physical features such as rivers, marshes and hills. Only 42.7% of parishes in the country having any form of health facility (Health Inventory, 2000). Even where the facilities exist, access to basic elements of the health care package is far from optimal. As a result of many years of civil strife and neglect, there is a massive back log of dilapidated infrastructure which compromises efficiency and discourages utilisation. In addition, the quality and range of care that is provided at existing health facilities still requires a lot of improvement.

Below is a table that shows the current infrastructure in comparison to the minimum recommended infrastructure requirements:

Table 2. Status of the health Infrastructure

HEALTH UNIT	PHYSICAL STRUCTURE	BEDS	LOCATION	POPULATION	NEED	EXISTING	GAP
Health Center I	None	0	Village	1,000	0	0	0
Health Center II	Out Patient Services Only	0	Parish	5,000	3624	746	2878
Health Center III	Out Patient Services, Maternity, General Ward and Laboratory	8	Sub-County	20,000	679	679	20
Health Center IV	Out Patient Services, Wards, Theatre, Laboratory and Blood Transfusion.	25	County	100,000	127	127	0
General Hospital	Hospital, Laboratory, X-ray	100	District	100,000 to 1,000,000	87	87	0
RRH	Specialists Services	250	Region (3-5 districts)	1,000,000 – 2,000,000	12	10	2
NRH	Advanced Tertiary Care	450	National	Over 20,000,000	2	2	0

RRH – Regional Referral Hospital
NRH – National Referral Hospital
New Bed Capacity for Butabika Hospital will be 450 after Renovation.

Sources: 1 Inventory of Health Services in Uganda for the Year 2000, Health Planning Department, Ministry of Health Uganda
2 Health Sub-Districts in Uganda, Concept Paper, January 1999, Ministry of Health, Uganda
3 The National Health Policy, October 1999, Ministry of Health.

Health Sector Strategic Plan, Ministry of Health, Uganda.

The infrastructure above includes both Government and NGO Health facilities that have been designated as responsible for the respective levels. The infrastructure requirements in the future may change as a result of population, geographical factors and health seeking behaviour. Where a higher level facility (e.g. hospital or health Centre) exists, it is assumes responsible for the lower levels.

1.2.4 Human Resources for Health

Human resources for health remain inadequate. The continued attrition of health workers in the face of the Government ban on recruitment led to further decline in the availability of human resources for the health sector. The trained health workers are both inadequate in numbers, and worse still, inappropriately distributed. Whereas more than 80% of the population is found in the rural areas, the distribution of trained health workers favours the urban areas.

A recent study (MOH, 1999) on the inventory of human resources for health in the public facilities indicated that only 34% of the established positions were filled by qualified staff. The rest were either filled by untrained nursing aides or remained vacant.
Current human resource management practices compound the difficulties. Wages are inadequate and irregular. Negative attitudes to health workers in some districts by leaders and managers erode staff morale and compromise the quality of health care that they provide to the population

1.2.5 Decentralisation

The National Constitution (1995) and the Local Authorities Act (1997) have apportioned responsibilities between central line ministries and local authorities. Services delivery is a responsibility of the local authorities. The line ministries are responsible for policy, standards and guidelines, supervision and monitoring, technical support and resource mobilisation. Implementing these reforms has raised a number of issues the most pertinent of which are: capacity to implement programs, bottlenecks in channelling funds, personnel management and priority setting in resource allocation. Ownership and accountability for out puts by communities and local leaders is yet to be fully appreciated. In general terms however, decentralisation has been warmly embraced and has contributed to improvements in service delivery through increased community participation and better supervision. This potential will be enhanced by this HSSP.

1.2.6 Mainstreaming a Gender Perspective in the Health Sector

The National Health Policy has enshrined the mainstreaming gender in health services delivery. The National Gender Policy is an integral part of the national development process and has been incorporated into this plan. Each element of the minimum health care package and the other four outputs of the HSSP will exhibit a gender perspective.

1.3 The Health Sector Strategic Plan

The Government of Uganda led by the Ministry of Health and in partnership with Development Partners and other stakeholders have worked closely during the past two years to develop this Health Sector Strategic Plan. It is the implementation strategy for the 1999 Health Policy and the health component of the Poverty Eradication Action Plan (PEAP). The plan has prioritised areas of action, set targets and defined organisation and management approaches for the health sector over the plan period 2000/01 – 2004/05, and is based on the MTEF, donor and other funding projections.

The principal aims of the Health Sector Strategic Plan (HSSP) are to:

- Improve access of the population to the Uganda National Minimum Health Care Package (UNMHCP), special attention will be placed on increasing effective access for the poor, the difficult to reach and the otherwise disadvantaged.
- Improve the quality of delivery of the package and
- Reduce inequalities between various segments of the population in accessing quality services.

Particular attention will be paid to:

- Training, recruitment, rational deployment, motivation and retention of qualified staff across the country,
- Rehabilitation and improvement in the performance of existing facilities while providing new facilities to identified underserved populations,
- Social mobilisation for community empowerment and participation in the management and monitoring of health services and
- Better co-ordination and management of resources through ensuring that all stakeholders adhere to the Sector-Wide Approaches code of conduct.

The purpose of this document, therefore, is:

- To relate the ongoing health sector reform to health development in the Uganda context;

- To guide the participation of all stakeholders in health development in Uganda.

- To exhibit a health sector strategic framework, with coherent goals, objectives and targets for the next five years;

- To indicate the level of investment in terms of costs required for achieving the policy objectives agreed upon by the Government of Uganda and its development partners.

- To monitor the performance of the sector at all levels.

Chapter 2

IMPLEMENTING THE UGANDA NATIONAL MINUMUM HEALTH CARE PACKAGE

2.1. Introduction

Uganda is classified among the poorest countries in the world. The country is struggling to recover from decades of civil strife and is severely constrained and overburdened by debt. It has a heavy resultant disease burden of preventable infectious diseases and has at the same time to contend with an emerging incidence of non-communicable diseases. The country has also been badly hit by the HIV/AIDS pandemic. The Health Sector Strategic Plan has thus found it imperative to plan carefully, to prioritise judiciously and to allocate rationally the limited available resources. Several studies including the Burden of Disease and Cost Effectiveness Study (1995), the Uganda Participatory Poverty Assessment Project (UPPAP1998) and analysis of Ministry of Health HMIS have been used to define the leading causes of morbidity and premature death in the population. These have been presented in 1.2.2.2.

This Chapter will describe how the Uganda National Minimum Health Care Package (UNMHCP) will be delivered. The presentation consists of a description of the current status, states the objectives and implementation strategies in each case. This is followed by Logical frames which summarise expected outputs, the verification indicators and key assumptions.

Detailed operational plans at the centre, district and sub-district levels will be elaborated out of these as part of the three year rolling plans and within the framework of MTEF development process. Districts will also enjoy the flexibility of adding specific district priorities that are not in the UNMHCP. For example some districts have a heavy burden of filarial hydrocele of the testis, others have a major problem with trachoma or sleeping sickness, yet others are seriously incapacitated by river blindness, bilharzia or guinea worm infestation.

2.2 Technical Health Care Programmes

The technical health care programmes, which constitute the Minimum Health Care Package, are cost effective interventions that are considered to have the highest impact on reducing morbidity and mortality from the major contributors to the disease burden using existing resources.

The technical health care programmes in the Minimum Health Care Package include:

1. Control of Communicable Diseases: Malaria; STD/HIV/AIDS; Tuberculosis
2. Integrated Management of Childhood illness
3. Sexual and Reproductive Health and Rights
4. Immunisation
5. Environmental Health
6. Health Education and Promotion
7. School Health
8. Epidemic & Disaster Prevention, Preparedness and Response
9. Improving Nutrition

10. Interventions against diseases targeted for elimination or eradication
11. Strengthening Mental Health Services
12. Essential Clinical Care

2.1 CONTROL OF COMMUNICABLE DISEASES

2.1.1 Description

The program on control of specific communicable diseases contains some of the most severe health problems in Uganda. These are Malaria, Tuberculosis and STD/HIVAIDS. These communicable diseases are among the most common causes of death and illness across the age profile as revealed by the Burden of Disease study of 1995.

2.1.2 Objectives

Malaria.

Objective: To prevent and control malaria morbidity and mortality

The national targets by the end of the plan period are:

- Increase from 30% to 60% the proportion of the population that receive effective treatment for malaria within 24 hrs of the onset of symptoms
- 60% of the proportion of pregnant women receive protection against malaria through intermittent presumptive treatment with SP
- Increase from 5% to 50% the proportion of children under-5 protected by ITM
- Reduce malaria case fatality at hospital level from 5% - 3%.

STD/HIV/AIDS

Objective: To prevent and control STD/HIV/AIDS transmission and mitigate the personal effects of AIDS

The national targets by the end of the plan period are:

- Attain a 25% reduction in HIV sero-prevalence
- Increase and sustain male condom use from 50% to 75% in rural areas and sustain the rate in urban areas at/above the current rate of 80%.
- Increase female condom use to about 25% for both urban and rural areas
- All health units (HC III and above) to provide HIV voluntary counselling and testing services.
- Reduce the mother to child HIV transmission from the current 25-27% to 15%
- Achieve 100% HIV free blood for transfusion at all levels
- Effective management of STDs and opportunistic infections provided in all health units
- Achieve 100% compliance universal infection control procedures in all health units public and private
- Provide counselling and psychosocial support to individuals and families affected by HIV.
- Promote and participate in Research to develop a vaccine and improve prevent and care of HIV/AIDS

T B

Objective: Control of TB through early diagnosis and treatment

The national targets by the end of the plan period are:

- Achieve 100% national coverage with community DOTS,
- Achieve an increase in TB treatment and cure rate (TB success rate) from 60% to 80%.

2.1.3 Implementation Strategy

In order to control the present scourge of both epidemic and endemic diseases, the Government has established focal programs in the Ministry of Health to support the District Health Teams in the planning and implementation of disease prevention and control programmes relevant to each district. More importantly, successful implementation of these control measures under the HSSP will depend on revitalisation of health centres and the efficient operation of the Health Sub-district and the community health departments of the hospitals. At the community level, social mobilisation through the Village Health Committees (VHC) will be an important strategy. Gender specific strategies will be developed to ensure that both men and women are involved in the prevention and control of communicable diseases .

At the National level, the Department of National Disease Control, in collaboration with other Departments in the MoH, will be responsible for policy development, overall co-ordination and guidance on the prevention and control of communicable diseases throughout the country. In addition, it will provide technical supervision and support to District Directors of Health Services. Furthermore, the Department of National Disease Control will co-ordinate with the NGO sector on the establishments of standards and regulations affecting the program, and for monitoring the delivery of public sector and non- governmental disease control activities throughout Uganda.

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of prevention and control of communicable disease activities. Each DHMT will support and guide the HSD teams to develop their respective operational plans and budgets

Implementation arrangements for prevention and control of communicable diseases are given in logframes in the subsequent pages.

HSSP Logframe: Control of communicable diseases – Malaria

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Malaria control system operational	1.1 % of Health units using current malaria control standards and guidelines 1.2 Existence of budgeted plans for malaria control activities at central and district levels 1.3 Proportion of district/subdistrict health teams and health units with staff adequately trained in case management and malaria prevention, and with appropriate facilities 1.4 Proportion of simple and severe malaria cases correctly diagnosed and treated in all age groups within 24 hours. 1.5 Proportion of pregnant women receiving protection against malaria through IPT. 1.6 Malaria case fatality rates in hospitals. 1.7 Proportion of children under-5 sleeping under impregnated bednets	1.1 Plan documents, financial reports 1.2 District monthly and annual reports; health facility reports; inventory reports; procurement records; training reports; support supervision reports 1.3 HMIS, District reports, patient records, support supervision and quality control reports 1.4 Disease surveillance reports District reports; health facility reports; reports on epidemics; reports on periodic surveys	1. Political commitment to increasing accessibility to health services maintained 2. Collaboration with IMCI maintained 3. Partnership with both health and non-health sectors sustained 4. Taxes and tariffs on insecticide treated materials and insecticides waived 5. Levels of drug resistance remain under control
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop and review gender sensitive policies, guidelines & standards for malaria control at all levels 1.2 Build capacity for malaria control in terms of planning, needs assessment, fund-raising, resource allocation and training 1.3 Implement malaria control activities in case management, intermittent presumptive treatment in pregnancy, vector control (in particular insecticide-treated materials) and epidemic preparedness and response 1.4 Design and conduct gender responsive advocacy and IEC campaign Design and implement effective systems for disease surveillance, monitoring and evaluation, and epidemic forecasting	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders	Detailed Assumptions will be formulated by the Programme, District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

HSSP Logframe: Control of communicable diseases – STD/HIV/AIDS

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Prevention and control of the transmission of STD/HIV/AIDS strengthened 2. Mitigation of individual and community impact of HIV/AIDS 3. Provision of HIV free blood at all levels 4. Surveillance, Monitoring and Evaluation and support for programme management system operational 4. Vaccine development research promoted and strengthened.	1.1 Knowledge about STD/HIV/AIDS 1.2 Number of casual sexual relationships 1.3 Condom use and availability 1.4 HIV sero-prevalence rate at sentinel sites and children Under-5 1.5 STD case management 1.6 STD incidence in men and prevalence in women 1.7 % of health units offering VCT 2.1 Proportion of health facilities equipped with drugs and diagnostic facilities 2.2 Proportion of health workers able to administer standard diagnostic treatment and counseling 2.3 Proportion of health facilities practicing infection control according to universal precautions 3.1 % of HIV transmission caused through blood transfusion Availability of data sets and information on the above indicators 4.1. Availability of Research protocols	1.1 KAPB surveys, 1.2 STD facility surveys 1.3 HIV sentinel surveillance 2.1 Special studies 2.2 Review of records for procurement and distribution of condoms 2.3 Condom availability surveys 4.1 Research reports	1. Functional Districts health care systems 2. Trained health workers at peripheral level will be recruited 3. Procurement system will be streamlined 4. International interest in vaccine development maintained.
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Promote behaviour change through IEC programmes 1.2 Conduct special survey; epidemiological surveillance 1.3 Ensure availability and distribute condoms 1.4 Make early diagnosis and treatment of STD; Conduct training of health workers in STD/HIV/AIDS care management, prevention and counselling 1.5 Provide safe blood for transfusion. 2.1 Provide voluntary counselling and testing; provide medical care and counselling to PWA 2.2 Procure and supply drugs, medical supplies and diagnostic equipment 3.1 Develop and disseminate planning guidelines; 3.2 Provide infection control guidelines to all health facilities 3.3 Conduct monitoring and evaluation of STD/HIV/AIDS (surveillance, behavioural studies, special surveys)	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

HSSP Logframe: Control of communicable diseases – Tuberculosis

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1 Prevention and control of Tuberculosis intensified and integrated in the Health System	1.1 Proportion of TB patients on DOTS 1.2 Availability of anti – TB drugs at health facilities 1.3 Number of reported defaulters, new cases and contact cases and the cure rate 1.4 Number of health workers trained in diagnosis and treatment of TB 1.5 Number of districts/facilities with correct reporting 1.6 Number of districts with DOTS	1.1 Records of cases; reports; special surveys; treatment guidelines 1.2 Inventory of drug; treatment cards 1.3 Field visit reports; record books; treatment cards; health facility and district reports 1.4 Training reports; Supervisory visits; performance appraisal; health facility reports 1.5 Periodic reports; district and health facility reports; survey reports 1.6 Field visits and Reports on DOTS at the district level	1 Stable population 2 Political commitment 3 Functional District Health Services 4 Security sustained.
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Promote TB prevention and treatment; provide guidelines for standard treatment; review treatment regimes 1.2 Procure and distribute adequate anti – TB drugs, and medical supplies 1.3 Develop and implement a comprehensive mechanism for contact tracing, new cases and defaulters 1.4 Conduct training for health workers in the diagnosis and treatment of TB 1.5 Implement a comprehensive surveillance system; Conduct operational research on chemoprophylaxis 1.6 Implement community based DOTS	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

2.2 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

2.2.1 Description

Integrated Management of Childhood Illness is an approach intended to provide health care to children in a holistic manner. Specifically, it is intended to integrate CDD/ARI, immunisation, and case management of malaria and nutrition in children. These entities account for 70% of all childhood illnesses in Uganda. The Control of Diarrhoeal Diseases Programme (CDD) will address diarrhoea management with special emphasis on diarrhoeal diseases of epidemic potential.

2.2.2 Objectives

The objective is to reduce morbidity and mortality among under-5s due common childhood illness.

The national targets by the end of the plan period are:

- achieve 100% coverage with Components I and II of IMCI
- achieve a 50% coverage with component III (Community Component
- Reduce Case Fatality Rate from Diarrhoeal diseases of epidemic potential from 6.0% to 1%.
- Reduce annual diarrhoeal disease incidence from 30/1,000 to 15/1,000 population.

IMCI and CDD programmes are expected to achieve the following:

- Improved Case Management of childhood illness
- Improved performance of health workers in IMCI at first level and referral facilities
- Strengthened district and central level capacity for implementation of IMCI;
- Improved availability of drugs and supplies for IMCI and CDD;
- Improved gender specific community capacity for correct home care and health care seeking behaviour for common childhood illness with special attention on mothers and children;
- Introduce IMCI training in all paramedical, nursing, midwifery and medical schools
- Improved referral system and quality of care for children with severe illness.
- Support capacity building at central and district levels for reduction of diarrhoea.
- Increased community awareness of IMCI and CDD related issues.
- Intensify advocacy and social mobilisation for control of diarrhoeal diseases of epidemic potential
- Conduct operational research on diarrhoeal diseases and IMCI

2.2.3 Implementation Strategy

At the national level, the Division of Child Health will be responsible for development of policy, overall co-ordination, development of standards and guidelines, monitoring and evaluation of the IMCI and CDD implementation process. The division will provide technical support supervision to the districts. It will co-ordinate with other child health related institutions such as Universities, NGOs , Private sector and other relevant international agencies. The main focus of implementation will be at the district level where specific strategies for social mobilisation will be developed for both men and women involved in management of common childhood illness and diarrhoeal diseases.

The District Health Management Team will co-ordinate all IMCI and CDD activities in the districts. In addition the team will ensure the availability of logistics and supplies required for IMCI and CDD implementation. Each HSD will design its own implementation plan to institutionalise IMCI at all levels of the HSD by the end of the plan period.

Implementation arrangements for Integrated Management of Childhood Illness and Control of Diarrhoeal Diseases are given in logframes below.

HSSP Logframe: Integrated Management of Childhood Illness

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Integrated Management of Childhood Illness operationalised at all health care delivery levels	1.1 Proportion of facilities, schools and institutions implementing IMCI approaches 1.2 Number of health workers trained on IMCI approach 1.3 Proportion of health facilities with adequate IMCI facility support 1.4 Proportion of districts with guidelines for monitoring and e1valuation of IMCI interventions 1.5 Proportion of communities with IMCI interventions 1.6 Proportion of under 5 children with common childhood illness correctly referred from one level to another	1.1 Field visits, reports from facilities and districts, programmes and institutions 1.2 Training reports from health units and districts; staff appraisal reports; facility record 1.3 Research reports, utility of research reports 1.4 Field visits, feed back from communities, NGOs, and districts, survey reports 1.5 Health facility records, district reports	1. Co-operation among institutions and actors expected 2. Health workers motivated to implement IMCI and manage epidemics 3. CDD will be the focal unit for managing cholera and dysentery epidemics
2. Capacity to manage diarrhoea at health units and community levels established and strengthened .	2.1 Proportion of health facilities and institutions utilising CDD guidelines and plans. 2.2 Proportion of districts with guidelines for monitoring and evaluation of CDD activities 2.3 Proportion of communities using ORT interventions	2.1 Field visits, reports from facilities and districts, programmes and institutions 2.2 Reports from communities, NGOs and district survey reports 2.3 Health facility records, district reports,	
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
3.1Promote and use IMCI approach in all facilities, institutions including schools and key programme areas 3.0 Train and re – orient health workers on IMCI and CDD preparedness and response 3.1 Carry out support supervision 3.2 Carry out advocacy for IMCI and CDD management in the districts 3.3 Incorporate IMCI into the training curricula for health workers 3.4 Conduct operational research 3.5 Design implement and evaluate appropriate interventions for behavioural change at community level 3.6 Promote IMCI referral system and community participation in control of diarrhoea. 3.7 Establish and strengthen harmony between the major actors in IMCI 3.8 Distribute logistics for diarrhoea management 3.9 Incorporate diarhhoeal disease prevention and control into institutions' (police, Army, prison and schools) health programmes	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

2.3 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

2.3.1 Description

Sexual and Reproductive Health and Rights is an important program in the Health Sector Strategic Plan in view of the high maternal and child mortality rates. Effective implementation of this program is expected to contribute significantly to reduction of maternal, peri-natal, infant and under-5 morbidity and mortality rates. Family planning activities are aimed at reducing total fertility rate, in addition to its contribution to improved maternal and infant health.

2.3.2 Objectives

The objective of Sexual and Reproductive Health and Rights is to contribute to the reduction of neonatal, infant and maternal morbidity and mortality

The national targets by the end of the plan period are:

- Reduce mortal mortality ratio by 30% from 506 to 354 per 100,000 live births
- Increase contraceptive prevalence rate from 15% to 30%
- Increase the deliveries supervised by skilled health workers from 38%to 50%
- Increase Tetanus Toxoid (TT2) coverage for pregnant women from 50% to 80%

The Sexual and Reproductive Health and Rights programme will:

- Advocate for sexual and reproductive rights
- Integrate quality Sexual and Reproductive health services into the activities of all existing health units and communities;
- Support capacity building through proper training to improve the performance of public sector and non-governmental staff delivering services (Doctors, Anaesthetic Officers, TBA, Midwives, CHW, etc);
- Establish adolescent friendly health services at all HC IIIs and above facilities
- Provide drugs, supplies, equipment and support services;
- Increase antenatal and post-natal care coverage;
- Increase access to emergency obstetric care and strengthen the referral services;

2.3.3 Implementation Strategy

Effective implementation of the Sexual and Reproductive Health and Rights program under the HSSP will depend on revitalisation of health centres and the efficient operation of the Health Sub-district and the community health departments of the hospitals.

The Reproductive Health Division of the Department of Community Health in the Ministry of Health will be responsible for policy development, overall co-ordination and guidance of Sexual and Reproductive Health and Rights services throughout the country as well as technical supervision and support to District Directors of Health Services. The Department will co-ordinate with the Population Secretariat and the NGO sector, on the establishments of standards and regulations affecting Sexual and Reproductive Health and Rights services, and for monitoring the delivery of public and non-governmental MCH services throughout Uganda. At the district level, the District Director of Health Services is responsible for the planning, management and co-ordination of all activities.

During implementation of the Health Sector Strategic Plan, MoH proposes to provide financial and material support to the Sexual and Reproductive Health and Rights activities of NGOs particularly those working in difficult and isolated rural areas. Because these services constitute the core of the country's package of priority health intervention, the private sector will be encouraged as partners in sharing responsibilities.

Currently, donors play a central role in financing considerable costs of the activities. However, government will continue to identify and direct resources to the most cost-effective interventions to ensure sustainability. Most significant is the need to halt the duplication and overlapping of activities in the program and ensure efficiency of resource use during the plan period by establishing necessary tools for effective prioritisation, planning and co-ordination. This underscores the determination for joint future planning between the government and the donor community.

Implementation arrangements for Sexual and Reproductive Health and Rights are given in the logframes on the next page.

HSSP Logframe: Sexual and Reproductive Health & Rights

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1 Maternal and infant mortality reduced through comprehensive and integrated reproductive health services	1.1 SRH policy, guidelines and standards in place (including adolescent health policy) 1.2 Percentage of health facilities providing adolescent friendly services 1.3 Number of health units providing integrated SRH services including daily FP services 1.4 Percentage of Health Units providing basic and comprehensive obstetric care. 1.5 Number of health facilities with referral logistics (vehicles & communication equipment)	1.1 Policy documents, Guideline documents on SRH, utility of documents 1.2 KAPB surveys on adolescent sexual and reproductive groups, district & health facility reports 1.3 Guidelines documents; inventory records 1.4 Health facility records; utilisation rates; routine data 1.5 Inventory of equipment; field visits	1. Level of political support 2. Continued collaboration with relevant technical programmes 3. Continuous financial support 4. Collaboration with other HIS sub systems
Activities at the operational level	**Verifiable indicators**	**Means of verification**	**Key Assumptions**
1.1 Develop, review and disseminate Sexual and Reproductive Health Policy, standards and guidelines 1.2 Provide adolescent health services in health facilities 1.3 Provide integrated daily SRH services in all health facilities 1.4 Equip referral health facilities with communication equipment and vehicles 1.5 Train service providers in SRH service delivery 1.6 Develop, produce and disseminate IEC materials & messages 1.7 Conduct support supervision to the districts to monitor SRH activities 1.8 Support and conduct appropriate operational research at national and district levels 1.9 Integrate IEC into School health programmes	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4 OTHER PUBLIC HEALTH INTERVENTIONS

Preventable diseases account for 75% of the national disease burden. Effective implementation of the following public health interventions will prevent and control the majority of health problems in the country:

1. Immunisation
2. Environmental Health
3. Health Education and Promotion
4. School Health
5. Epidemic and Disaster Prevention, Preparedness and Response
6. Improving Nutrition
7. Interventions against diseases targeted for Elimination or Eradication.

2.4.1 IMMUNISATION

2.4.1.1 Description

Immunisation is a cost effective intervention which contributes to improvement of health indices in a relatively short period of time. The Uganda National Expanded Programme on Immunisation (UNEPI) against the following six vaccine preventable diseases namely, measles, poliomyelitis, whooping cough, tetanus, tuberculosis and diphtheria will be revitalised and expanded. The basic aim is to reverse the decline and achieve the national and regional coverage targets and thereby reduce morbidity and mortality resulting from these diseases. Campaigns will be used whenever appropriate, as will be the possible introduction of additional vaccines (e. g. Yellow Fever, Hepatitis B).

2.4.1.2 **Objectives**

The main objective is to attain the highest levels of coverage such that the EPI target diseases are no longer of public health significance in the country.

The national targets by the end of the plan period are:

- Achieve coverage of children 12 – 23 months fully immunised from 44% to 70%
- Increase DPT3 coverage from 55% to 65% by end of Year One and to 70% at end of Year Five
- Increase TT2 coverage of pregnant women to 80% by the end of Year Five

The Immunisation program is expected to:

- Reduce morbidity and mortality from the six immunisable diseases
- Equip all districts with functional cold chain system (adequate vaccines, supplies and equipment) and strengthen the capacity for cold chain maintenance at all levels.
- Strengthen the collection and management of immunisation data at the centre and district levels
- Conduct IEC for immunisation services at all levels.
- Develop and strengthen capacity of Human Resources for health including training and support supervision.
- Ensure timely delivery of immunisation logistics at all levels.
- Monitor and supervise delivery of immunisation service to ensure quality.
- Monitor the incidence of indicator Immunisation target diseases.
- Work towards National Vaccine Independence.

2.4.1.3 Implementation Strategy

At the national and lower levels, participation of political and other community leaders in active mobilisation of communities will be a major strategy. An Inter Agency Committee representing a wide range of civil society and stake holders has been established. It will co-ordinate activities and mobilise resources.

At the Ministry of Health level, the Department of National Disease Control in collaboration with other relevant technical departments will be responsible for policy development, overall co-ordination and guidance on immunisation. Technical supervision will be undertaken by technical staff of UNEPI who will co-ordinate with the NGO sector on the establishment of standards and regulations affecting the program and monitoring service delivery. In addition, the Ministry of Health will explore the possibility of introducing additional vaccines especially Hepatitis B Vaccine into the routine programme.

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of immunisation services with all agencies working at the District level. All health facilities, public and NGO, will offer EPI services on a regular and consistent basis including outreach services

A dedicated outreach programme will be put in place to serve the "hard- to-reach populations".

Mass campaigns will be expanded in a phased manner against selected target diseases namely polio and measles. This strategy will be applied as appropriate, so as to make EPI target diseases no longer of public health significance in the country.

Effective implementation of the immunisation program will depend on well equipped health units with a functioning cold chain system. Capacity building for staff in technical areas of the program will be intensified throughout the plan period
Implementation arrangements for the Expanded Program on Immunisation are given in the logframes below

HSSP Logframe: Immunisation

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Immunisation services revitalised and expanded	1.1 Availability of all Immunisation vaccines at all levels of service delivery 1.2 Availability of functioning cold chain equipment 1.3 Availability of functioning equipment (steriliser, gas cylinders, vehicles, bicycles, motor cycles) 1.4 Number of supervisory visits conducted to the districts 1.5 Number of operational outreach services; Number of advocacy meetings held per period 1.6 Number of immunisation sessions at the static unit per defined period; Number of children immunised per session 1.7 Number of Immunisation /IEC materials produced and disseminated; Number of mass media organisations participating in the promotion of Immunisation services; Frequency of production of IEC 1.8 Established comprehensive surveillance system 1.9 Number of health workers trained and re oriented to Immunisation	1.1 Procurement records, Stock records, agency and facility reports 1.2 Inventory records, reports from districts and facilities 1.3 As 3.8.1 above 1.4 Field visits 1.5 Supervisory reports 1.6 District and facility reports 1.7 As above 1.8 Meetings, news papers, radio and TV adverts 1.9 Surveys, coverage data, incidence of Immunisation target diseases 1.10 Training reports; personnel reports; field visits	1. Political support will be maintained
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop/update and disseminate national EPI policy and guidelines including injection safety 1.2 Estimate and procure vaccine 1.3 Assess cold chain requirements 1.4 Procure logistics for Immunisation activities (radio sets, vehicles, gas cylinders, cold chain equipment etc) 1.5 Distribute equipment, logistics and vaccines 1.6 Conduct supervisory visits at all levels 1.7 Advocate for support and sustainability of Immunisation services 1.8 Conduct immunisation at all levels 1.9 Develop gender responsive mobilisation strategies and disseminate Immunisation/IEC materials 1.10 Develop and disseminiate gender responsive IEC materials 1.11 Conduct national coverage surveys; Establish a functional surveillance system 1.12 Train health workers and support staff on Immunisation	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4.2 ENVIRONMENTAL HEALTH

2.4.2.1 Description

Environmental factors are major determinants of health outcomes. The programme will focus on raising awareness in the population to the relationships between their health and their surroundings. It will address issues of access to safe water, waste disposal, and both at household, institutional and urban settings. This program provides health services that aim to alleviate current poor sanitary living conditions and food contamination by improving the number of households with access to latrine and safe water. There is also need to manage health issues related to environmental and/or occupational hazards such as toxic agents and worm infestation in agriculture and hazards to health in other occupations. In addition, food and personal hygiene have to be maintained to prevent communicable diseases. There will be need to adopt appropriate technology for vulnerable communities including those with special geo-physical conditions. Furthermore, health regulations will require enforcement and updating.

2.4.2.2 Objectives

The main objective of the programme is to contribute to the attainment of a significant reduction in morbidity and mortality due to environmental health related conditions.

The national targets by the end of the plan period are:

- To increase access to safe water from 43.9% to 75% by end of the plan period.
- All 45 districts will be carrying out regular drinking water quality surveillance activities.
- Increase safe waste disposal including human excreta in 60% of households and institutions in Uganda by end 2004.
- An Environmental Health Act and subsidiary legislation in place and being fully enforced.

The Environmental Health program through the National Environmental Sanitation Plan and the Kampala Declaration, on sanitation is expected to:

- Implement minimum environmental health services package with special emphasis on safe water supply and sanitation as spelt out in the National Health Policy and the Kampala Declaration
- Strengthen collaborative mechanisms at various levels and with relevant agencies for promotion of safe water and sanitation and occupational health;
- Promote proper food hygiene and safety, management of waste (solids and liquid), pollution control, and occupational health and safety in workplaces;
- Promote gender responsive IEC to support community mobilisation on environmental health matters;
- Promote clean and hygienic living conditions at household level.
- Integrate Sanitation and hygiene in school health and educational programmes.

2.4.2.3 Implementation Strategy

Regular monitoring and awareness campaigns will be undertaken to facilitate all households to have access to safe human waste disposal systems as well as safe refuse disposal methods. Llegislation will also be developed to guide safe water and environmental sanitation, pollution control, disposal of industrial and chemical waste, and promotion of public safety in motor vehicles. Water and environmental sanitation underpin much of the activities envisaged by

other technical programs that aim to reduce child and infant mortality, and epidemic prevention and control. Without this program, much of work done by IMCI, MCH and Nutrition programs would be undermined. Furthermore, effective implementation of this program will depend on sensitising the communities on proper sanitary behaviour and the active involvement of NGO and other Government Agencies particularly, with the relevant Ministry responsible for the construction work./provision of water systems. Appropriate environmental measures including anti - worm infestation in communities will be implemented.

The Division of Environmental Health in collaboration with Health Education at the MoH, will be responsible for policy development, overall co-ordination and guidance on sanitation and safe water services throughout the country, as well as technical supervision and support to District Directors of Health Services. It will co-ordinate with the NGO, and other Government agencies on the establishment of standards and regulations affecting the program, and for monitoring the delivery of public and private sector sanitation and safe water services throughout Uganda. At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of sanitation and safe water services with all agencies working at the district level. Implementation arrangements for Environmental Health are given in the logframe below.

HSSP Logframe: Environmental Health

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1. Personal, household, institutional and community hygiene and sanitation promoted	1.1 Availability, completeness and clarity of policy documents, regulations and guidelines Number of districts fully operationalising the Kampala Declaration on Sanitation (KDS) 1.2 Work places with occupational health and safety provisions. 1.3 Percentage of households and institutions with appropriate hygiene and sanitation and safe water sources/handling 1.4 Number of water testing kits procured and in use 1.5 Percentage of households, health facilities, and training institutions with access to clean, adequate and safe water. 1.6 Percentage of households and institutions with safe means of refuse and waste disposal. 1.7 Number of health workers trained in environmental health management 1.8 Number of completed studies 1.9 Number of bore holes and pit latrines constructed and springs protected 1.10 Availability of mechanisms for management of hazardous material and medical waste	1.1 Policy documents, laws, guidelines and regulations, utility of manuals 1.2 Field visits, district and community reports 1.3 Periodic surveys, routine field visits 1.4 Distribution lists for water kits 1.5 Field visits, district records, coverage survey reports 1.6 IEC materials, media messages, field visits, district and community reports 1.7 Reports of environmental health agencies, surveys of waste disposal practices 1.8 Training records 1.9 Supervision reports, district reports 1.10 Media messages, feedback from users, record of meeting proceedings 1.11 Study reports 1.12 Field visits, construction reports on latrines and bore holes, district and community reports 1.13 Guidelines, policy documents, institutional reports	1. In collaboration with other Water Development Agencies 2. Institutions and households build and operate waste disposal infrastructure according to set standards 3. Collaboration with other agencies whose activities are related to environmental health 4. Political and community commitment
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**

1.1 Develop and review environmental health policies including food hygiene, supportive laws, regulations and guidelines 1.2 Protect water sources 1.3 Monitor the accessibility and quality of water; functional latrine 1.4 Establish Environmental Health information management system 1.5 Procure and distribute water testing kits 1.6 Ensure safe water management 1.7 Promote proper housing and household/ school hygiene and sanitation 1.8 Establish effective management of wastes from households institutions and industries 1.9 Train health workers on environmental health management 1.10 Carry out support supervision and monitoring and evaluation of environmental health activities including occupational health and safety; 1.11 Conduct advocacy meetings at all levels; Promote public awareness on importance of food and personal hygiene 1.12 Carry out household, institutional, and community surveys on functional latrine coverage; Assess environmental health needs 1.13 Promote construction and use of pit latrines and bore holes 1.14 Promote proper management of domestic, institutional and industrial solid, liquid and other hazardous wastes 1.15 Recommend mitigation measures on Environmental health matters 1.16 Carry out inspections and licensing in food handling and processing facilities; 1.17 Train personnel in water quality surveillance techniques; 1.18 Produce gender responsive IEC materials on environmental health	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4.3 HEALTH EDUCATION AND PROMOTION

2.4.3.1 Description

Knowledge and attitudes of the population are key determinants of health seeking behavour of communities. In Uganda it has been stated that the commonest cause of morbidity and premature mortality is ignorance of causative factors of disease and measures to promote health and prevent ill health. A comprehensive Health Education and Promotion program will therefore be implemented as an essential part of all the health programmes .

2.4.3.2 Objectives

The main objectives of Health Education and Promotion are to promote individual and community responsibility for better health and to advocate for the HSSP.

The national targets by the end of the plan period are: (i) 95% public awareness of personal and community responsibility for better health. (ii) provide IEC materials to all HC I/Village Health Committees (VHC). (iii) implement an effective advocacy plan for the HSSP, all stakeholders to be familiarised with the National Health Policy and HSSP. (iv) Recruit positive media participation in health education and promotion.

The Health Education and Promotion program is expected to:

- Promote adoption of health promotive and disease preventive behaviours at individual and community levels
- Support the development and adaptation of strategies for dissemination of specific program messages through various mechanisms;
- Create demand for and effective utilisation of health services
- Collaborate with other sector institutions in promotion of community participation and advocacy for health

2.4.3.3 Implementation Strategy

Effective implementation of the Health Education and Promotion program under the HSSP will depend on successful integration with, and a clear understanding of the activities of associated technical programs. The Health Education and Promotion program will need to develop close operating links with other line ministries. Mechanisms will be developed to streamline program activities and eliminate duplication and wastage.

At the national level, the Health Promotion and Education Division will collaborate with specific technical programs in policy development, overall co-ordination and guidance on Health Promotion and Education activities throughout the country. In addition, it will conduct technical supervision and support to District Directors of Health Services. The Health Promotion and Education Division will co-ordinate NGOs, and other Government agencies to establish standards and regulations pertaining to the program, and will monitor the delivery of public and non-governmental IEC activities throughout Uganda.

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of gender responsive IEC activities with all agencies working at the District including District Information Office.

Implementation arrangements for Health Promotion and Education are given in the logframes below

HSSP Logframe: Health Education and Promotion

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Comprehensive & effective Information, Education and Communication programme strengthened	1.1 availability of IEC materials at all levels 1.2 Percentage increase in persons adopting health promotive and disease prevention behaviours e.g condom use, latrine coverage and use. 1.3 Percentage increase in persons seeking and utilising health services. 1.4 Percentage increase in knowledge of available services and their importance. 1.5 Number of mass media organisations participating in dissemination of messages 1.6 Percentage increase in communities actively participating in health. 1.6 Proportion of Health Workers and community resource persons trained in IEC 1.7 Number and quality of operational researches conducted 1.8 Proprtion of of schools conducting School Health Promotion activities 1.9 Number of districts supported to develop IEC messages in local languages for specific target groups	1.1 Community surveys, reports, listening to media production, inventory 1.2 Timeliness of dissemination, success of reaching the targets, KAPB studies 1.3 Reports from field visits, report from monitoring firms 1.4 District and community reports, media messages 1.5 Training records, utility of IEC materials, performance of trainer in the field 1.6 Final research and programme reports 1.7 School curricular, annual school reports, district reports, feed back from school children 1.8 District reports, field visits	1. Conducive political environment 2. Availability of resources 3. Co-operation with other sectors
Activities at the operational	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop, distribute and disseminate gender sensitive IEC materials and messages 1.2 Support mobilisilisation of communities (using gender specific strategies) for health through promotion of IEC through out the country 1.3 Monitor mass media health messages 1.4 Promote gender sensitive IEC campaigns using varoius media 1.5 Develop capacity for gender responsive IEC at all levels 1.6 Carry out operational research 1.7 1.7 Provide support to districts to develop gender responsive IEC materials 1.8 Publicise the NHP and HSSP	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4.4 SCHOOL HEALTH

2.4.4.1 Description

The School Health Programme is intended to provide comprehensive preventive and promotive health services to school-going children (5-24 years), estimated at 45% (8,055,459) of the national population (1991 census). Focus will be put on primary and secondary schools and teacher training institutions. The programme will improve the health of the school children, reduce the dropout rates and enhance performance in schools. This will augment the Government programmes on education, including Universal Primary Education (UPE).

2.4.4.2 Objectives

The main objectives of School Health Programme are to improve the health status of the school children, their families and teachers and to inculcate health seeking behaviour among this population group.

The national targets by end of plan period (2004/05) are:

- All primary schools (public and private) implementing the national School Health Programme
- All primary schools (public and private) having adequate pit latrine stance per pupil population in accordance with national standards
- All primary schools (public and private) having adequate hand washing facilities.
- All secondary schools (Public and Private) with adolescent health services.

School health programme is expected to:

- Improve personal hygiene and promote healthy life styles among school children
- Ensure health education and its delivery in schools;
- Strengthen medical and dental care services for school children;
- Promote construction and use of pit latrines in all schools;
- Promote provision of safe water supplies in all schools;
- Improve physical and psychosocial school environment;
- Improve nutritional status of school children;
- Strengthen physical education and recreation.
- Improve health seeking behaviour among school children, their households and their teachers

2.4.4.3 Implementation strategy

At the national level, the Ministry of Health in collaboration with the Ministry of Education and Sports and other school health stakeholders will formulate and implement a comprehensive health preventive and promotional school programme. Schools will be adequately equipped to provide health education and health promotional activities. The Ministry of Health will provide guidelines, advocacy and technical supervision to the districts. It will co-ordinate and collaborate with other technical child health related institutions for effective implementation of the program.

At the district level, the District Director Health Services will collaborate with the District Education Officer and District Inspectors of schools to ensure co-ordinated implementation of the school health program.

HSSP Logframe: School Health

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1. Comprehensive School health program strengthened, co-ordinated and integrated in existing health education and social services.	1.1 Availability of school health policy and implementation guidelines 1.2 Percentage of schools with operational school health programmes 1.3 Number of advocacy meetings/workshops held 1.4 Number of appropriate IEC materials and messages disseminated 1.5 School curricular with health content 1.6 Frequency of health related tests and examinations	1.1 Policy implementation guidelines, document. 1.2 Field visits, district and workshop reports, Curricula documents, training materials, 1.3 IEC materials 1.4 Guidelines and standards, utility of documents 1.5 Curricular, examination papers	1. Level of political support 2. Continued collaboration with relevant technical programmes 3. Continuous financial support
Activities at the operational level	**Verifiable indicators**	**Means of verification**	**Key Assumptions**
1.1 Develop a gender sensitive national school health policy 1.2 Develop and implement a gender responsive school health programme 1.3 Review and disseminate to all stakeholders at all levels, School Health standards guidelines and curricula 1.4 Support adolescent health activities in schools 1.5 Support Districts train health workers, school teachers and parents in School Health services 1.6 Conduct gender advocacy meetings and IEC campaigns 1.7 Develop, produce and disseminate gender responsive IEC materials & messages 1.8 Conduct operational research in school health 1.9 Conduct support supervision to monitor School Health activities 1.10 Promote construction of and use of safe water sources, pit latrines and hand washing facilities. 1.11 Support regular de-worming of school children 1.12 Support malaria and other control strategies in schools	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4.5 EPIDEMIC & DISASTER PREVENTION, PREPAREDNESS AND RESPONSE

2.4.5.1 Description

The program aims to improve emergency preparedness and response at both national and district levels in order to promote health, prevent disease and reduce death among the affected population. It will also cover endemic and epidemic emergencies and disasters including flooding, internal displacement of person, refugees, man made disaster etc. The program aims at ensuring availability of funds, equipment, and drugs and supplies in adequate quantities at all time. This will enable Government to control and manage health emergencies on a continuous basis through promotion, disease prevention and integrated disease surveillance and community based surveillance. Establishment of an effective communication and co-ordination system to ensure efficient information flow, will constitute a major component of this program.

2.4.5.2 Objective

The main objective of the programme is prevention, early detection and prompt response to health emergencies and other diseases of public health importance

The national targets for the programme by the end of the plan period are:

- A functional integrated disease surveillance system in place
- Response to all confirmed epidemics within 24-48 hours

The program on emergencies, epidemic and disaster response is expected to:

- Integrate Surveillance, Emergency, Epidemic and Disaster Response activities into community health services;
- Conduct gender responsive IEC on Emergency, Epidemic and Disaster Response;
- Provide appropriate logistics, medical supplies and capacity for surveillance and management of epidemics;
- Improve on communication and referral at National, District Health Offices, Hospitals, Health Centres and communities for surveillance, emergencies, disasters and epidemics.
- Strengthen the National Laboratory support network at all levels
- Strengthen collaboration and linkages with other government sectors, neighbouring countries, and donor agencies and other stakeholders.
- Maintain a system for management of endemic and epidemic emergencies
- Maintain a system for surveillance of endemic and epidemic emergencies

2.4.5.3 Implementation Strategy

Capacity building will be an important activity for this program during the plan period. The HSSP also considers the training of health workers in Integrated Disease Surveillance, Emergency, Epidemic and Disaster Response management as effective strategies to minimise the negative effect of health emergencies

At the national level, the Department of National Disease Control, in collaboration with the Office of the Prime Minister and with other departments within the Ministry of Health will be responsible for policy development, overall co-ordination and guidance on Surveillance, Emergency, Epidemic and Disaster Response throughout the country. In addition, the

department will organise technical supervision and support to District Directors of Health Services. Continuous community based surveillance will be maintained at all levels through the Health Sub – Districts. The Director of Health, Community and Clinical Services will co-ordinate with other government sectors, NGO , neighbouring countries and international agencies in accordance with the Great Lakes and WHO protocols on the establishment of standards and regulations affecting the program.

The Director General of Health Services will ensure adequate funds, buffer stock of emergency drugs and other medical supplies at national and regional levels. The DDHS will maintain similar budgets and supplies at the district level.

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of Integrated Disease Surveillance, Emergency, Epidemic and Disaster Response with all agencies working within the District. Implementation arrangements for Integrated Disease Surveillance, Emergencies, Epidemic Preparedness and disaster responses are given in the logframes below.

HSSP Logframe: Epidemic & Disaster Prevention, Preparedness and Response

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1. System of Epidemic Prevention, Preparedness, Response, and Management complex emergencies operational at all levels of health care delivery 2. System of Integrated surveillance, forecasting and early detection of epidemic, disaster and emergencies in place	2.1 Availability, clarity and user friendliness of national guidelines of integrated disease surveillance and epidemic control 2.2 Unified epidemic monitoring system established 2.3 Number of epidemics reported and controlled successfully 2.4 Quantity of emergency stocks and equipment available for epidemic and disaster control at all levels and institutions 2.5 Proportion of health facilities with established and functional system including current guidelines case definition; proportion of affected population using the system 2.6 Number of personnel trained in surveillance and emergency response 2.7 Percent of districts with IEC strategy on surveillance and disaster preparedness and response 2.8 Percentage of districts with functioning disaster committees 2.9 Number of countries, districts and agencies with established forum for collaboration 2.10	1.1 Guideline documents, standards 1.2 Field visits, district and health facility progress reports 1.3 Media reports, routinely collected district level emergency reports, surveys, reports from local authorities 1.4 Equipment and drug inventory, distribution lists, field visits, annual reports from all levels and institutions 1.5 Field visits, staff records, annual health facility and district reports 1.6 Personnel development reports 1.7 Strategy documents, records of service utilisation 1.8 Field visits, minutes of committee meetings, plan documents, district reports 1.9 Agreements, memoranda of understanding, minutes of meetings (ministerial, inter – country, inter – districts etc)	1.1 Level of political commitment and inter – agency collaboration 1.8 Functional Disaster Preparedness Committee.
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop and distribute national guidelines on integrated disease surveillance, epidemic control and early warning systems 1.2 Establish epidemic and disaster early warning system 1.3 Educate communities on use	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.

surveillance tools, epidemic and disaster response and implement activities 1.4 Provide appropriate equipment, drugs and technology for epidemic and disaster control at all levels and institutions 1.5 Provide appropriate staff and services in the casualty departments of health facilities 1.6 Train health workers and communities in emergency management and surveillance. 1.7 Develop and implement district specific gender responsive IEC strategy 1.8 Establish emergency and disaster committees at all levels of health care delivery 1.9 Develop protocols for collaboration between neighbouring countries, districts and international agencies 1.10 Develop communication and disease notification system 1.11 Establish data bank for Risk Assessment. 1.12 Strengthen Laboratory capacity through training and equipment. 1.13 Build capacity for data collection, analysis and utilisation 1.14 Conduct operational research and investigate reported outbreaks.			
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4.6 IMPROVING NUTRITION

2.4.6.1 Description

The nutritional status of the population, particularly children and women is poor and has been identified as a major health problem in Uganda. In order to control diseases due to nutritional anaemia, protein energy malnutrition, Iodine deficiency disorders and Vitamin A deficiency; a combination of strategies including awareness building, case management, rehabilitation, supplementation, food fortification and diet diversification will be employed. The department of community health will use a multi-sectoral approach with other sectors in implementation of strategies to improve the nutritional status.

2.4.6.2 Objectives

The main objective is to contribute towards the improvement of the nutritional status of the population with special emphasis on mothers and children

The national targets by the end of the plan period are:

- Reduce stunting in the under – 5 children from 38% to 28%;
- Reduce under weight in the under-5 children from 26% to 20%
- Increase exclusive breast feeding at 6 months from 68% to 75%
- Increase and sustain Vitamin A supplementation coverage for children 6-59 months from 80% – 95%
- Increase the proportion of households consuming Iodated salt from 69% to 100%
- Increase public awareness on appropriate nutrition practises from x% to 95%

The programme will be expected to:

- Provide policies and guidelines in conjunction with the National Food and Nutrition Council
- Support capacity building at central and district levels for reduction of malnutrition
- Promote nutrition programs at different levels to reduce micro-nutrient deficiency disorders
- Establish an effective national growth monitoring and promotion system nation-wide
- Provide support supervision to the districts
- Formulate and enforce nutrition related legislation in conjunction with other relevant sectors
- Intensify gender responsive advocacy and social mobilisation for nutrition at all levels
- Provide guidelines for monitoring and evaluation of nutrition interventions
- Target the school going population through the School Health Programme.

2.4.6.3 Implementation Strategy

The strategy of sensitising households on balanced diets for children and young adults will be adopted. Upgrading the existing health centres, implementing Health Sub-District (HSD) and the community health departments of the hospitals will ensure effective implementation of Nutrition programs targeting households and communities.

At the national Level, the Nutrition Unit under the Department of Community Health in collaboration with other technical departments, programs, other Government Ministries and

agencies, will be responsible for policy development, overall co-ordination and guidance on nutrition throughout the country as well as technical supervision and support to Districts. The Department of Community Health will co-ordinate NGO sector on the establishment of standards and regulations affecting the program. Furthermore, it will create linkages within the Department in the sections of Nutrition and IMCI community component and other development partners.

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of nutrition activities at the District. Implementation arrangements for Nutrition program are given in the logframes below.

HSSP Logframe: Improving Nutrition

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1 Improved nutritional status through intensified services	1.1 Availability of an inter – sectoral nutritional policy 1.2 Percentage reduction of micro – nutrient disorders in the communities 1.3 Proportion of health facilities with adequate equipment, logistics and personnel; proportion of facilities offering appropriate nutrition services 1.4 National Food and Nutritional Council established; Availability of National Food Policy 1.5 Proportion of households implementing appropriate nutrition practices 1.6 Nutrition monitoring and evaluation system established and implemented 1.7 Percentage of malnourished children rehabilitated; number of patients given diet therapy; number of health units providing diet therapy 1.8 Number of special studies completed (e.g. identified cases of micro – nutrient deficiency, PEM) 1.9 Number of health workers trained in nutrition management; number of nutrition monitors trained	1.1 Nutrition policy documents, standards and guidelines 1.2 Community surveys 1.3 Field visits, inventory records, district and facility reports 1.4 Statutory documents; policy document 1.5 Periodic nutrition surveys, reports, routinely collected district data 1.6 Routinely collected data, HIS/Community HIS reports 1.7 Health facility records 1.8 Supervisory reports, district and facility reports 1.9 Quality survey reports 1.10 Training reports	1. Collaboration framework with all other sectors and agencies on nutrition is established
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop policy and formulate gender responsive policy and guidelines in collaboration with all key actors 1.2 Provide food supplementation and nutrition education 1.3 Provide equipment, logistics and personnel 1.4 Establish National Food and Nutritional Council 1.5 Conduct gender specific household IEC on nutrition 1.6 Develop and maintain an effective surveillance system for nutrition 1.7 Provide diet therapy 1.8 Carry out support supervision 1.9 Conduct special nutrition surveys; growth monitoring 1.10 Conduct training of health workers 1.11 Include nutrition in the school health programmes	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.4.7 INTERVENTIONS AGAINST DISEASES TARGETED FOR ERADICATION

2.4.7.1 Description

The Government of Uganda is a signatory to international resolutions committed to the elimination and eradication of some diseases. Diseases targeted for eradication or elimination include poliomyelitis, guinea worm and oncocerciasis, measles, leprosy. Accordingly the HSSP has a programme to ensure that the country plays its role along with other nations. It will be essential to ensure that cross boarder disease surveillance and control is strengthened through regional and bilateral collaboration.

2.4.7.2 Objectives

The main objective is to achieve the national and global targets for eradication/elimination.

The program for disease elimination and eradication is expected to:

- Strengthen the existing programs for disease elimination/eradication. They are:-

    a. Poliomyelitis
    b. Onchocerciasis
    c. Guinea worm
    d. Leprosy
    e. Vitamin A Deficiency Disorders
    f. Iodine Deficiency Disorders
    g. Neonatal Tetanus

- Conduct gender responsive IEC on diseases targeted for elimination and eradication.

2.4.7.3 Implementation Strategy

Management strengthening and capacity building will be crucial during the plan period. The Health Sector Strategic Plan emphasises sensitisation of communities about diseases for elimination and eradication.

At the national level, the Ministry of Health through the Department of National Disease Control and in collaboration with other departments, will be responsible for policy development, overall co-ordination and guidance on diseases for elimination and eradication. Furthermore, it will provide technical support and supervision to the districts as well as collaborate with development partners and other stakeholders.

At the District level, the District Director of Health Services, together with the District Health Management Teams, will plan, manage and monitor diseases targeted for eradication.

HSSP Logframe: Interventions against diseases targeted for eradication

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Intervention against diseases targeted for eradication intensified 2. A system for forecasting and early detection of target diseases in place	1.1 Availability, clarity and ease to use plans and guidelines 1.2 Level/trend of disease burden 1.3 Availability of drugs and medical supplies 1.4 Percentage of facilities with functional equipment 1.5 Proportion of the population receiving timely information 1.6 Percentage of health workers trained in specific areas of intervention 1.7 Number of agencies jointly involved in the intervention programme 2.1 Availability, clarity and ease of use of guidelines on integrated disease surveillance 2.2 Training conducted on integrated disease surveillance 2.3 Availability of data bank on target diseases	1.1 Published guidelines and plans; updated international documents and reports; completed disease notification forms; published article; conference proceedings 1.2 Rapid appraisal; summaries of routinely collected district and national programme data; reports of epidemiological studies; sample surveys; programme impact evaluation reports 1.3 Field visits and progress reports 1.4 as above 1.5 Report from agencies – Government and Non – governmental implementing intervention programmes; periodic survey reports 1.6 Training reports; performance reports 1.7 Agency reports; minutes of meetings; financial reports 2.1 Published guidelines and written reports on occurrence of target diseases 2.2 Number of personnel trained in integrated disease surveillance 2.3 Data on target diseases and written reports	1. Consensus of action plan is reached and government is ready to adopt resolutions 2. Access to intervention sites not deterred by natural or man made disasters 3. Commitment to intervention programmes by communities and health workers 4. Co-operation between government and partners
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop/update gender specific guidelines and plans for elimination / eradication (guinea worm, oncocerciasis, poliomyelitis, neonatal tetanus and measles) 1.2 Monitor magnitude of disease problem 1.3 Estimate and procure drugs/vaccines and medical supplies required for elimination 1.4 Equip all facilities to provide services for elimination 1.5 Educate and mobilise the community (using gender specific strategies) in prevention and control of these diseases 1.6 Train and re – orient personnel in the control and eradication measures 1.7 Establish collaboration between all key health and health related agencies	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.5 STRENGTHENING MENTAL HEALTH SERVICES

2.5.1 Description

Mental health is amongst the most pressing health needs in Uganda. The Government intends to address the heavy burden of mental illness in the country. In this regard, Government will promote, prevent and support a comprehensive mental health program that addresses disorders such as schizophrenia, psychosocial disorders, neurological disorders, psychosocial consequences of civil strife and conflict etc.

2.5.2 Objectives

The main objective is to provide improved access to primary mental health services to the entire population and to ensure ready access to quality mental health referral services at district, regional and national levels.

The Mental Health Program is expected to:

- Develop policy and guidelines for implementation of mental health services;
- Provide, co-ordinate and educate populations on mental health promotion and prevention;
- Reactivate the Mental Health Co-ordinating Committee at national level and create intersectoral committees at district levels;
- Integrate mental health into all the general health services from HC I up to the district
- Establish a system of integrating mental health patients into their families and communities;
- Establish a system to address psycho-social needs arising as a consequence of disaster or conflict situations
- Identify and address effects of violence including violence against women.
- Introduce a gender responsive mental health component in paramedical, nursing, midwifery and medical school curricula

2.5.3 Implementation Strategy

The Government of Uganda will strengthen the Ministry of Health, in the planning, and implementation of prevention and control measures of mental illnesses and disabilities to the districts. The program will make use of the existing infrastructure and where applicable upgrade/rehabilitate facilities to provide this service. Capacity building will be intensified for health workers at all levels to carry out this undertaking.

At the National level, the Ministry of Health, in consultation with the National Mental Referral Hospital and other departments, will be responsible for policy development, overall co-ordination and guidance. In addition, it will provide technical supervision, training and support to districts and reorientation to community based care. It will co-ordinate with the NGOs, donor agencies, and others stakeholders on the establishments of standards and regulations, and monitoring the delivery of public and non-governmental Mental Health activities throughout Uganda.

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of Mental Health activities at the District level.

Lower level health units including the Village Health Committee will play a key role in the follow up and rehabilitation of patients.

HSSP Logframe: Strengthening Mental Health Services

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1. Mental health services expanded and strengthened	1.1 Availability of a mental health policy 1.2 Percentage of population receiving mental health information 1.3 Number of health personnel trained in mental health 1.4 Percentage of health facilities with functional mental health services; 1.5 Number of health facilities rehabilitated and equipped 1.6 Percentage of mental health patients integrated into their communities 1.7 Number of h/w trained on psychological support on violence against women.	1.1 Mental health Policy documents 1.2 Reports of periodic surveys; routinely collected district and national level mental health statistics 1.3 Reports by Government agencies and partners (NGOs, private providers, International agencies) implementing district level mental health programmes; Survey reports 1.4 Reports on training carried out on management of mental illnesses 1.5 Mental service coverage survey reports; field visits, reports of agencies 1.6 Programme impact evaluation report; reports of sample surveys 1.7 Patient records; surveys; intervention reports	1. Policy makers and implementing agencies are able and willing to adopt interventions indicated as policy priorities 2. Availability of funds 3. IEC campaigns are available and effective 4. Appropriate skills available, Skilled personnel can be retained or recruited at that level 5. Mental health in the establishment of the District 6. Mental health drugs are included on the Essential Drugs List
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop/review, publish and distribute mental health policy, 1.11 Support districts to develop mental health plans 1.12 Conduct periodic surveys; collect and analyse routine mental health data ; establish surveillance system 1.13 Sensitise population on mental health issues and problems (media activities, workshops, IEC materials) 1.14 Organise training for health workers on mental health services and management; Review curricula to integrate mental health in training 1.15 Provide mental health services at all levels; Support supervision at all levels 1.16 Rehabilitate and/or construct and equip health facilities 1.17 Procure and distribute mental health drugs and supplies 1.18 Design and implement a monitoring programme of integration 1.19 Members of the Mental Health Co-ordinating committee identified and appointed with TORs 1.20 Needs assessment on special mental health (people affected by conflict, gender based violence) done and intervention carried out. 1.21 Develop and integrate psychological support training for health personnel on violence against women	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

2.6 ESSENTIAL CLINICAL CARE

2.6.1 Description

The program on essential clinical services includes care of injuries and common illnesses including non-communicable diseases, palliative care, oral health, ear/eye care, disability and rehabilitation. Accidents and other injuries form significant proportion of the national burden of disease at all levels.

2.6.2 Objectives

The general objective of this programme is to provide basic care for common illness including non-communicable diseases and injuries

The national targets by the end of the plan period are:

- All health facilities to provide basic services including public health education for the common illness including non-communicable diseases.
- All health facilities to manage common injuries according to the level of the health units and refer appropriately.
- All HCs will be providing palliative care services graded by level.
- All health facilities to provide preventive and curative oral health to the communities and schools and refer appropriately.
- All health facilities to provide rehabilitative health services.

The program of Essential Clinical Services will be expected to:

- Integrate the preventive, promotive, curative, rehabilitative and palliative care into the Health Care System;
- Increase accessibility of the population to appropriate essential clinical care;
- Increase community awareness on the causes and methods of prevention of common illnesses, injuries, disabilities and non-communicable diseases;
- Provide appropriate logistic and medical supplies at all levels of care;
- Encourage early detection and management of non – communicable diseases;
- Promote community participation in care of terminally ill patients;
- Promote public oral health care;
- Prevent disabilities arising from eye and ear diseases
- Improve the referral system;
- Strengthen collaboration with other government institutions, NGO facilities, and private sector and donor agencies for the provision of essential clinical care;
- Promote pro-health life styles and health seeking behaviour among the population.

2.6.3 Implementation Strategy

Capacity building will be an important activity of this program. Health workers at the different levels will be trained and retrained to provide quality essential clinical care according to set guidelines.

At the National level, the Department of Clinical Services will be responsible for policy development, overall co-ordination, and development of standards and guidelines for essential clinical services. This will be done along side the development and improvement of

health infrastructure, also in the Department of Clinical Services. The Department will provide technical supervision and support to the Districts, and maintain continuous working dialogue with other Directorates and Referral Hospitals. It will also co-ordinate with other institutions like the National Medical Store, National Drug Authority, NGO and private health facilities, and other international agencies like WHO and UNICEF.

At district level, the District Directorate of Health Services will be responsible for the distribution of standards and guidelines, delivery of logistics and supplies, and implementation and co-ordination of essential clinical services program.

HSSP Logframe: Essential Clinical Care – Disabilities and Rehabilitative Health

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1. Disability and rehabilitative health services initiated, expanded and strengthened	1.1 Availability, ease of use policies, plans, guidelines and standards 1.2 Proportion of communities and health workers with IEC materials 1.3 Proportion of health facilities equipped 1.4 Number of students taken in institutions 1.5 Number of health workers trained. 1.6 Number of curricula with rehabilitation and disability component 1.7 Number of PHC programs implementing disability and rehabilitative services. 1.8 Tailored course for primary ear care implemented 1.9 Number of districts visited to conduct advocacy meetings 1.10 Number of districts provided with technical back up 1.11 Number of quality research conducted 1.12 Information system for disability & rehabilitation established	1.1 Policy, plan, guideline documents, utility of these documents 1.2 Materials, field visits, feedback from communities, district and health facility reports 1.3 Inventory, field visits 1.4 Institution records, Inventory, field visits 1.5 Training reports, performance appraisal reports 1.6 Curricula document, Reports from training institutions, students and tutors 1.7 Program reports, District, health facility and community reports 1.8 Training institutions report, field visit reports 1.9 District reports, field visits, minutes of meetings 1.10 Field visit reports, district and health facility reports 1.11 Research reports, utilisation of research findings 1.12 Data, reports, records	1.2 Government commitment to disability issues
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop/review, disseminate national Policy, Plans, Guidelines and Standards 1.2 Develop guidelines for periodic examinations on non-communicable diseases according to sex and age. 1.3 Produce and disseminate gender responsive IEC materials and messages to communities and health workers 1.4 Provide equipment and supplies to all levels 1.5 Advocate for increased intake of trainees in rehabilitative medicine 1.6 Conduct in-services training of health workers maintaining a gender balance 1.7 Integrate disability and rehabilitation into the curricula of training institutions 1.8 Integrate disability and rehabilitation into relevant PHC programs 1.9 Initiate a tailored course for primary ear care for clinical officers 1.10 Advocate for deployment of personnel with rehabilitative skills to the districts 1.11 Provide technical backup to the districts 1.12 Conduct operational research 1.13 Develop and implement a comprehensive information system	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

HSSP Logframe: Essential Clinical Care – Injuries/Palliative Care/Oral Health/Non-Communicable disease

Output	Verifiable Indicators	Means of Verification	Key Assumptions
2. Care for Injuries and common illnesses provided in all health facilities	2.1 Availability, ease of use policies, plans, guidelines and standards 2.2 Number of facilities providing care according to guidelines 2.3 Proportion of patients receiving appropriate care 2.4 Proportion of communities receiving IEC on injuries and common illnesses	2.1 Policy, plan, guideline documents, utility of these documents 2.2 Health facility reports, routine data, field visits, surveys 2.3 As above 2.4 Surveys, feedback reports from communities	1 Availability of essential supplies 2 Recruitment and deployment of trained personnel
3. Accessibility to palliative care for chronically and terminally ill persons increased	31. Proportion of patients receiving palliative care 32. Number of health providers trained in palliative care	3.1 Field visits, feedback from communities, district and health facility reports 3.2 Training reports, performance appraisal reports	
4. Oral/dental care available at all levels of care	3.4 Proportion of health facilities equipped and providing dental care 3.5 Number of PHC programs implementing oral care 3.6 Availability, ease of use policies, plans, guidelines and standards	4.1 Program reports, District, health facility and community reports 4.2 District reports, field visits, health facility reports 4.3 Policies, guidelines, plans at all levels	
5. Prevention and Control of Non-Communicable diseases strengthened	3.7 Proportion of population aware of non-communicable diseases and practising health life styles. 3.8 Framework and guidelines for Collaboration with private sector and tertiary institutions		
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
2.1 Develop/review, disseminate national Policy, Plans, Guidelines and Standards 2.2 Produce and disseminate gender responsive IEC materials and messages to communities and health workers 2.3 Provide equipment and supplies to all levels 2.4 Conduct training and retraining of health workers (maintaining a gender balance) on management of injuries and common illnesses 2.5 Provide technical backup to the districts 3.1 Carry out training of health providers on palliative care 3.2 Provide supplies for palliative care at all levels of health care 3.3 Integrate palliative care into the curricula of training institutions 3.4 Provide technical backup to the districts 4.1 Conduct in-services training of health workers on oral health 4.2 Integrate oral health into relevant PHC programs 4.3 Develop, publish and disseminate policies, guidelines and standards 4.4 Provide technical backup to the districts 4.5 Conduct a National Oral Health	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.

Survey. 4.6 Public awareness on early detection, appropriate treatment and referral 4.7 Develop a framework for collaboration with private sector for tertiary care.			
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

Chapter 3

HEALTH CARE DELIVERY SYSTEM

The health care delivery system has undergone reorganisation and restructuring to improve performance at all levels. The main aim is to create an efficient and effective system that will cope with the current reforms that Government is undertaking. This chapter will present how the centre and the districts will execute their respective roles.

3.1 National Level Health Organisation and Management

3.1.1 Description

Under the new Constitution and the 1997 Local Governments Act, responsibilities have been defined for Central Government and districts. The core functions of the Ministry of Health are :

- Policy formulation, standards, setting and quality assurance,
- Resource mobilisation,
- Capacity development and technical support,
- Provision of nationally co-ordinated services, e.g Epidemic control,
- Co-ordination of health services,
- Monitoring and evaluation of the overall sector performance,
- Training.

The responsibilities of the Districts are:

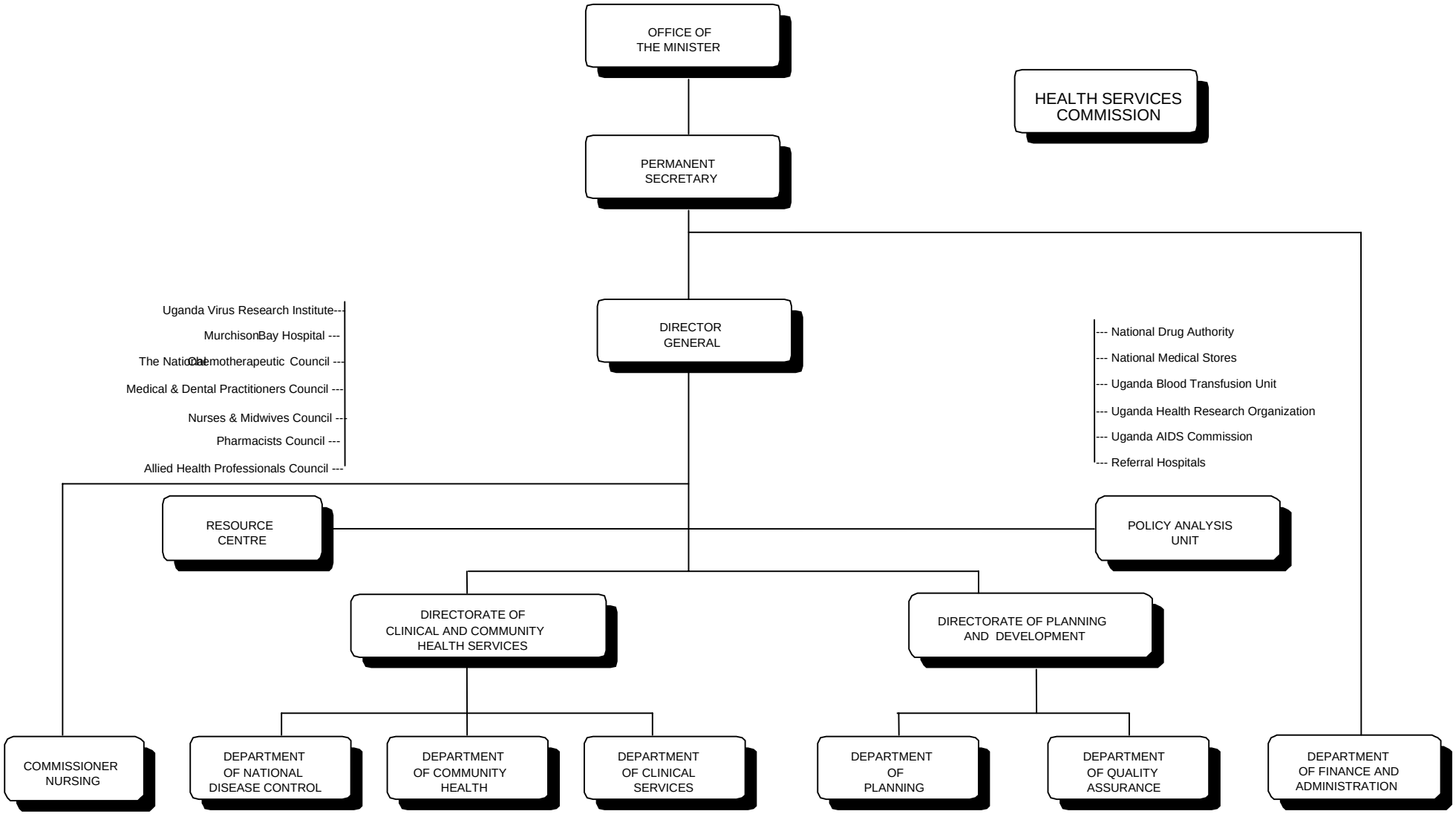
- Implementation of National Health Policies,
- Planning and management of district health services,
- Provision of disease prevention, health promotion, curative and rehabilitative services, with emphasis on the Minimum Health Care Package and related national priorities,
- Vector Control,
- Health Education,
- Ensuring provision of safe water and environment sanitation and
- Health data collection, management, interpretation, dissemination and utilisation.

3.1.2. Central Ministry of Health

The Central Ministry of Health has been restructured in line with the new mandate and core functions. All the new positions in the restructured Ministry of Health have been filled. The organogram in Figure III on page 54 shows the macro structure of the Ministry of Health. Restructuring is regarded as a continuous process. This structure will therefore be subject to review and amendment as experience and need demand.

Health Service delivery has been decentralised to the district and sub-district levels. Districts and sub-districts are now preparing their own annual workplans, with support from the centre. Restructuring the District Health System is in progress including streamlining the collaboration of the districts with NGOs and private sector. Regulation of Traditional Practictioners through a legal framework is to be accomplished during the plan period.

MACRO STRUCTURE OF THE MINISTRY OF HEALTH



The collaboration between Government and Development Partners and other stakeholders in health is crucial for the successful implementation of the Health Sector Strategic Plan. Government has, therefore, adopted the Sector-Wide Approach as a means of fostering health development. As such, common working arrangements will be agreed by all parties in the health sector and will include planning, budgeting, disbursement, programme management, procurement, support supervision, accounting, reporting, monitoring and evaluation. These arrangements will be defined in a Memorandum of Understanding between the Government of Uganda and its Development Partners who will make financial contributions to the sector.

3.1.3 Reorganisation and Restructuring of Institutions

Government has embarked on reorganising and restructuring the management of institutions affiliated to the Ministry of Health in order to enhance their performance. These include:

Health Services Commission

The Health Service Commission is a statutory body established in the 1995 Constitution. It is responsible for reviewing the terms and conditions of service of health workers. It reports directly to Parliament. It gets its budgets directly from Parliament. The Health Services Bill which determines the operational aspects of the Commission and also establishes the code of conduct of all health workers has been put before Parliament and will become law during Year I of this HSSP.

Autonomous Institutions

The following institutions are already autonomous:

- National Medical Stores
- National Drug Authority
- Uganda AIDS Commission

Government intends to make the following institutions autonomous:

- Uganda National Health Research Organisation (UNHRO): The HSSP envisages the establishment of UNHRO to co-ordinate health related research. The following existing institutions will fall under UNHRO: Uganda Virus Research Institute, Natural Chemotherapeutic Research Institute, Uganda Cancer Institute, Trypanosomiasis Research Institute (Tororo), National Public Health Laboratories, Joint Clinical Research Centre.
- National Referral Hospitals
- Regional Referral Hospitals
- Uganda National Blood Transfusion Service.

Professional Bodies

The following professional bodies have been established by statute to regulate the practice of health professionals. They will be responsible for enforcing standards of performance, ethical practice and professional qualifications.

- Medical and Dental Practitioners Council
- Nurses and Midwives Council

- Allied Health Professionals Council
- Pharmacists Council

Other professional associations which bring together various groups of health professionals will be encouraged and supported as a means of mobilising professional will and standards.

Transferred Institutions

The following institutions have been transferred from the Ministry of Health:

- Murchison Bay Hospital to the Ministry of Internal Affairs
- National Sleeping Sickness Program to District Authorities
- Occupational Health to Ministry of Labour.
- Basic Training Institutions Basic to Ministry of Education and Sports

3.2 Decentralised Health Care System

In line with the 1995 Constitution and the 1997 Local Governments Act, the new roles of the Local Authorities are:

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

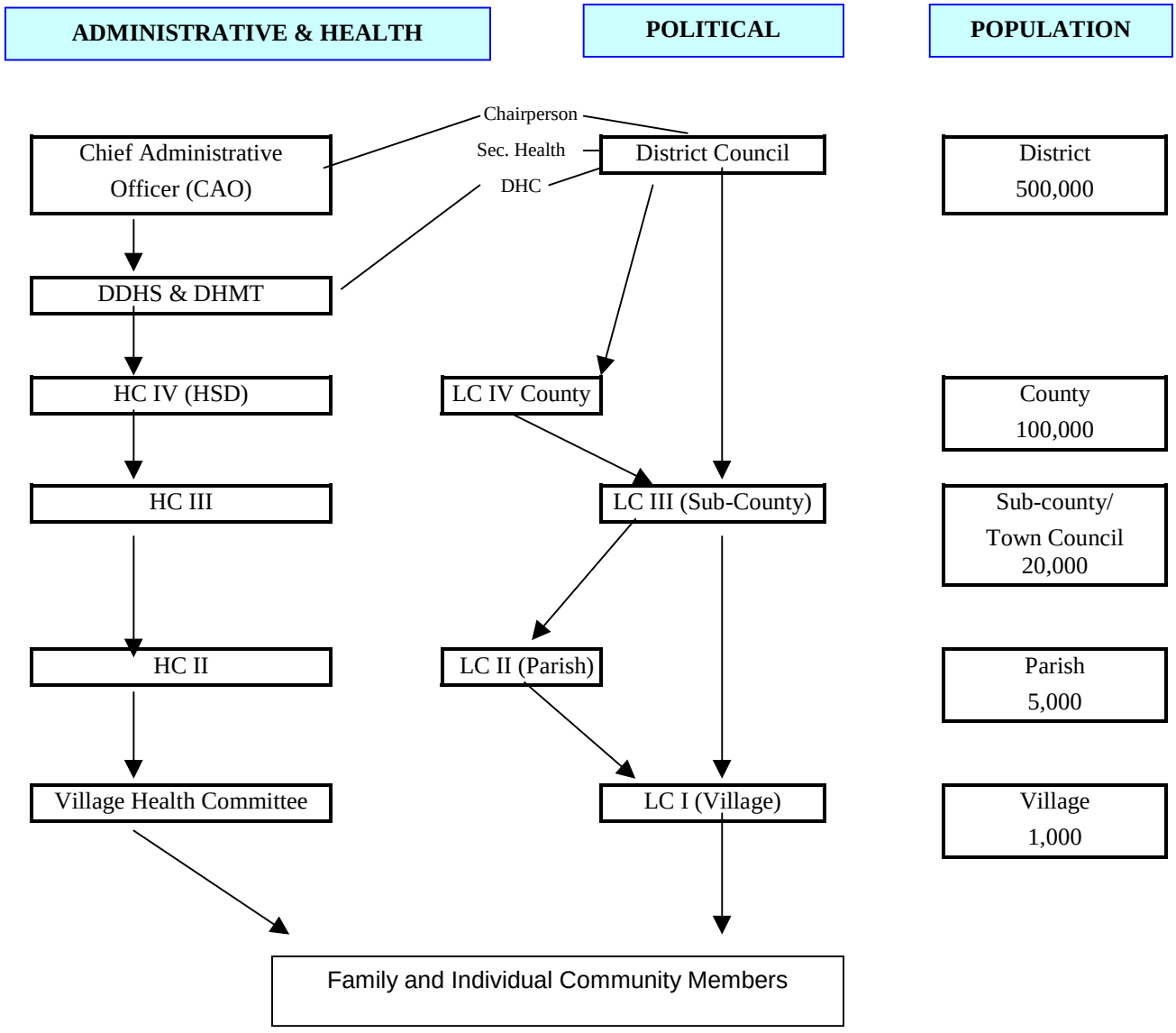
The structure for management of health services in the district is led by the District Council through the District Health Committee. The District Health Management Team is headed by the District Director of Health Services and composed of the Heads of Health Sub-Districts and section heads. Figure IV on page 58 shows the structures for District Health Services delivery. The diagram shows the linkages between the political, administrative and technical arms of the various levels of the Health Care Delivery System and the related committees whose roles and responsibilities will be clearly defined.

The Ministry of Health will propose appropriate amendments to the Local Government Act in order to facilitate achievement of the HSSP objectives

The Health Sub-District (HSD) serving a population of approximately 100,000 people, will consist of lower Health Centres III, II and Village Health Committees. Each HSD headquarter will be located at Health Centre IV. The HSD will take a higher level of health services nearer to the population, including the management of obstetric emergencies. It will also improve the level of technical support and supervision of lower level health services. The leadership of the Health Sub-District may be based at the government, NGO or private health facility and its head will be designated a member of the District Health Management Team (DHMT).

Management capacity at District, HSD and Sub-county levels will remain a high priority during the implementation of the HSSP.

Figure IV: DISTRICT STRUCTURE FOR HEALTH CARE DELIVERY



Key

KEY:
CAO = Chief Administrative Officer
DDHS = Director of District Health Services
DHMT = District Health Management Team
DHC = District Health Committee
HSD = Health Sub-District
HC = Health Care
LC = Local Council

The Central Ministry of Health will relate to the districts in executing its roles through the following channels:-

- Service Standards and guidelines for health services delivery and management will be developed, updated and disseminated regularly. This will be co-ordinated by the QAD and led by Technical Departments.
- The annual Planning Cycle will be implemented strictly. Support to the districts for this will be provided by the Health Planning Department.
- Pre-planned quarterly support supervision visits to the districts will be co-ordinated by the QAD.
- Technical Departments will carry out biannual visits to supervise and provide technical support. Additional visits will be made as needed.
- Emergency visits will be made depending on need.
- The MOH is also responsible for co-ordinating and providing support to districts for epidemic and disaster prevention, preparedness and management.
- Regional Referral Hospitals will provide support and supervision through Specialists.
- In specified areas zonal support teams will be designated to strengthen Technical suport.
- The districts can request technical support from the centre for identified needs. On the other hand, the MOH may offer technical support if a need is identified.
- On top of all these, Top Management of the MOH will have an additional programme of supervision and support to the districts.

3.2.1 District Service Commission

The District Service Commissions (DSC) are responsible for appointment, discipline and setting the conditions of service for district health staff. They use guidelines issued by the Health Service Commission. In the recruitment of health workers, a representative from Ministry of Health participates in the recruitment of senior district of staff on the invitation of the DSC.

3.2.2 Community Empowerment and Participation

Gender sensitive community participation and empowerment are accorded high priority in the HSSP. A Village Health Committee or similar structure will be established in every village to be responsible for:

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

3.2 Partnership with the Private Sector in Health Services

The Health Policy recognises that the private sector is a major partner in health care and service delivery. There are three categories of private sector partners namely:

- Traditional Practitioners
- Non Governmental Organisations (NGOs)
- Private Health Care Providers.

Traditional Practitioners

A significant amount of work has already been done to recognise and mobilise traditional health practitioners in the country. During the plan period, a law will be enacted to recognise, co-ordinate and regulate their practice and a draft Bill on Traditional Medicine is already in advanced stages of development.

NGO Health Care Providers

This category of health care providers is already collaborating closely with government to promote the shared objectives of avoiding duplication, increasing coverage and improving equity and financial access of the poor to health care. Already staff are being seconded to NGOs units and funds are disbursed directly to these units through the districts. The plan envisages strengthening this collaboration through the development of service contracts and increasing subventions to the NGOs.

Private Health Care Providers

The Health Sector Strategic Plan intends to bring this group of providers into an identified segment of the health care system by encouraging and facilitating them through:

- Contracting out services in public health institutions,
- Facilitating increased investment in tertiary health care by providing incentives to investors to develop centres of excellence,
- Enacting a law for Compulsory Health Insurance for the formally employed and
- Strengthening the supervision and regulation of the private health care providers .

3.4 Linkages and inter-sector collaboration.

The Health Policy recognises that health outcomes are influenced by many factors in other sectors. For that reason, inter-sectoral collaboration in the implementation of HSSP is considered a priority. The following sectors have been identified as close partners:

- Ministry of Finance, Planning and Economic Development,
- Ministry of Local Government,
- Ministry of Agriculture, Animal Industry and Fisheries,
- Ministry of Water and Natural Resources,
- Ministry of Education and Sports,
- Ministry of Gender and Community Development and
- Religious organisations

These have participated in the development of this plan and will play an important role in its implementation. Extensive use of these partnerships will also be made through the co-ordination mechanisms of the revised PEAP.

HSSP Logical Framework: Health Care Delivery System

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Sector management and organisation restructured and operational 2. Partnership with the private sector operationalised and strengthened.	1.1 Macro & micro organisational structure approved and implemented; positions in structure filled. 1.2 Recommendations of Government on human resource development are implemented 1.3 Organisation/management and financial systems operationalised 1.4 Existing Statutes and development of new Statutes reviewed 1.5 Boards and Councils appointed 1.6 Number and quality of personnel trained in appropriate fields 1.7 Level and timeliness of decentralisation implementation 3.2 Co-ordination system of private sector partners in place 2.2 Framework for public – private sector collaboration established and operational at all levels.	1.1 Personnel document Policy, Guidelines and Standards on personnel deployment; reorganised structure. 1.2 Reports of meetings of Ministry of Health Management and other Government agencies; Constitution and Local Governments Act, 1997 1.3 Reorganised management, organisation and financial system; Financial guidelines to districts 1.4 Review reports and statutes; Policy documents 1.5 Record of Minutes of meetings; Policy documents 1.1 HRD Records; reports on courses undertaken 1.7 Evaluation and progress reports; supervisory visits; updates of LGA ; other statutory publications 2.1 Documents, minutes of meeting	1. Political support and commitment by Government and Donors 2. Public Service Reform is implemented 3. Political consideration and approval for autonomy 4. Commitment and continued collaboration from all stakeholders
Activities at operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Restructuring in a phased manner (Recruit & re-deploy staff; formation of Uganda National Health Research Organisation, referral hospitals) 1.2 Conduct capacity needs assessment; meetings; set up committees and provide in-service training on new roles 1.3 Establish management boards; operationalize boards (Terms of reference, Budgetary support, Statutory powers) 1.4 Formulate instruments for granting autonomy; seek approval; establish & provide financial & logistical support 1.5 Establish Health Service Commission; hospital boards and other councils 1.6 Review the progress of health sector decentralisation 2.1 Develop framework for public private sector collaboration 2.2 Strengthen the Public – Private collaboration.	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

Chapter 4

INTEGRATED SUPPORT SYSTEMS

The following will support the effective delivery of the Uganda National Minimum Health Care Package and health sector development:

1. Human Resources Development and Management
2. Policy and Planning
3. Quality Assurance
4. Health Management Information System
5. Research and Development
6. Health Infrastructure Development and Maintenance
7. Health Laboratory Support Services
8. Procurement of Drugs, Equipment, other Health Supplies and Logistics
9. Health Care Financing
10. Legal and Regulatory Framework

4.1 HUMAN RESOURCES DEVELOPMENT

4.1.1 Description

The Health Sector Strategic Plan recognises that on going reforms including decentralisation of health service delivery poses major challenges in human resource management. Effective response to these challenges will require significant upgrading of technical, operational and management capacity at all levels. The medium-term objective is attain by the end of the HSSP period, at least 75% of the minimum staffing norms at each level of the district health system. Among the key strategies for achieving this objective are: (a) the progressive replacement of untrained staff by converting nursing aides to nursing assistants through an appropriate formal course; (b) the adoption and implementation of a realistic medium term health infrastructure development plan that is fully consistent with the human resources projections; and (c) improving working conditions so as to minimise attrition rates. In this regard, all efforts will be made to ensure consistency between Human Resource Development and the Health Infrastructure Development Plans.

Table 3 Recommended staffing for lower level health centres

Cadre of staff	Number recommended per level		
	HC II	HC III	HC IV
Medical officer (ADDHS)			1
Comprehensive Nurse (Registered)		1	2
Comprehensive Nurse (Enrolled)	1	2	2
Clinical Officer		1	2
Dispenser			1
Public Health Dental Assistant			1
Laboratory Technician			1
Laboratory Assistant		1	1
Anaesthetic Officer			1
Health Educator			1
Health Information Assistant			1
Health Assistant		1	
Nursing Assistant	2	1	1
Health Inspector			1
Medical Entomology Officer			0.5

Table 4. Human Resource Production by Year (Nursing Cadre)

YEAR	Enrolled Nurse	Enrolled Comprehensive Nurse	Nursing Assistants	
			New	Old
2000/01	686	-	3600	1125
2001/02	686	-	1575	1125
2002/03	686	200	-	-
2003/04	430	630	-	-
2004/05	-	630	-	-

4.1.2 Objectives

The Human Resources Development and Management program is expected to:

- Develop and operationalise the sector human resource medium term plan for all levels;
- Improve personnel management and technical skills at all levels;
- Enhance capability of local health training institutions in collaboration with the Ministry of Education and Sports;
- In collaboration with the National Health Service and District Service Commissions, implement effective incentive schemes to attract trained staff to under-served areas;
- Improve productivity and accountability of health personnel;
- Implement the Continuing Education policy in close collaboration with the health related professional councils.
- Establish linkages with overseas institutions to promote HRD

4.1.3 Implementation Strategy

Implementation of the Human Resources for Health Medium Term Plan will include stronger emphasis on management. Capacity building for staff at all levels will be intensified for achieving the required improvement in the quality of health care. As a priority, there will be a deliberate effort to build institutional capacity at the district level. In collaboration with the Ministry of Education and Sports, basic training will be strengthened to meet the needs of the sector. The Ministry of Health, in collaboration with the Health Professional Councils, will identify training needs of staff and address them through appropriate, integrated continuing education, professional assessment and registration programs. The Ministry of Health will provide technical guidance and support to the Ministry of Education and Sports for curriculum development, quality assurance and development of training capacity to cover the current and future human resource needs of the sector and to maintain and improve the quality of basic health training. Together with the Health Service Commission, the District Service Commissions and appropriate line Ministries, the Ministry of Health will address issues of equity and rationalisation with regard to recruitment, deployment and retention of staff.

Districts will be supported to overcome current de-motivating factors such as ineffective pay roll management, salary payment delays and arrears, lack of appreciation and to establish performance based career progression schemes.

HSSP Logframe: Human Resources Development

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Policy for Human Resource Development formulated and implemented	1.1 Availability of HRD policy conforming to government standards and plans, including gender balance 1.2 Staffing standards defined and disseminated 1.3 Adequate health professionals; regulated staffing in health units; consumption by private sector 1.4 Proportionate numbers for male and female in health services 1.5 Training plans based on human resource needs assessment on quality and quantity 1.6 Result – Oriented Management operationalised (e. g number of staff who benefit from continuous medical education) 1.7 Number of personnel trained and deployed in accordance to HR Plan; Long term human resource development plan established 1.8 Human Resource Data bank established 1.9 Staff turn over maintained at an acceptable rate (acceptable staff attrition rate) 1.10 Mechanisms for co-ordinated training and management at national and district level developed 1.11 Job descriptions in place 1.12 Proportion of health workers attending CME	1.1 Policy documents, plans 1.2 Records from training institutions and private sector 1.3 Input and output records from medical school and other training institutions 1.4 Baseline data on human resource needs assessment 1.5 Productivity analysis 1.6 Records on training & staffing level 1.7 Guidelines and procedures, HRH Development plans, records of training, district reports 1.8 HR Development data 1.9 Survey/studies, HRH evaluation 1.10 Records of training, district and health facility reports 1.11 Job descriptions 1.12 Records for registration	1. Involvement of the Health Service Commission, District Service Commissions in Human Resource Management 2. Increase in the wage bill to discourage attrition 3. No freeze on employment
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop and implement a human resource development plan 1.2 Rationalise and integrate management of health training institutions 1.3 Promote gender sensitive training 1.4 Reinforce national guidelines for staffing standards in all health facilities and establish a mechanism for compliance 1.5 Recruit and deploy staff 1.6 Promote a mechanism for professional advancement through staff performance appraisal 1.7 Provide in – service and advanced training opportunities for all categories 1.8 Develop a computerised personnel information management system 1.9 Develop incentive structure and carrier mobility 1.10 Develop mechanisms for co-ordination of training activities 1.11 Develop job descriptions for health personnel 1.12 Institutionalise CME	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			Preconditions
Refer to Ch. 5 for costing of the Strategic Plan			To be established

4.2 POLICY, PLANNING, AND QUALITY ASSURANCE

4.2.1 Description

The degree of success in implementing the HSSP will depend on the level of effectiveness of the systems and structures put in place to ensure policy development, planning, effective implementation and quality assurance. During the plan period, therefore, the Ministry of Health will strengthen its capacity for policy analysis and formulation, planning, monitoring and evaluation. In the Year 0 (1999-2000), the health sector partnership will establish appropriate structures and systems for rolling out the Strategic Plan under the SWAps arrangement and within the overall framework of the revised National Poverty Eradication Action Plan.

5.2.2 Objectives

The main objectives are to:

- Strengthen the capacity of the MOH in policy analysis and formulation, planning, budgeting, and in monitoring and evaluation of all health development activities;
- Strengthen the Health Management Information System including establishment of the National Health Data Bank;
- Identify appropriate indicators for monitoring key HSSP targets, their impact on health status, and on progress in redressing inequalities in health;
- Strengthen the capacity of the Ministry of Health in developing and disseminating standards and guidelines and in monitoring quality of health care services in the districts.
- Develop and implement appropriate plans for building capacity of District Health Teams, Health Sub-districts and Health Units in health planning, implementation and management;
- Streamline the planning process to achieve a clear and coherent linkage between the HSSP and the MTEF/BFP on the one hand, and between these and the District and HSD three year rolling plans;
- Establish an appropriate mechanism for periodic joint GoU/Partners review of the performance of the health sector
- Institutionalise supportive supervision system at all levels of the sector.

5.2.3 Implementation Strategy

At the National level, the Ministry of Health, through the Directorate of Planning and Development, will provide overall co-ordination and guidance for Policy, Planning and Quality Assurance throughout the country, as well as, technical backup and support to the districts. The management system within the MoH will be streamlined and strengthened for more effective and speedier decision making. The linkages between the Directorate of Planning and Development, the SWAps co-ordination mechanisms and the central technical programmes will also be strengthened. Supervision by the centre will be co-ordinated and supervision at lower levels will be facilitated to ensure compliance with service standards.

At the district level, the expanded District Health Management Teams under the leadership of the District Director of Health Services will be strengthened through the inclusion of HSD team leaders and NFPP sector partners. The DHMTs will be provided with more consistent support

through integrated central and zonal district support teams. The attainment of higher levels of concordance between the HSSP, District and HSD rolling plans, will be accorded the highest level of priority.

Accountability of the service providers to their client communities will be fostered through more effective community mobilization and participation, community-led Health Unit Management Committees, and District level and Lower Local Government general oversight.

HSSP Log Frame: Policy, Planning and Quality Assurance

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1 Functional Planning Structure at all levels	1.1 Plan framework & guidelines developed, disseminated & used 1.2 Ability to prepare plans at various levels 1.3 Proportion of districts with work plans according to the plan frame and using the during implementation	1.1 Planning Guidelines, Policy & Plan Reports, annual health profile 1.2 Evaluation Reports, Policy documents, plans and district visits 1.3 Minutes of meetings 1.4 Work plans at various levels	Appropriate deployment of staff to carry out planning functions Formation of the National Planning Authority
2. Comprehensive information system in the health sector utilised and strengthened	2.1 Comprehensive recording & reporting mechanisms in the health sector 2.2 Unified & operational surveillance system established 2.3 Number of district monthly reports on key health indicators completed 2.4 Proportion of health facilities using data for decision making	2.1 Inventory of health services, data base 2.2 Disease profile; support supervision and field visits 2.3 District Reports 2.4 Health facility and district plans	
3. Quality Assurance Programme capable of enforcing standards in the health care delivery	3.1 Number of facilities using quality assurance guidelines correctly ; proportion of health facilities meeting minimum established standards 3.2 Availability of supervision guidelines produced 3.3 Number of supervision visits made to health care facilities 3.4 Number of health care personnel trained in quality assurance at all levels 3.5 Number of special surveys and studies carried out 3.6 Number of meetings held on QA	3.1 Periodic evaluation of health care facility performance 3.2 Supervision guidelines in use, reports from health facilities 3.3 Periodic Reports on quality assurance standards by facilities at all levels (public and private) 3.4 Training reports, district and health facility records 3.5 KAPB survey reports, feedback from users 3.6 Minutes of meetings, reports 4.1 Studies, surveys, monitoring and field visits	Political and professional support Collaboration with other law enforcement agencies Conducive environment
4. Policy analysis and development strengthened	4.1 Health issues and priority areas addressed by the policy(ies) 4.2 Level of policy compliance at all levels in the health sector 4.3 Availability, clarity and utility of policy documents at all levels of health care delivery 4.4 Frequency of field visits; number of health facilities and districts visited 4.5 Mechanism for policy analysis & development in place 4.6 Evaluation/policy analysis report 4.7 Proportion of training needs addressed Personnel trained in policy development and analysis	4.2 Policy documents, Record of meetings, resolutions 4.3 Policy documents 4.4 Support supervision and field visits reports, district and health facility reports 4.5 Special studies – Stakeholder analysis, Political Mapping Reports 4.6 Training needs assessment report 4.7 Personnel development reports	

Activities at the operational level	Verifiable Indicators	Means of Verification	Key Assumptions
1.1 Carry out consultations & develop policy and plans 1.2 Provide technical back up to the districts 1.3 Establish planning framework at all levels 1.4 Carry out mid – term reviews 1.5 Produce annual plans 2.1 Collect, compile and analyse data 2.2 Disseminate information; 2.3 Establish data bases at all levels; Produce QA protocols for all levels 3.2 Institutionalise continuous quality improvement mechanisms at all levels 3.3 Conduct supervision and monitoring 3.4 Build capacity for quality assurance 3.5 Conduct studies and surveys on users' and providers' satisfaction 3.6 Hold regular QA meetings	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders at the appropriate time	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders at the appropriate time	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders at the appropriate time
4.1 Identify policy priority areas for the health sector and develop relevant policy recommendations 4.2 Build consensus with all stakeholders in policy development 4.3 Publish and disseminate policy documents 4.4 Provide technical back-up to policy implementers 4.5 Carry out regular supervision and monitoring 4.6 Evaluate policy effectiveness 4.7 Identify training needs in policy development and analysis 4.3.1 Train personnel in policy development and analysis			
Input			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

4.3 RESEARCH AND DEVELOPMENT

4.3.1 Description

Research is a critical tool for evidence-based policy and decision making. It provides an informed basis for guiding and rationalising implementation of the health sector strategic plan. During the plan period, health and health-related research will be organised and co-ordinated by the Uganda National Health Research Organisation (UNHRO).

4.3.2 Objectives

- Undertake research on health trends and the economic consequences of disease, disability and ill-health;
- Assess the cost-effectiveness of various HSSP strategies;
- Monitor the impact of health interventions on the PEAP objectives;
- Provide guidance for the implementation of the health policy and sector strategic plan;
- Develop capacity for research at all levels.

4.3.3 Implementation Strategy

Effective execution of this program during the plan period will depend upon the ability of the Directorate of Planning and Development and UNHRO to mobilise the relevant skills and resources to analyse, disseminate and utilise health research results.

At the National level, the UNHRO Secretariat will provide overall co-ordination and guidance for Research and Development throughout the country, as well as, technical backup and support to districts. The Secretariat will be responsible for mobilising resources, setting priority research agenda, commissioning and organising health research in collaboration with other research and academic institutions, NGOs, and other national and international organisations.

At the district level, the District Director of Health Services will be responsible for identification of research priorities, and the co-ordination of Research.

HSSP Log Frame: Research and Development

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1 Health care delivery and policy formulation improved through health research	2.2 A functional UNHRO Secretariat in place 1.2 A functional UNHRO Board of Directors established 1.3 Research Institutions under the management of UNHRO 1.4 Existence of standard research procedures 1.5 Number of quality health research proposals developed 1.6 Number and quality of research studies funded, conducted and completed 1.7 Number of research reports utilised	1.1 UNHRO Statute 1.2 Appointment letters for Board Members; Minutes of the Board meetings 1.3 UNHRO Statute 1.4 Guidelines on standard research procedures 1.5 Research proposals; grant applications 1.6 Documents and reports on research findings 1.7 Dissemination meetings; research-based interventions, programmes and policy development	Government to ratify the creation and management of UNHRO Political support
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Present UNHRO Bill for Cabinet and Parliamentary approval 1.2 Appoint UNHRO Board of Directors 1.3 Re – organise research institutions under UNHRO 1.4 Streamline research operational procedures 1.5 Develop capacity for research; design, conduct operational and essential research studies on health and related issues 1.6 Develop grant application procedures and secure funding 1.7 Develop and implement an appropriate dissemination mechanism for research findings 1.8 Mobilise resources for research	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Input			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

4.4 HEALTH CARE FINANCING

4.4.1 Description

The health care financing strategy seeks to ensure equity and efficiency in resource mobilisation, allocation and utilisation during the plan period. The National Health Policy and HSSP call for the setting out of explicit methods for broadening the financing base for the sector; methods that will promote increased efficiency, fairness, risk pooling, and protecting the poor and vulnerable groups in a manner that is sustainable.

4.4.2 Objectives

The key objectives of the health care financing component are to:

- Ensure effectiveness, efficiency, and equity in the allocation and utilisation of resources in the health sector consistent with the objectives of the National Poverty Eradication Action Plan;
- Eliminate factors of cost and affordability as barriers to access to essential care;
- Attain significant additional resources for the health sector and to focus their use on the most relevant and cost-effective priority health interventions.
- Ensure full accountability and transparency in the use of these resources through result oriented management at all levels.

4.4.3 Implementation Strategy

The Directorate of Planning and Development will take lead in the designing, implementing and monitoring of health care financing activities. In this regard, the Health Planning Department will finalise the Health Financing Policy and Strategy Paper that will provide the guiding principles for health care financing in Uganda. To attain policy objectives set out in this Strategy, Government will seek to increase progressively, the level of its funding to the health sector. It is envisaged that Government will continue to target public resources, including official development assistance, on the elements of the HSSP that are demonstrably the most cost-effective, have the greatest impact on reducing mortality and morbidity, and/or have a clear bias to protecting the poor and most vulnerable population. In addition, it will match all development investments to resources available for recurrent costs; and within recurrent spending, to gradually increase the allocation to non-wage operational costs.

The Directorate will continue to develop and support alternative financing schemes such as user fees, health insurance, and other community resource mobilisation efforts. However, Government will ensure that such schemes do not unduly discriminate against the poor and vulnerable groups, distort the demand for care, or the provision of health services.

The Directorate will ensure that all financial transactions using Government funds including, Central Government and donor transfers to local authorities, and locally generated resources, user fees, will be administered strictly within the financial regulations of Government. It will also monitor trends in funding both between and within districts.

At the district level, the District Director of Health Services, under the overall direction of the District Council, will be responsible for the implementation of health financing initiatives,

accountability and co-ordination of other sources of financing for health and within the context of the integrated district health plan.

HSSP Log Frame: Health Financing

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1. Efficient and sustainable health care financing system established and operational	1.1 Per capita expenditure on health (Proportion of Government, donor, private contribution to the health sector) 1.2 Percentage allocation to priority areas 1.3 Proportion of health facilities and districts with guidelines on proper financial management systems 1.4 Level of resource utilisation on planned activities 1.5 Number of facilities with functioning accounting system 1.6 Number of health financing schemes implemented 1.7 Availability, clarity, and utility of a unified financial reporting system for donors 1.8 Percentage of personnel trained in financial management 1.9 Type of services contracted out; number of contracts awarded 1.10 Proportion of districts facilitated in development of budgets 1.11 Service unit cost 1.12 Level and impact of resource utilisation 1.13 Alternative financing mechanisms in place 1.14 Availability of a Data bank	1.1 Expenditure reports, studies, surveys and analysis, Background to the Budget, PPA; Record of donor contribution, Expenditure surveys and analysis reports, Donor Co-ordination Unit records; Household survey reports, health unit financing analysis reports 1.2 Programme reports, departmental financial records 1.3 Financial reports, guidelines, accountability reports, analysis reports 1.4 As above 1.5 Books of accounts, Financial records and accountability reports 1.6 Protocols and guidelines, health facility and district reports 1.7 Accounting standards and guidelines for donors 1.8 Personnel training records, district and health facility reports 1.9 Service contracts, Statutes, health facility and district reports 1.10 Field visits 1.11 Cost study report 1.12 Resource utilisation analysis and assessment reports, field visits, survey reports on trends 1.13 Health financing protocols and guidelines 1.14 Health financing reports	Macroeconomic gains maintained and improved upon. Health remain a priority PEAP target. Official development assistance at least maintain at current levels. SWAps process operates as planned.
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Carry out analysis of health expenditure surveys, analysis of financial resource allocation, private out of pocket contribution studies and household surveys 1.2 Establish donor profiles on contribution and activity support 1.3 Establish financial management system to promote efficiency, transparency & accountability 1.4 Monitor and evaluate resource utilisation 1.5 Conduct analysis of final annual accounts, set up National Health Accounts 1.6 Develop management and	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.

accounting criteria for rational and equitable allocation within the health sector 1.7 Develop and implement guidelines for health care financing schemes 1.8 Develop standards for unified budgeting, accounting, disbursement and reporting system for donors 1.9 Train personnel in health sector financial management 1.10 Establish modalities for privatisation of services; Establish basis for hospital autonomy 1.11 Facilitate the development of annual district health budgets 1.12 Carry out cost analysis in the health sector 1.13 Assess available health sector resources in relation to health needs 1.14 Develop, design and implement health financing mechanisms (e. g user fees) 1.15 Set up a health care financing data bank			
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

4.5 HEALTH INFRASTRUCTURE

4.5.1 Description

There is evidence to show that distance to health facilities is a significant barrier to access to health care by the poor. Presently the percentage of households within walking distance to a health facility ranges from 9% in Kitgum to 100% in Kampala. The national average is 49%. The populations with the least access are also the ones with minimum capacity to initiate infrastructure development for themselves. There is also a massive backlog of dilapidated infrastructure which compromises efficiency, quality and therefore access. Other health infrastructure issues include medical equipment, communication equipment, water and energy, all of which are required to build synergy in a functional health care system with routinely maintained infrastructure. The link between health infrastructure development and human resource availability will be a key determinant of the pace of new construction.

4.5.2 **Objectives:**

The key objectives of health infrastructure are to:

- Rehabilitate and improve the performance of existing health facilities
- Increase access to within 5 kilometres of households from 49% to 80% by 20005
- Provide appropriate medical equipment for health care,
- Establish a functional referral system
- Provide a sustainable maintenance programme.

4.5.3 Implementation Strategy

A comprehensive National Health Infrastructure Development and Maintenance Plan will be developed as part of the Health Sector Strategic Plan. Seven levels of health service delivery have been identified namely:

Table 5: Planned Health levels

Health Centre	Level and approx. population	Services to be provided
I	Village - 1,000	Community Based Preventive and Promotive Health Services. Village Health Committee or similar status.
II	Parish - 5,000	Preventive, Promotive and Outpatient Curative Health Services, outreach care
III	Sub-county - 20,000	Preventive, Promotive, Outpatient Curative, Maternity and In-patient Health Services and Laboratory services.
IV	County – 100,000	Preventive, Promotive, Out patient Curative, Maternity, In-patient Health Services, Emergency surgery and Blood Transfusion and Laboratory services.
V	General Hospital – 500,000	In addition to services offered at HC IV, other general services will be provided. It will also provide in-service training, consultation and research to community based health care programmes.
VI	Regional Referral Hospital - 2,000,000	In addition to services offered at the general hospital, specialist services will be offered, such as psychiatry, Ear, Nose and Throat (ENT), Ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services.
VII	National Referral Hospital	These provide comprehensive specialist services. In addition, they are involved in teaching and research.

Level I, will be a functional Village Health Committee (VHC) to spearhead community participation and will be equiped with basic tools such as a register, identification badge and a bicycle. The VHCs will be set up in a phased manner over the plan period.

Facilities at levels III to VII are already established. New construction will apply only for level II. During the plan period, geographical access to health facilities will be increased from 49% to 80% by constructing new health facilities as shown in Table 6.

Table. 6. Number of Health Centre II to be constructed over the plan period

Year	1	2	3	4	5
No. of units to be constructed	20	65	250	250	300

NB. Year one will focus on mapping and prioritisation. Construction will be limited to identified underserved areas.

Criteria for prioritisation have been established and will be used to regulate and co-ordinate community initiatives in new construction.
Rehabilitation of health facilities will also be phased following a survey that will be conducted during year one.
Provision for preventive maintenance will be part of the Medium Term Expenditure Framework. The Health Infrastructure Plan also includes a revised Medical Equipment Policy and Plan. Provision has been made for transport which includes bicycles, ambulances and other vehicles for supervision. Appropriate Information Communication Technologies (ICT) including telematics have been piloted in some districts and hospitals and will be extended.

The Role of Hospitals

The Health Sector Strategic Plan recognises the important role the hospitals play in complementing Primary Health Care. These hospitals also provide primary health care services in the locations in which they are.

Regional Referral Hospitals will be responsible for providing technical support and supervision to districts and general hospitals in their defined catchment areas. At present there are ten of these. Mbarara University Teaching Hospital will revert from being funded and managed through the Ministry of Education and Sports to the Ministry of Health to enable it to perform its supervisory services and provide technical support to the regions.

It is envisaged that during the plan period, it will become necessary to designate new Regional Referral Hospitals. This will follow the elaboration of a Hospital Policy for the sector.

The two National Referral Hospitals namely, Mulago and Butabika Hospitals, provide highly specialised services. They are also the headquarters for higher training and research. They will move progressively towards autonomy. During Year One, Interim management Boards will be appointed. These boards will be mandated to guide the hospitals towards full autonomy.

HSSP Logframe: Health Infrastructure

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1 Functional health care infrastructure at all level	1.1 Infrastructure developed and number of health facilities constructed 1.2 Number of facilities upgraded 1.3 Number of health facilities rehabilitated/renovated 1.4 Number of facilities fully equipped 1.5 Number of studies carried out 1.6 Number of facilities regularly maintained 1.7 Number of facilities with up to date inventories 1.8 Availability of hospital policy	1.1 Annual reports, field visits 1.2 District visits, Reports, financial reports of expenditure 1.3 Site visits, Reports of rehabilitated units 1.4 Support supervision, Delivery documentation, equipment inventory 1.5 Survey reports 1.6 District and health facility reports, field visits, invoices 1.7 Infrastructure Inventories	1. Appropriate buildings and equipment at all levels of health care delivery 2. Commitment to infrastructure development plan, provisions in the budget framework paper
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop infrastructure plan and Construct facilities 1.2 Up-grade health facilities 1.3 Rehabilitate/Renovate health care facilities 1.4 Equip facilities; Supervise and monitor equipment installation 1.5 Carry out a needs assessment for new health facilities, equipment 1.6 Carry out regular maintenance 1.7 Develop Hospital Policy 1.8 Extend Information Communication Technologies (ICT).	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

4.6 PROCUREMENT AND MANAGEMENT OF DRUGS, EQUIPMENT, OTHER HEALTH SUPPLIES AND LOGISTICS

4.6.1 Description

This component of the HSSP aims to assure consistent availability of safe and efficacious essential drugs, other health supplies and logistics required for the effective delivery of the Minimum Health Care package nation wide. It will develop a harmonised, sustainable and efficient procurement and supplies management system. The HSSP sets out a comprehensive approach to drugs and medical supplies, including drug policy development, co-ordinated selection and quantification of needs, procurement, storage and distribution, rational drug use, cost recovery, quality control and drug regulation.

4.6.2 **Objectives**

The Ministry of Health will:

- Develop and implement a harmonised procurement system for drugs, medical supplies and logistics in the health sector. This will be done in line with the Uganda Government/local government Procurement procedures;
- Ensure the availability of essential drugs, other medical supplies and logistics at all levels of health care delivery;
- Develop and review the drug policy including financing, price regulation and competition, rational drug use and accountability;
- Set up an effective management structure for the pharmaceutical sector with clearly defined roles and responsibilities for each of the major players;
- Strengthen the drug regulatory system in the country to ensure quality assurance of all pharmaceutical and other medical supplies.

4.6.3 Implementation Strategy

Effective management and procurement of the Drugs, Medical Supplies and logistics will depend, among other factors, on the availability of resources, a revitalised system of procurement, storage and distribution, improved management controls and correction of the defects in the cost recovery system.

At the National Level, the Ministry of Health, in collaboration with the National Drug Authority, the National Medical Stores and Professional Councils will be responsible for overall co-ordination and guidance of procurement of pharmaceuticals, other medical supplies and logistics and their rational use. These institutions will provide technical supervision of quality control, regulation and support to the districts. In addition, professional bodies will enforce maintenance of the highest levels of ethics and professional standards in the practice. The capacity of the Ministry of Health will be strengthened to enable it provide overall co-ordination of the harmonised management of the pharmaceutical sector.

Efforts will be made to preserve the "public good" functions of the restructured and partially divested National Medical Stores.

Districts will ratify the procurement system in line with the Local Government Procurement regulations.

HSSP Log Frame: Procurement and management of Drugs, Equipment, other Health Supplies and Logistics

Output	Verifiable Indicators	Means of Verification	Key Assumptions
1 Efficient and integrated procurement, distribution and storage system.	1.1 Procurement, distribution and storage system established 1.2 Facilities with inventory control systems 1.3 Availability of elaborate computerised inventory control system 1.4 Personnel trained in inventory control system	1.1 Procurement policy and standard records 1.2 Site inspections, audit reports, field visit reports 1.3 Inventory records, Surveys 1.4 Training reports	
2 Appropriate and adequate logistics	2.1 Sound logistics principles and practices in place 2.2 Quantity of logistics available 2.3 Number of health facilities and districts with a computerised system	2.1 Documents 2.2 Field visits, surveys, inventory reports 2.3 Field visits, health facility and district reports	Adequate skills available at all levels 1 Resources available
3 Efficient and effective drugs and medical supplies management system	3.1 Availability of essential drugs, medical supplies and logistics at all levels of health care delivery 3.2 Availability of a comprehensive drug, medical supplies and logistic procurement plan 3.3 Level of rational drug use; stock-outs at the health facility 3.4 Proportion of districts and health facilities utilising drug stocks rationally; Level of wastage 3.5 Availability of a comprehensive drug supply and distribution system 3.6 Turn-over rate of medical supplies 3.7 Percentage of drugs within acceptable standards	3.1 Stock records, periodic and special surveys, sample studies 3.2 Cost analysis reports, medical supply inventory record, NMS procurement records, documents of budgetary provisions, Procurement plan documents, Tender documents 3.3 Treatment guidelines, prescriptions at health facilities, field visits, patient registers 3.4 As above 3.5 Records, stock cards, requisition and issue vouchers 3.6 Training guidelines and reports, district and health facility records 3.7 Quality Control Laboratory records, NDA reports	2 Harmonisation of procurement and distribution 3 Adherence to set standards and guidelines on drug management 4 Government support and commitment to enforce regulation
Activities at the operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Carry out a situation analysis on procurement, distribution and storage system; Develop procurement protocols and relevant quantification methods 3.1 Upgrade the distribution and storage system 1.3 Computerise the inventory control system; and carry out continuous inventory assessment 2.1 Identify training needs; train personnel in inventory control 2.2 Procurement of medical supplies and logistics including drugs. 2.3 Computerise the logistics system 3.1 Carry out drug quantification studies	Detailed Activities and indicators will be formulated by the Program, District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders.

3.2 Identify resources required to stock health facilities and districts with adequate medical supplies 3.3 Develop and implement appropriate drug procurement plan 3.4 Continuously update and disseminate guidelines on rational drug use 3.5 Monitor and supervise rational drug use at all levels 3.6 Monitor and supervise the supply and distribution of drugs 3.7 Train personnel in rational use of drugs 3.8 Carry out drug quality control			
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic Plan			To be established

4.7 LABORATORY SUPPORT SERVICES

4.7.1 Description

Effective implementation of many elements of the HSSP will require adequate laboratory support, if the policy objectives of effectiveness and efficiency are to be attained.

The 1999 Laboratory Needs Assessment Study conducted in 12 districts showed major deficiencies in the national health laboratory network, particularly at the Health Centre levels *(Laboratory Needs Assessment, January 2000, AMREF & MoH).* Scope for support in microbiology and basic haematology was very limited. Most peripheral medical laboratories were understaffed, under-equipped and in constant shortage of reagents. Many were inadequately housed or supplied with basic utilities such as running water, safe drainage or dependable source of light.

The HSSP will seek to remedy these deficiencies.

4.7.2 Objectives:

- To develop a comprehensive National Medical Laboratory Service Policy;
- To strengthen central capacity for assuming effective national laboratory services quality assurance;
- Upgrade the staffing and competence of medical laboratory personnel;
- To ensure adequate supplies and equipment for medical laboratories at all levels.

4.7.3 Implementation Strategy

A comprehensive national policy on medical laboratory services will be formulated in the early phase of implementation of the HSSP. The capacity of the Ministry of Health to lead in this process will be strengthened through local technical assistance. Similarly, district capacity will be strengthened through the progressive deployment of senior Medical Laboratory Technologist in each district. The strengthened capacity will be used to:

- Review laboratory service standards at each level of the public health system;
- Establish needs in personnel, equipment and supplies at each level;
- Establish a National Medical Laboratory Quality Assessment Scheme;
- Institute a programme for continuous monitoring of drug efficacy for the most common drugs used in management of the components of the UNMHCP;
- Laboratory personnel to be included in the national continuing medical education programme.

HSSP Logical Framework: Laboratory Support Services

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1. A functioning laboratory support system at all levels of health care	1.1 Policy document in place; 1.2 Proportion of health units meeting minimum laboratory service standards by district; 1.3 Annual assessment of laboratory services	1.1 Policy document; 1.2 Service assessment reports 1.3 Assessment reports	1. Importance of laboratory support appreciated at all levels. 2. laboratory services will be adequately staffed and funded 3. District Authorities will act on the Assessment findings.
Activities at operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.1 Develop National Policy on Health Laboratory Services; 1.2 Develop health laboratory service standards; 1.3 Establish and operationalise National Laboratory Quality Assessment Schemes ; 1.4 Procure and distribute effective laboratory supplies and logistics to all levels of health care.	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholders
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

4.8 LEGAL AND REGULATORY FRAMEWORK

4.8.1 Description

The aspirations of the National Health Policy and HSSP will not be attained without the support of an effective Legal and Regulatory framework. A review of all health related laws was undertaken three years ago. A draft Health Services Commission Act including a Code of Conduct for health workers is before parliament. On top of these professional Councils for Medical Practitioners and Dentists, Nurses and Midwives and Allied Health Workers have been established by law and are operational. The Pharmacy Act is due for review together with the National Drug Authority Statute. Other law enforcement agencies, such the Police, IGG, Local Councils at all levels, also need to work in close collaboration with the above to ensure that in the provision of health services individuals and society are protected from avoidable harm.

4.8.2 Objectives:

To review and develop the relevant legal instruments that will govern and regulate health and health-related activities in the country, in order to ensure that the principles and objectives of the health policy are attained. Government will therefore update and/or formulate and disseminate laws, regulations and enforcement mechanisms related to:

- Development, management regulation and control of the National Health Services;
- Traditional Medicine, including Traditional Midwifery;
- Registration, manufacture, importation, storage, sale, distribution, dispensing and use of pharmaceuticals, vaccines, health equipment and appliances, and other medical supplies;
- Training in, and conducting of, medical and health research;
- Use and disposal of hazardous materials;
- Protection of workers against health hazards related to their employment in liaison with relevant organisations;
- Food hygiene and safety;
- Health services provided by Religious Organisations and other Non-profit organizations;
- The establishment and operation of private-for-profit health and health related services;
- Environmental Health Control, in collaboration with other relevant authorities and agencies;
- Control of public advertising on health and health care;
- Consumer protection, especially for the vulnerable groups including women, children and persons with disability;
- Stigmatisation and denial due to ill health or incapacity; and
- Other areas that are deemed appropriate.

4.8.3 Implementation Strategy

In order to ensure effective implementation of the relevant legal instruments, existing legal structures will be utilised as much as possible. At the National Level, the Ministry of Health, in collaboration with Ministry of Justice and the law enforcement bodies, will be responsible for the preparatory work for the identification, amendment, repealing and applying laws and

regulations relating to the health sector. In addition, the Ministry of Health, in close collaboration with the health-related professional councils, will continue to carry out inspection of health care and related services, so as to safeguard the interest of the public.

At the district level, the Expanded District Health Management Team under the technical leadership of the District Director of Health Services, will be responsible for implementation of the relevant laws and regulations, and to ensure the effective and harmonious implementation of the health policy and plan.

HSSP Logical Framework: Legal and Regulatory Framework

Output	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
4. A functioning legal and regulatory framework for the health sector	4.1 Regulatory mechanism established for the health sector; 4.2 Relevant and up to date laws in place; 4.3 Number of law defaulters brought to court; 4.4 Number of professional councils supported; 4.5 Number of professional councils with a self-regulatory code.	1.4 Legal documents, supervision reports; 1.5 As in 1.1 above; 1.6 Enforcement reports; 1.7 Regulatory manuals.	
Activities at operational level	**Verifiable Indicators**	**Means of Verification**	**Key Assumptions**
1.5 Develop and gain approval of laws; 1.6 Publish and disseminate laws; 1.7 Enforce laws in collaboration with other law enforcement bodies; 1.8 Support professional councils to develop and implement regulatory mechanisms.	Detailed Activities and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Means of verification and indicators will be formulated by the Program , District Authorities and other stakeholders.	Detailed Assumptions will be formulated by the Program , District Authorities and other stakeholderse
Inputs			**Preconditions**
Refer to Ch. 5 for costing of the Strategic plan			To be established

Chapter 5

COSTING AND FINANCING OF HEALTH SECTOR STRATEGIC PLAN

Introduction

This chapter provides the broad indicative cost framework for the Health Sector Strategic Plan over a 5 year period. An illustrative financial plan required to cover the estimated costs is also included.

5.1 Costing of Health Sector Strategic Plan

5.1.1 Costing Methodology

The costing of the Health Sector Strategic Plan is largely facility based except for the estimated costs at central level. The costing applies to both Government and NGO facilities and assumes that irrespective of whether the facility is Government or NGO, the requirements for the same facility level are similar. The cost estimates provide for only one health facility per given unit population, which largely corresponds to the existing administrative levels, adjusting for double counting in the following manner:

1. Where a higher level health facility (e.g. Hospital) existed, it was assumed that no additional health facility would be required for the next lower level (e.g. Health Center II, III, IV). Therefore for the lowest level, the parish, since all the higher level facilities are located within the parish, the number of Health Center IIs were discounted by the total number of higher facilities.

2. The existing health facilities, both public and NGO, were reviewed (Inventory of Health services in Uganda, 1997 - MOH). Using a random sample of districts, and looking at health facilities (both public and NGO) at sub-county level, the rate of facility double counting was estimated at 17%. This rate was applied to the existing health facilities.

In order to determine financial resource allocation among the components of the minimum package (Intra-package Resource Allocation), a weighting system using the burden of disease and other epidemiological indicators was employed. Consideration was also given to the relative intervention cost per case. An intensity factor, which represents an additional investment to avert a loss of life, was applied to each disease entity within the components of the minimum package. Relative index was then derived to guide intra-package resource allocation. The intra-package resource allocation was applied to the cost estimate after deducting the costs of the common items. The common items include personnel costs, utilities, maintenance, physical facility construction and rehabilitation, furniture, beds and equipment, cold chain and communication equipment, transport equipment, initial training, vaccines, and recurrent and capital costs for the Ministry of Health and tertiary institutions.

The weighting methodology described above excludes the component of essential clinical care and the sub-components of health education and school health, immunization and diseases for eradication. Ten percent of the minimum package costs was allocated to essential clinical care. The total cost for IEC was allocated to health education and school health given the cross cutting nature of the intervention.

5.1.1.1 Recurrent costs for delivering the Minimum Health Care Package

The Minimum Health Care Package will be delivered at all levels of health care. The following are the critical logistics required for effective delivery of the Minimum Health Care Package at all levels of health care and the methodology for determining the cost of logistics at each level of health care. Explanation on how these cost estimates were derived are available in a separate document.

Drugs
The estimation of drug consumption, in terms of funds required, was based on the Drug Quantification Exercise carried out by the National Drug Authority. The estimation was corrected for the current level of accessibility of the population to health facilities, which is estimated at 49%. An annual per capita drug consumption rate was calculated and based on the country population, the national annual drug requirement was arrived at. The allocation of the drug requirements to health facilities was then based on the relative annual patient load for the particular level of health facility.

Drugs include the costs for minimum stock of essential drugs at different levels of health facility. In estimating the drug cost, the calculation utilised the output statistics and performance indicators from the inventory of health services in Uganda for the year 1996. The data includes outpatient and inpatient statistics, average length of stay, occupancy rate, and number of beds. Minimum average price for drugs per outpatient visit was derived and applied for all the health centre levels. For the health centre III, IV and the District Hospital with inpatient facilities, minimum average price of drugs per admission was estimated and applied. Under drugs are included the other expendable supplies such as syringes, cotton wool, gloves, bandages etc.

Vaccines
The vaccine requirement was obtained from the UNEPI estimations. The cost for vaccines was not allocated to the health facility levels but rather reflected as a national requirement. The eventual allocation would have to be based on the population coverage at the different levels.

Personnel and Training
In terms of the basic component of the recurrent cost, clinical personnel salaries and benefits, as well as costs for support staff, were estimated using the minimum standard staffing norms for government district health services. The salary and benefit levels were based on the payment scales of the public service in Uganda. The salaries and benefits were kept constant over the plan period but estimated in US Dollars, in order to take care of the local currency inflation. Since the scales for given cadres of staff have an intra and inter-scale range, the salary and benefit level used for a given cadre was mid-way the range, such that although the majority of the staff belong to the lower end of the range, this strategy would allow for modest annual increments in salaries.

Bed/Hotel
Hospital beds/hotel costs for health centre III and IV include basic meals and laundry estimated at minimum average price.

Laboratory and X-ray

Laboratory supplies for minimum service were estimated for outpatient and admission using a utilisation ratio of 40% and 50% respectively. In the case of X-ray, a utilisation ratio of 20% and 5% was applied for outpatient and admission respectively.

Other operational items

- Office supplies are administrative consumables by the staff of the health centres, which is calculated as 1% of total cost of clinical and support staff.
- Travel expenses include accommodation and other incidentals during the field operations and were estimated as a percentage of clinical and support staff costs, which are 15% for health Centre I and II, 10% for Health Centre III and IV and 2% for District Hospital. The intensity of field operation was assumed to be higher at Health Centre I and II than Health Centre III, IV and District Hospital.
- Utility costs were estimated at 1% of the facilities (Building) only.
- Maintenance costs were estimated for all the capital items ranging from 1% for communication equipment to 10% for vehicles.
- Supervision includes only the DHMT staff cost. The supervision cost for other levels has been accounted for in the travel expenses.
- Information, Education and Communication (IEC) and Social Marketing costs were estimated from the 5-year plan of action for the MoH Health Education Department.
- National Management Support costs cover services provided by the .MOH upon special request from the districts in the areas of policy analysis and formulation, logistic support, information systems, co-ordination, initial training of personnel and surveillance. A provision of 1 percent of total recurrent cost has been made to cover such management overheads.

Table 7 summarises the annual cost of the critical logistics required for delivering the Minimum Health care package at each of the different levels of health care.

Table 7. Cost of Delivering the Minimum Health Care Package at each of the different levels of health care.

Facilities/Inputs	**HC I**	**HC II**	**HC III**	**HC IV**	**GHOSP**	**DHMT**	**National**
		US $	**US $**	**US $**	**US $**	**US $**	
Recurrent Costs							
Clinical Personnel	-	2,168	4,938	12,440	100,583	50,679	
Drugs	-	8,250	18,500	44,000	102,600	-	
Vaccines	-	-	-	-	-	-	2,363,391
Hospital Beds/Hotel costs	-	-	2,769	4,077	25,385	-	
Laboratory supplies	-	-	3,846	6,231	8,354	-	
X-ray supplies	-	-	-	-	12,615	-	
Office supplies	14	22	71	180	1,197	624	
Travel expenses	-	409	714	1,804	2,395	6,242	
Utility	-	175	598	1,536	7,692	538	
Maintenance	20	565	3,425	10,809	58,784	10,619	
Support staff	-	562	2,201	5,597	19,151	11,745	
Supervision allowances	-	136	357	902	1,197	3,121	
IEC and Social marketing	64	192	934	4,647	4,647	-	
In-service Training costs	108	217	494	1,244	15,091	-	
National Management support	42.34	127	488	1,035	3,597	836	
Total Recurrent Costs	**248**	**12,829**	**39,335**	**94,501**	**363,289**	**84,405**	**2,363,391**

5.1.1.2 Capital costs

a). Construction of Health Facilities

The construction costs were obtained from the Health Infrastructure Working Group Report (January 2000)**,** for the health centers II to IV, based on standard architectural plans. The gap in health infrastructure was identified largely at the level of health centre II, apart from the up-grading of health centre IVs. New construction of health facilities was therefore focussed on Health Centre IIs. The rate and magnitude of health centre II construction was determined by the availability of financial and human resources. The cost estimates for furniture, beds and medical equipment were obtained from the MOH (Medical Equipment Policy). In this regard, for General Hospitals and Health Centres IV, two-thirds of the full cost estimate was applied, while for Health Centres II (newly constructed) the full cost was applied.

b). Equipment and Logistics

Direct costs for the refrigerators, communication equipment, vehicles, motorcycles, bicycles and medical equipment were used.

c). Initial training

Initial training was considered as a capital cost with a useful life of 25 years. A provision of 1 percent has been made to account for the annualised costs incurred in providing initial training, while in-service training costs were estimated at 10 percent of clinical staff costs.

Table 8 summarises the unit cost of the major capital costs.

Table 8. Unit costs of major capital costs

Capital Cost	HC I	HC II	HC III	HC IV	GHOSP	DHMT
		US $	US $	US $	US $	US $
Facilities		21,333	74,000	83,705	0	0
Furniture, Beds & Med. Equip.		3,333	40,000	77,778	950,000	0
Refrigerators, Coolers		935	935	1,950	1,950	1,950
Communication Equipments		0	1,000	1,000	2,500	1,000
Vehicles		0	0	20,000	20,000	20,000
Motorcycles		0	2,000	2,000	2,000	2,000
Bicycles	80	80	80	80	0	0
Initial Training		1,777	6,612	13,328	65,073	8,102
TOTAL	**80**	**24,328**	**110,544**	**302,016**	**1,785,423**	**179,952**

d). Rehabilitation of General Hospitals and Health Centres

The unit cost for the rehabilitation of General Hospitals (District Hospitals) was assumed to be half the cost of rehabilitation of a regional referral hospital. As for the health centres, the cost estimate was derived from an average cost estimate for rehabilitation of 20 health centres in Kumi District (MOH/DfID Cost Figures, 1999).

5.1.1.3. Health Councils and Autonomous Bodies

The costs for professional councils and other autonomous bodies like Uganda Blood Transfusion Services were derived from their respective budget estimates.

5.1.1.4. Referral Hospitals

Development and recurrent costs for referral hospitals i.e. Mulago Hospital Complex, Butabika Hospital and other referral hospitals were obtained from the Medium Term Expenditure Framework of Government (Ministry of Finance, Planning and Economic Development, 2000). However, for the rehabilitation of regional referral hospitals, the costs were based on the rehabilitation costs of Soroti Hospital (MOH/IDA Report, 1999)

5.1.1.5. Ministry of Health Headquarters

Development and recurrent costs for the Ministry of Health Headquarters were obtained from the Medium Term Expenditure Framework of Government (Ministry of Finance, Planning and Economic Development, 2000).

5.1.2 Cost Presentations

Table 7 provides the breakdown of recurrent and capital costs of (1) delivering the Minimum Health Care Package in Uganda, and (2) referral hospitals, MoH headquarters, and Health Councils and Autonomous bodies. The Plan will be implemented through a network of health facilities (health centres, general hospitals, referral hospitals) and district health management teams.

The Minimum Health Care Package comprises health care interventions contained in the National Health Policy, 1999. In costing the HSSP, the definition of health infrastructure for service delivery was based on the principles of affordability, accessibility and equity. In addition, the cost framework reflects the minimum health package and other policy principles defined in the policy document. It further provides the structure, which will guide the development of operational plans at all levels.

Table 9: Intra Package Resource Allocation Over the Period of 5 Years (indicative)

	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5	
Minimum Package Components	**Amount (US$)**	***%***	**Amount (US$)**	***%***	**Amount (US$)**	***%***	**Amount (US$)**	***%***	**Amount (US$)**	***%***
1 ***Control of Communicable Diseases***										
Malaria	3,166,060	*2.0*	3,311,455	*1.9*	4,007,349	*1.9*	4,130,696	*2.0*	4,224,845	*2.1*
STI/HIV/AIDS	1,609,278	*1.0*	1,683,181	*0.9*	2,036,897	*1.0*	2,099,594	*1.0*	2,147,448	*1.1*
Tuberculosis	1,380,467	*0.9*	1,443,863	*0.8*	1,747,287	*0.8*	1,801,069	*0.9*	1,842,119	*0.9*
	-		-		-		-		-	
2 ***Management of Childhood Illness***	21,781,433	*13.7*	22,781,701	*12.8*	27,569,215	*13.3*	28,417,805	*13.6*	29,065,513	*14.5*
	-		-		-		-		-	
3 ***Sexual and Reproductive Health and Rights***	9,680,168	*6.1*	10,124,710	*5.7*	12,252,391	*5.9*	12,629,523	*6.1*	12,917,380	*6.4*
			-							
4 ***Public Health Interventions***			-							
			-							
Environmental Health	721,550	*0.5*	754,686	*0.4*	913,281	*0.4*	941,393	*0.5*	962,849	*0.5*
Epidemic preparedness and Response	102,579	*0.1*	107,289	*0.1*	129,836	*0.1*	133,832	*0.1*	136,883	*0.1*
Improving Nutrition	1,366,589	*0.9*	1,429,347	*0.8*	1,729,720	*0.8*	1,782,962	*0.9*	1,823,600	*0.9*
Immunization (operational)	1,346,637	*0.8*	1,269,372	*0.7*	1,340,819	*0.6*	1,406,684	*0.7*	1,535,726	*0.8*
**Diseases for Eradication	2,835,025	*1.8*	2,607,182	*1.5*	2,686,760	*1.3*	2,749,992	*1.3*	2,929,036	*1.5*
IEC	1,249,621	*0.8*	1,149,192	*0.6*	1,184,269	*0.6*	1,212,140	*0.6*	1,291,059	*0.6*
* Health Education										
* School Health										
5 ***Mental Health***	2,763,590	*1.7*	2,890,502	*1.6*	3,497,934	*1.7*	3,605,601	*1.7*	3,687,781	*1.8*
6 ***Essential Clinical Care***	8,788,578	*5.5*	9,192,176	*5.1*	11,123,887	*5.4*	11,466,284	*5.5*	11,727,627	*5.8*
7 ***Common Items***	102,002,437	*64.2*	119,864,630	*67.1*	136,955,098	*66.1*	136,253,846	*65.3*	126,767,173	*63.0*
Total Package	**158,794,012**	*100.0*	**178,609,287**	*100.0*	**207,174,742**	*100.0*	**208,631,420**	*100.0*	**201,059,039**	*100.0*

Note:

1. Common items applies to all interventions.
2. Common items include:
   a) Personnel
   b) Utilities
   c) Maintenance
   d) Physical facilities, furniture& beds, refrigerators, coolers, medical equipment
   e) Communication equipment, vehicles, motorcycles and bicycles; and
   f) Initial training
   g) Rehabilitation of Health Centres
   h) Rehabilitation of GHOSPs and Regional Referral Hospitals
   I) Recurrent and capital costs at MOH HQTRS, Mulago, Butabika, Health Councils,and other Autonomous Bodies
   j) Research (operational)
   k) Monitoring of HSSP
   l) Vaccines

SUMMARY PROJECTIONS OF COSTS AND FINANCING OF THE HSSP [2000/01-2004/05] (constant US$)

Category	YEAR 1 2000/01	YEAR 2 2001/02	YEAR 3 2002/03	YEAR 4 2003/04	YEAR 5 2004/05	Total
UNMHC Package						
Recurrent Costs	95,617,217	100,905,572	108,177,678	111,736,227	114,940,743	531,377,437
of which						
Recurrent (HC I - HC IV)	57,849,498	62,608,406	69,527,548	72,733,132	75,584,683	
Recurrent (DHT)	3,798,225	3,798,225	3,798,225	3,798,225	3,798,225	
Recurrent (GHOSP incl NGO)	31,606,103	32,135,550	32,488,514	32,841,479	33,194,444	
Vaccine	2,363,391	2,363,391	2,363,391	2,363,391	2,363,391	
Recurrent funded in Dev. Budget						
Capital Costs	13,963,034	15,940,814	30,077,929	27,961,492	28,662,846	116,606,115
of which						
Capital (HC I-HC IV)	7,108,362	622,106	11,811,026	7,611,922	8,127,156	
Rehabilitation of HCs	0	2,961,200	3,849,560	3,849,560	4,145,680	
Capital (DHT)	222,750	770,000	770,000	770,000	660,000	
Capital (GHOSP incl NGO)	200,250	3,556,667	5,717,333	7,800,000	7,800,000	
Rehabilitation of (GHOSP incl NGO)		4,700,000	4,700,000	4,700,000	4,700,000	
Basic Training	3,431,672	3,330,841	3,230,010	3,230,010	3,230,010	
Total UNMHC Package	**109,580,251**	**116,846,386**	**138,255,607**	**139,697,719**	**143,603,589**	647,983,552
Total (Ref. & MoH)	**49,213,761**	**61,762,901**	**68,919,135**	**68,933,701**	**57,455,450**	306,284,948
GRAND TOTAL COSTS	**158,794,012**	**178,609,287**	**207,174,742**	**208,631,420**	**201,059,039**	954,268,500
RESOURCE ENVELOPE	**159,621,573**	**180,821,573**	**205,046,573**	**205,046,573**	**205,046,573**	
of which						
GoU/Donor	**141,731,250**	**162,931,250**	**187,156,250**	**187,156,250**	**187,156,250**	
Community/NGO/Local Revenue	**17,890,323**	**17,890,323**	**17,890,323**	**17,890,323**	**17,890,323**	
RESOURCES MINUS GRAND TOTAL COSTS	**827,561**	**2,212,286**	**(2,128,169)**	**(3,584,847)**	**3,987,534**	
GoU Resources as % of Recurrent Costs	112%	117%	122%	119%	117%	
DETAILS OF CAPITAL COSTS						
HC II (No. of unitsfor construction)	20	58	250	260	280	868
HC IV (No. of units for up-grading)	45					45

Notes:

1. All figures are in US $ at MoFPED projected exchange rate
2. No increase assumed in real rate of pay
3. Recurrent costs (HC I-HC IV) in 1999/2000 equal to PHC Grant plus 2/3 lunch allowance plus NGO estimated recurrent lower level unit spending
4. Recurrent costs for GHOSP (incl.NGO) include Govt funding to public and NGO units as well as the estimated NGO own contributions.
5. Recurrent costs in development budget in 1999/2000 equal allowances, consumables, other goods and vehicle O&M (figure for 1998/99 assumed to apply)
6. Donor development costs for Mulago and Butabika included in the figures
7. Costs for initial and in-service training for health personnel included.
8. Estimates for rehabilitation of hospitalsprovided by the Health Infrastructure Working Group.
9. The expenditure estimates above also cover NGO facilities.
10. Estimated resource input from the NGOs, community and local revenue (government) are included in the resource envelope.
11. Under capital costs for HC II-HC IV, the costs for furniture, beds and medical equipment are spread equally over the last 4 years, while for GHOSP they are spread over the 2 – 5 year as follows (5,10,15,15 respectively)
12. Rehabilitation of HC II- HC IV starts in Year 2 as follows: Yr 2 = 100 HCs, Yr 3 = 130 HCs, Yr 4 = 130 Hcs and Yr 5 = 140 HCs).
13. Rehabilitation of GHOSP (incl. NGO) starts in Year 1 as follows: Yr 1 = 3 GHOSPs, Yr 2 = 2 GHOSPs, Yr 3 = 2 GHOSPs, Yr 4 = 2 GHOSPs and Yr 5 = 2 GHOSPs).
14. Rehabilitation of referral hospitals starts in year 2 as follows: Rehabilitation of Mbarara and Jinja over a 3 year period.
15. The rehabilitation of hospitals (GHOSPs, Referral, Butabika, and Mulago have been phased over time.
16. Research costs estimated at US $ 0.50 per capita per annum.
17. Costs for monitoring the HSSP estimated at 1% of plan cost.
18. Butabika: Rehabilitation starts in year 2 and is completed in Yr 5 (Includes equipment).
19. Budget lines for MoH HQTRs separated from project budget, which earlier was reflected as MoH HQTRs budget.
20. Line for National Service Delivery Programmes introduced to handle nationally managed components of service delivery,e.g. Blood Transfusion Services.
21. The GoU/Donor resource projections for Yr 1-3 have been provided by MoFPED (MTEF); in absence of projections beyond Yr 3, Yrs 4 & 5 have remained at Yr 3 level.

5.2 Financing the Health Sector Strategic Plan

5.2.1. Introduction

Due to the large number of stakeholders involved in the provision and consumption of health care, the financing arrangements for the sector are quite complex. This is illustrated in the diagram, which outlines the main financial flows from sources of health care funds to where health care services are utilised. Each arrow shows a flow of funds, for example:

- Households **provide** funds to: Mulago and Butabika hospitals, referral hospitals, general hospitals, district PHC, NGO units, private for profit providers and the traditional sector.
- The Ministry of Health Headquarters **receive** funds from GoU and Donors.

By quantifying all of these financial flows, one can construct types of income and expenditure accounts for the health sector which are known as National Health Accounts (NHA). The NHA methodology will prove useful in evaluating the financing arrangements for the HSSP and developing an appropriate financing strategy for the plan.

In reality, the activities outlined in the HSSP, which require financing, do not represent the entire health sector. The HSSP has not addressed the activities and financing of: private for profit providers, employers clinics and the traditional sector. The health care entities that **are** covered by the HSSP are shown as shaded boxes in the diagram and it will be necessary to ensure that they receive sufficient funds to fulfill their roles in implementing the plan.

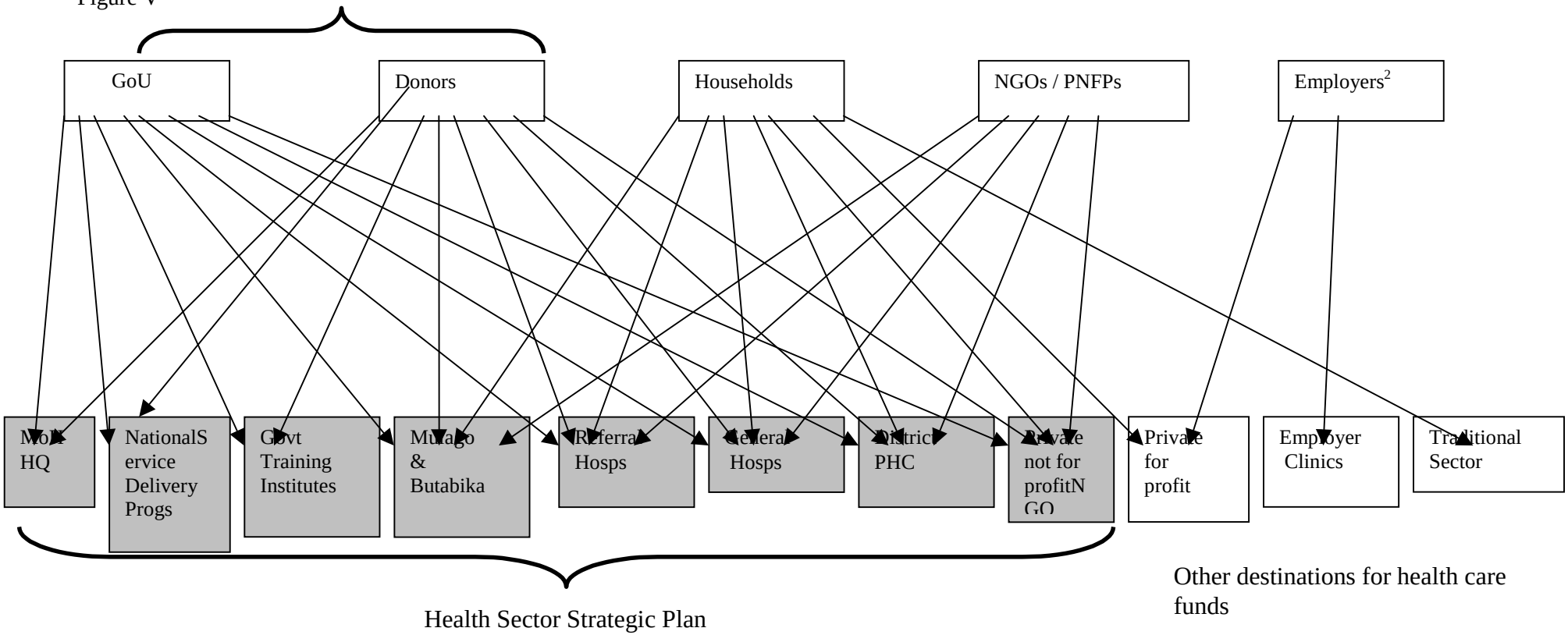
The cost projections, both recurrent and capital, have been provided for each of the HSSP elements over the next five years. The challenge however is whether the sums of finances received from the different sources meet the cost projections. For example, will the sum of funds received by General Hospitals from all five funding sources in 2000/01 meet the projected funding requirement of approximately 35 million dollars? Making these assessments of potential funding gaps across the components of the HSSP will help GoU and development partners determine the viability of the plan as a whole.

Financing the Health Sector Strategic Plan

Sources of Funds

MTEF[1]

Figure V



Notes:

1. Medium Term Expenditure Framework figures do not include GoU funds for the HSSP provided through unconditional grants to districts.
2. Employers likely to contributing some funds towards health costs in the public sector (arrows not shown)

- Shaded boxes show destinations covered by the HSSP boxes.

5.2.2 The Resource Envelope for the Health Sector Strategic Plan

The diagram above shows that there are five significant sources of financing the HSSP. These are:

Government of Uganda

Government of Uganda funding to the HSSP is provided through the following mechanims: recurrent budget and project funding as shown in the MTEF, unconditional grants to the Districts and local tax revenues. Of these mechanisms the largest contribution will come from the MTEF route and accurate projections are available for these funds as a result of the figures provided by the Ministry of Finance for the next three years. A summary of the MTEF funding for the year 2000/01, which shows allocations compatible with the HSSP is provided in table below. A more detailed analysis of the MTEF can be found in the Ministry of Health's Budget Framework Paper.

		Medium Term Expenditure Framework for the Ministry of Health					
All amounts in Billions of Shillings		2000/01					
		Recurrent		Development		Total	Total
		GoU		GoU	Donor	GoU	Resource
Vote	Budget Heading	Wage	Non-wage				Envelope
14	Health MoH Headquarters	2.64	8.03	0.10	1.41	10.77	12.18
14	Health Projects			11.07	124.80	11.07	135.88
14	National Service Delivery Programmes		6.95			6.95	6.95
19	Butabika Hospital	0.56	0.94	0.18		1.68	1.68
23	Mulago Hospital Complex	5.50	5.46	0.57	5.80	11.53	17.33
50	NGO Health Units	0.00	5.94			5.94	5.94
60	Primary Health Care	8.90	17.58			26.48	26.48
60	General Hospitals	0.00	6.16			6.16	6.16
60	Health Training Schools	0.00	1.76			1.76	1.76
60	Referral Hospitals (& other delegated)	6.50	3.08			9.58	9.58
	Jinja Hospital	0.66	0.71			1.37	1.37
	4 Hospitals						
	4 Hospitals						
60	Lunch Allowance	9.18	0.00			9.18	9.18
	Sub-Total	**33.94**	**56.61**	**11.93**	**132.01**	**102.47**	**234.48**
	Mbarara Teaching Hospital	1.67	0.77			2.44	2.44
	Total	**35.61**	**57.38**	**11.93**	**132.01**	**104.91**	**236.92**

At present the amounts GoU funding provided through block grants and local tax revenues is less well known. Reasonable estimates of these sums must be calculated if the total magnitude of the resource envelope is to be determined.

Donors

Donor funding is largely captured in the MTEF. This includes recurrent budget support and donor project funding channeled through the Ministry of Health. Presently project funding is the largest element but over the period of the HSSP it is anticipated that the balance of donor support will shift towards budget support.

As budget allocations are made according to HSSP priorities, donor financing through budget support can be almost totally offset against HSSP costs. However due to the more autonomous nature of project funding, their contribution towards the HSSP is less certain. Investigations will therefore be made into all projects to determine their additional sums of resources that will support HSSP. In addition, measures will be undertaken to ensure that future projects are compatible with the HSSP to maximise the resources available to finance the plan.

It will also be necessary to capture the flows from donors to the HSSP that currently go directly to Districts and NGOs/PNFPs.

NGOs / PNFP

NGOs largely receive funding from Donors / GoU and households to carry out health care activities. However in addition they may act as a **source** of resources through monetary contributions and donations in kind. These will be quantified to evaluate their total contribution.

Employers

A recent study has shown that employers are increasingly providing health care benefits to their employees and their dependents. Where these benefits are in the form of independent health care services, these fall outside of the scope of the HSSP. However benefits in terms of payments and reimbursements for services in the public and PNFP units should be included in the HSSP envelope. As health care benefits from employers could potentially reach 15% of the population these resources may become more significant in future years. This could be facilitated by legislation and establishment of a formal sector workers health insurance scheme.

Households

Household studies have indicated that private household expenditures on health care services represent the largest element (in the order of 60%; HPD analysis) of funding to the health sector. However an accurate estimate of the household contribution and its allocation to the sub-sectors of: public/PNFP; private for profit and the traditional sector has been difficult to determine. The ongoing National Health Accounts work and household survey data will be used to improve the accuracy of household financing figures and more specifically quantify the sums flowing to the HSSP.

5.2.3 Comparison of projected HSSP costs and HSSP financing

For the HSSP to be implemented successfully it is essential that its projected costs are significantly covered by the projected resource envelope. The analysis provided in this chapter gives provisional data on both the costing and financing elements of the HSSP. However more work needs to be undertaken to improve the accuracy of these figures, particularly in the case of the resource envelope. Despite these shortcomings it is necessary and appropriate to compare the provisional figures at this stage to see whether there is likely to be a significant funding gap. This comparison is given in the table below which has been taken from table . All figures are in millions of US dollars.

Table 12. Comparison of projected HSSP costs and HSSP financing

	99/2000	2000/01	2001/02	2002/03	2003/04	2004/05	5 Year Total
HSSP Costs	158	159	179	207	209	201	955
HSSP Resource Envelope[1]	177	160	181	205	205	205	956
Funding Gap	(19)	(1)	(2)	2	4	(4)	(1)

Note 1: The resource envelope presented here included MTEF projections based on the Ministry of Finance's Budget Call Circular of March 2000. This included growing projections for project funding and here it is assumed that all these funds are available for the HSSP. This is an optimistic scenario. However to counterbalance this the resource envelope also includes conservative estimates for funding from block grants, local revenues, households and employers.

The figures presented above are the best estimates available at the present time and therefore caution should be exercised when assessing the relevance of the apparent small gap between costs and resources. More work will be undertaken to confirm that this really is the case.

However even at this early stage one can confirm that the predicted costs and the likely resources available are of a similar magnitude. This means that in terms of financing, the outputs set out in the HSSP are realistic and that the plan can be implemented as envisaged in this document.

5.2.4 The Health Financing Strategy

The Government of the Republic of Uganda (GOU) is fully committed to the implementation of the minimum health care package over the period of five years and will provide additional resources towards achieving the objectives of the plan. Government is just one partner though in the financing strategy and appropriate contributions will also be sought from the other financing sources previously mentioned. A specific Health Financing Strategy will be produced which will outline the roles and expectations of the different partners. In addition the strategy will identify potential new financing sources and mechanisms to raise additional funds, and address the issue of improving efficiency. As part of the Financing Strategy, Government will also implement a revised fee for services policy which will seek to provide revenue for improving services whilst exempting poor and vulnerable groups.

Chapter 6

IMPLEMENTATION AND MONITORING OF THE HEALTH SECTOR STRATEGIC PLAN

The Health Sector Strategic Plan has been finalised and having passed through approval stages will be launched at the beginning of FY 2000/01.

6.1 Implementation of the HSSP

The implementation of the HSSP will commence with Financial Year 2000/2001 in July.

6.1.1 Sector-Wide Approaches

The Health Sector Strategic Plan is to be implemented through a sector-wide approach whereby all stakeholders will participate only within the framework of the HSSP. Common working arrangements will be employed with the objective of using and strengthening existing Government of Uganda systems and structures. Development partners are encouraged to fund the Health Sector Strategic Plan through Central Budget Support in line with the Government of Uganda strategy towards Comprehensive Development Framework. However, in the interim, Government of Uganda has adopted a flexible approach to give time to development partners adjust to the new arrangements. Accordingly the modalities for funding the HSSP are:

- Central Budget Support,
- District Budget Support and
- Projects.

It is expected that all partners will move towards central budget support as they wind up pipeline projects. Respective responsibilities of the stakeholders will be spelt out in the Code of Conduct and the Memorandum of Understanding which will be signed by participating development partners and Government of Uganda.

6.1.2 Structures

Government of Uganda and stakeholders will retain some of the structures that have been used to develop the Health Sector Strategic Plan for its implementation.

- The Health Policy Implementation Committee (HPIC) and Health Sector Review Committee (HSRC) will be merged and called Health Policy Advisory Committee (HPAC). Membership and Terms of Reference will be reviewed. The method of work of HPAC will be integrated into the routine Ministry of Health structures and the frequency of meetings will progressively reduce. At least a quarterly meeting will be required to make preparations for the Joint Missions. HPAC will define its method of work.
- The Consultative Meetings and Joint Missions will continue. The October/November Mission to review performance of the sector for the prior financial year and the March/April Mission to agree on sector priorities and allocate resources for the following financial year based on draft central and district plans.
- National Health Assembly will meet annually in October/November. Its membership will compromise representations from all stakeholders from the centre, district, NGOs, Development Partners and civil society. The assembly will review the performance of the sector and identify priorityies.

6.1.3 Common Working Arrangements

These will be agreed by stakeholders in the following areas:

- Planning and Budgeting cycles
- Disbursement,
- Procurement,
- Financial Management and accountability,
- Monitoring and evaluation.
- Auditing

6.1.4 Centre – District Linkage:

According to the Constitution and the Local Government Acts, central line ministries are responsible for policy, setting of standards and guidelines, supervision and monitoring, technical support and resource mobilisation. The Local Authorities are responsible for service delivery.

The Health Sector Strategic Plan is a standard framework and guideline that the districts will use to elaborate three year rolling plans and annual work plans. The centre will provide technical support to the districts in preparing annual plans within the framework of the HSSP and will supervise and monitor the delivery of services using established central systems.

6.1.5 Advocacy for the Health Sector Strategic Plan

The Health Sector Strategic Plan will be launched during July 2000. A programme for publishing the objectives, targets and implementation arrangements at all levels has been developed by the Working Group on the Basic Package of Services.

6.2 Monitoring and evaluation of the HSSP

For the broad purpose of monitoring actions in the context of The Poverty Eradication Action Plan (PEAP), three indicators have been agreed on. These are:

- Per capita level (facility type) and age-specific outpatient department utilization
- Percentage of children under one year with DPT3 immunization according to schedule,
- Proportion of health centres by level with minimum staffing norms.

A larger number of about 45 indicators shall be used by technical programmes and districts for detailed monitoring and evaluation of interventions in the sector.

The HSSP incorporates a monitoring framework. Routine supervision and monitoring of the sector will be carried out in accordance with the National Supervision Guidelines and the HMIS will be strengthened. On top of this the Development Partners and Government of Uganda through the Joint Missions will monitor the performance of the sector using agreed sets of indicators shown in Table 13.

Table 13. Indicators for monitoring the health sector strategic plan nationally

	Category	Indicator	Purpose (what it measures)	Baseline Value	5-year target
1	Input	Percentage of Government of Uganda (GoU) budget allocated to health sector	Commitment of GoU to health	7.3%	
2	Input	Percentage of total GoU budget released time to the sector (non-salary recurrent and capital)	Level of government honouring of its commitment to the health sector	85%	100%
3	Input	Total public (GoU and donor) allocation to health per capita	Equity of health resource allocation	4.8$	6.0$
4	Process	Percentage of disbursed PHC conditional grant that are expended	Absorption capacity at the district level	50%	90%
5	Process	Proportion of districts submitting complete Health Management Information System (HMIS) monthly returns to MoH on time.	Management capacity through completeness and timeliness of reporting system	15.6%	80%
6	Process	Percentage of facilities without any stock outs of Chloroquine, measles vaccine, ORS and cotrimoxazole	Drug management protocols	29.1%	90%
7	Process	Percentage of health facilities explicitly displaying current user charge rates	Public communication of important information	24%	100%
8	Process	Percentage of unearmarked donor funds to the health sector through MoF	Trend of the nature of health funding	43.2%	80%
9	Process	Percentage of co-operating partners using a single set of procurement procedures	Extent to which development partners are prepared to use common procedures	*	90
10	Process	Percentage of population residing within 5 km of a health facility (public, or private not for profit) providing the national minimum health care package (NMHCP) by district	Equity and access (implementation of the NMHCP)	47%	75%
11	Output	Percentage of children <1yr receiving 3 doses of DPT according to schedule by district	Utilisation (an MTEF indicator)	41.4%	80%
12	Output	Proportion of health centres with at least the minimum staffing norms by level.	Level of staffing implementation of HRD policy	40%	80%
13	Output	Contraceptive Prevalence Rate (CPR)	Utilisation	15%	30%

	Category	Indicator	Purpose (what it measures)	Baseline Value	5-year target
14	Output	Proportion of surveyed population expressing satisfaction with the health services.	Quality of service delivery	*	70%
15	Output	Age-sex urban/rural specific HIV sero-prevalence rates	HIV infection	6.7% (all)	1.7%
16	Output	Percentage of deliveries taking place in a health facility (Government and NGO)	Utilization	25.2%	70%
17	Output	Total Government and NGO OPD utilisation per person by level and age group	Utilization	40% all levels	60%
18	Output	Health facility level-specific number of caesarean sections per 1,000 deliveries within the catchment area of the health facilities	The level of surgical obstetrical care at the HC IV	14%	7-10%
19	Output	Proportion of cases of TB notified compared to the expected TB cases load.	Measure of effectiveness of the National Intervention Strategy (Community Based – DOTS).	50%	70%
20		Proportional morbidity due to malaria expressed as percentage of malaria cases over the total OPD attendance per year.	Measure of burden of malaria and effectiveness of intervention measures.	20 – 40%	10 - 20%

Districts will also have the responsibility to monitor their operational plans using the subset of indicators for monitoring the health sector shown in Table 14 but with freedom to add indicators to monitor district specific needs

Table 14. Indicators for monitoring the Health Sector Strategic Plan at the district level

	Category	Indicator	Purpose (what it measures)	Baseline value	5-year target
1	Input	Total public (GoU and donor) allocation to health per capita	Equity of health resource allocation		
2	Process	Percentage of disbursed PHC conditional grant that are expended	Absorption capacity at the district level		

	Category	Indicator	Purpose (what it measures)	Baseline value	5-year target
3	Process	Proportion of health facilities submitting complete Health Management Information System (HMIS) monthly returns to MoH on time.	Management capacity through completeness and timeliness of reporting system	15.6%	80%
4	Process	Percentage of facilities without any stock outs of Chloroquine, measles vaccine, ORS and cotrimoxazole	Drug management	29.1%	90%
5	Process	Percentage of health facilities explicitly displaying current user charge rates	Public communication of important information	24%	100%
6	Process	Percentage of population residing within 5 km of a health facility (public, or private not for profit) providing the national minimum health care package (NMHCP)	Equity and access (implementation of the NMHCP)	47%	75%
7	Output	Percentage of children <1yr receiving 3 doses of DPT according to schedule by district	Utilisation (an MTEF indicator)	41.4%	80%
8	Output	Proportion of health facilities with at least the minimum staffing norms.	Level of staffing implementation of HRD policy	40%	80%
9	Output	Contraceptive Prevalence Rate (CPR)	Utilisation	15%	30%
10	Output	Proportion of surveyed population expressing satisfaction with the health services.	Quality of service delivery		70%
11	Output	Percentage of deliveries taking place in a health facility (Government and NGO)	Utilization	25.2%	70%
12	Output	Total Government and NGO OPD utilisation per person by level and age group	Utilization	40% all levels	60%
13	Output	Health facility level-specific number of caesarean sections per 1000 deliveries within the catchment area of the health facilities	The level of surgical obstetrical care at the HC IV	14%	7 – 10%
14	Output	Proportion of cases of TB notified compared to the expected TB cases load.	Measure of effectiveness of National Intervention Strategy (Community Based – DOTS)	50%	70%

	Category	Indicator	Purpose (what it measures)	Baseline value	5-year target
15		Proportional morbidity due to malaria expressed as percentage of malaria cases over the total OPD attendance per year.	Measure of burden of malaria and effectiveness of intervention measures	20 – 40%	10- 20%

Districts will further be encouraged, and supported, to identify indicators for monitoring health services at lower levels (e.g. sub-district level).