THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

HEALTH SECTOR DEVELOPMENT PLAN 2015/16 - 2019/20

September 2015

Hon. DR. TUMWESIGYE ELIODA

Minister of Health

Hon. DR. SARAH ACHIENG OPENDI

State Minister for Health
Primary Health Care

Hon. DR. BARYOMUNSI CHRIS

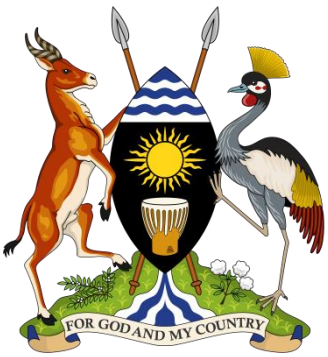
State Minister for Health
General Duties

DR. LUKWAGO ASUMAN

Permanent Secretary
Ministry of Health

DR. JANE ACHENG

Director General
Health Services



GOVERNMENT OF UGANDA
MINISTRY OF HEALTH

HEALTH SECTOR DEVELOPMENT PLAN 2015/16 - 2019/20

September 2015

Published by: Ministry of Health
P.O Box 7272,
Kampala, Uganda
Email: dghs@health.go.ug
Website: http://www.health.go.ug

BTC

Figure 1: Map of the Districts in Uganda

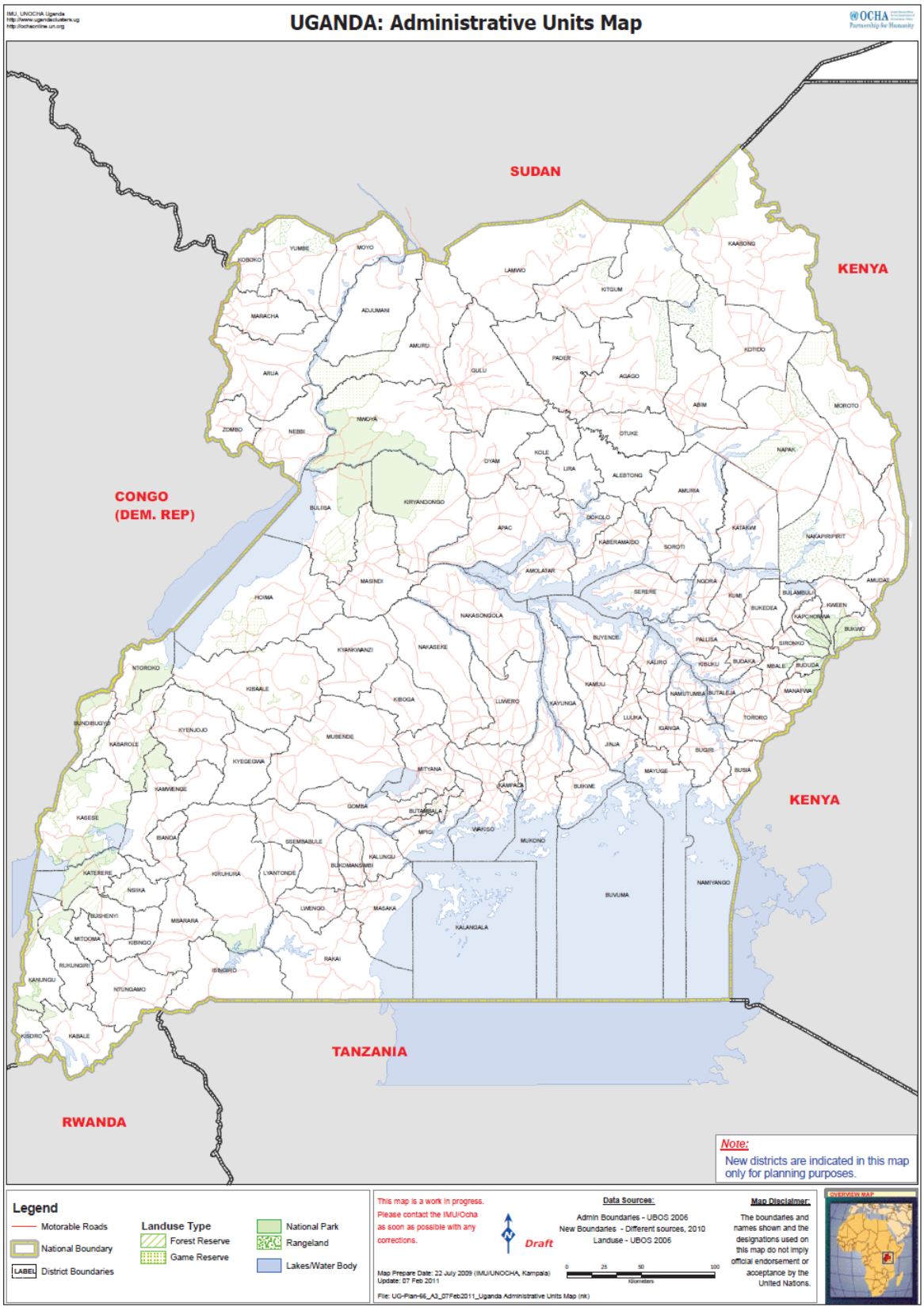


Table of Contents

List of Tables

List of Figures

Abbreviations

ADB	African Development Bank
AHSPR	Annual Health Sector Performance Report
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-retroviral
BeMONC	Basic Obstetric and New-born Care
CAP	Common African Position
CCM	Country Coordination Mechanism
CeMONC	Comprehensive Obstetric and New-born Care
CHEW	Community Health Extension Worker
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organisation
CUFH	China Uganda Friendship Hospital
DALY	Disability Adjusted Life Years
DHIS2	District Health Information System - 2
DHT	District Health Team
DHMT	District Health Management Team
EAC	East African Community
EDPR	Emergency and Disaster Preparedness and Response
EMHS	Essential Medicines and Health Supplies
EmONC	Emergency Obstetric and New-born Care
EOC	Emergency Operation Centre
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFTAM	Global Fund for TB, HIV/AIDs and Malaria
GGE	General Government Expenditure
GoU	Government of Uganda
HC	Health Center
HCT	HIV Counselling and Testing
HDP	Health Development Partner
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRH	Human Resource for Health
HSDP	Health Sector Development Plan
HSSIP	Health Sector Strategic and Investment Plan
HUMC	Health Unit Management Committee
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IHP+	International Health Partnerships Plus
IP	Implementing Partner
IPT	Intermittent Presumptive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
JANS	Joint Assessment of National Strategies
KCCA	Kampala City Council Authority
LLIN	Long Lasting Insecticide Net
LRI	Lower Respiratory Infection
MARP	Most at Risk Population
MDA	Ministries, Departments, Agencies
MDG	Millennium Development Goal
MDR	Multi Drug Resistant
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Disease
NCRI	National Chemotherapeutic Research Institute

NDA	National Drug Authority
NDP II	Second National Development Plan
NHA	National Health Accounts
NHP II	Second National Health Policy
NMS	National Medical Stores
NTD	Neglected Tropical Disease
OHT	One Health Tool
OOP	Out of Pocket
OPM	Office of the Prime Minister
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PHP	Private Health Provider
PMTCT	Prevention of Mother-To-Child Transmission
PNFP	Private-Not-For Profit
PPPH	Public Private Partnerships for Health
QI	Quality Improvement
RBF	Results Based Financing
RC	Resource Centre
RDT	Rapid Diagnostic Test
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RRH	Regional Referral Hospital
RTI/A	Road Traffic Injuries and Accidents
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TB	Tuberculosis
TCMP	Traditional and Complementary Medical Practitioners
THE	Total Health Expenditure
TWG	Technical Working Group
UBOS	Uganda Bureau Of Statistics
UBTS	Uganda Blood Transfusion Services
UDHS	Uganda Demographic Health Survey
UHC	Universal Health Coverage
UNAP	Uganda Nutrition Action Plan
UNMHCP	Uganda National Minimum Health Care Package
UNHRO	Uganda National Health Research Organization
UVRI	Uganda Virus Research Institute
VHF	Viral Haemorrhagic Fever
VHT	Village Health Team
WHO	World Health Organization
WHS	World Health Series

Glossary

E-Health The cost-effective and secure use of information and communications technologies in support of health and health-related field, including health care services, health surveillance, health literature, and health education, knowledge and research.

Elimination The reduction to zero incidence of a specified disease in a geographical area as a result to deliberate effort with continued intervention measures required.

Eradication The permanent reduction to zero of worldwide incidence of infection.

Essential Health Services Package In a low-income country consists of a limited list of public health and clinical services which will be provided at primary and/or secondary care level.

Global Health Health issues and determinants that cross national boundaries, are global in nature and require global agreements to address them. It brings together the disciplines of public health, international affairs, management, law and economics.

Governance The process through which government, partners and other organizations interact, relate to citizens and take decisions regarding health.

Quality of Care The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge of best practice.

Results Based Financing A form of funding for project implementation or service provision, where the principal, who provides the funding, pays the agent, who implements the project or provides the service, upon achieving predefined results (quantity and quality of health services delivered after verification).

Universal Health Coverage Ensuring that all people receive essential and good quality health services they need without suffering financial hardship. It is how to extend health care to more citizens in a way that guards against the risk of catastrophic out-of-pocket expenditures, improve health outcomes equitably and use available resources efficiently.

Village Health Team Are community volunteers who are selected by communities to provide correct health information, mobilize communities and provide linkage to health services.

Foreword

The second National Development Plan 2015/16 – 2019/20 was launched and sets Uganda's medium term strategic direction, development priorities and implementation strategies. The NDP's theme is "Strengthening Uganda's Competitiveness for Sustainable Wealth Creation, Employment and Inclusive Growth" and the thrust is to accelerate transformation of Ugandan society from a peasant to modern and prosperous country within 30 years.

With this guidance, the health sector led by the Ministry of Health elaborated the Health Sector Development Plan (HSDP) 2010/11 – 2014/15 to define the long and medium term health agenda and operationalise Uganda's aspirations as outlined in the NDP II. The development of HSDP has been informed by lessons from the Mid Term Review of the HSSIP, programme specific strategic plans, health research in Uganda and in the Region and the Global Health Agenda. The process of development of the HSDP was highly consultative, participatory and transparent. Stakeholders including public sector, line ministries, health service managers, district leaders, private sector, Civil Society Organizations and Development Partners were consulted on several levels and occasions. The process also benefited from the Joint Assessment of National Strategies (JANS) process which seeks to ensure that national strategies address the prevailing challenges, improve the focus and prioritization within national strategies and builds consensus among the partners in support of one national strategy for health development.

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

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

For God and My County

Hon. Dr. Elioda Tumwesigye, MP
MINISTER OF HEALTH

Preface

Over the last 30 years, Government has struggled to achieve better health for the people in Uganda and thereby contribute to the enhancement of the quality of life and productivity. Over the past five years, the implementation of HSSIP served to accelerate those efforts. The reforms, which Government has executed during the period of HSSIP have led to significant achievement of many output targets. This augurs well for better outcomes.

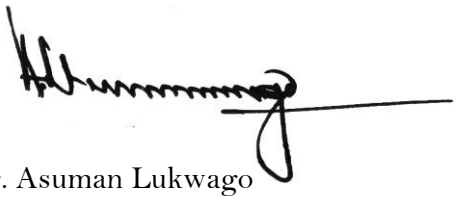
However, there is need to ensure that these gains are not reversed. To this end Government will continue to implement health sector reforms in the context of consolidating and extending these achievements. Government will build on those gains to attain even greater aspirations for the population.

The process of preparing HSDP, which is to guide the operations in the health sector for the next five years, has accorded Government and other stakeholders yet another opportunity to rethink approaches to better health in the country and assess prevailing strengths, weaknesses, opportunities and threats to success. Identifying these elements will be an integral feature in monitoring the implementation of HSDP.

Implementing the Uganda National Minimum Health Care Package continues to be the core strategy for achieving maximum outcomes in HSDP. A stronger focus has been placed on health promotion and disease prevention using a multi-sectoral approach. Furthermore deliberate efforts will be directed at harnessing the contribution of health related sectors and that of communities to the achievement of health outcomes on a sustainable basis.

I wish to express my appreciation to all those who worked tirelessly to produce this document. I call upon the population, the Local Governments in our country, Development Partners and Private sector to spare no efforts in implementing this Health Sector Development Plan 2015/16 - 2019/20.

HEALTH IS WEALTH



Dr. Asuman Lukwago
PERMANENT SECRETARY

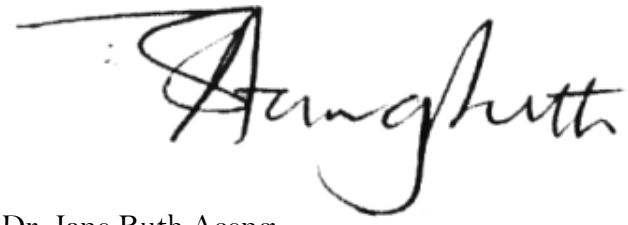
Acknowledgements

The Ministry of Health would like to express its appreciation to all key stakeholders who supported the process of developing this strategy through technical and financial support. The development process was consultative covering a wide range of stakeholders at national and sub-national levels including private and public sectors. The consultations covered government Ministries, Agencies and Departments, UN Agencies, Development Partners, Local Governments, Civil Society Organisations, the Academia, Professional Associations, renowned local consultancy firms and researchers in health, cultural and religious institutions among others.

The funding for the development of the HSDP was generously supported by Government of Uganda, the WHO Country and Regional Office, Belgian government through the Institutional Capacity Building Project.

Recognition is made to the National Planning Authority for the Technical assistance in shaping the HSDP to be in line with the Vision 2040 and the Second National Development Plan, the Consultant who supported costing of the strategy and the JANS Mission Team for their invaluable guidance in finalizing the strategy.

Special thanks go to Senior Top Management, Top Management, Health Policy Advisory Committee, Senior Management Committee and the WHO Programme Officers for the guiding the development process and the technical team led by the Director of Health Services Planning and Development and the Commissioner Planning.



Dr. Jane Ruth Aceng
DIRECTOR GENERAL HEALTH SERVICES

Executive Summary

This Health Sector Development Plan (HSDP) 2015/16 - 2019/20 is the second in a series of six 5-year Plans aimed at achieving Uganda Vision 2040 of a healthy and productive population that contributes to socio-economic growth and national development. The goal of this Plan is to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life. UHC makes it possible to ensure that all people receive essential and good quality health services they need without suffering financial hardship.

The Plan builds on the achievements registered under the Health Sector Strategic and Investment Plan (HSSIP) 2010/11 - 2014/15 and takes into consideration the challenges encountered and lessons learnt during its implementation. The achievements realized under HSSIP include among others: reduction in maternal mortality ratio from 438/100,000 (UDHS) live births in 2011 to 360/100,000 (WHS estimates) live births in 2014; reduction in under five mortality from 128/1000 live births in 2006 to 90/1000 live births in 2011 to 69/1000 (WHS estimates) live births in 2014 and reduction in infant mortality rate from 71/1000 live births in 2006 to 54/1000 live births in 2011 and 45/1000 (WHS estimates) in 2014. The impact of all this has been an improvement in the life expectancy at birth in Uganda, from a low of 47 and 45 years in 2000/01 for females and males respectively, to 57 and 54 years by 2011, and estimated to have improved further since then.

HIV, malaria, lower respiratory infections, meningitis and tuberculosis still are estimated to cause the highest numbers of years of life lost in Uganda. In addition to these major causes, the sector has faced challenges with new / re-emerging conditions that cause minimal burden but are significant public health risks e.g. polio, Hepatitis E & B, Ebola Virus Disease, Marburg, and the idiopathic 'Nodding disease'.

On the other hand, NCDs are increasingly becoming a major burden due to life style changes, increased life expectancy in addition to genetic factors. Although Protein Energy Malnutrition has also reduced, it still remains the underlying cause in nearly 60% of infant deaths (Uganda Nutrition Action Plan (UNAP) 2011 – 2016). The latest burden of risk factors show alcohol use, tobacco use, household air pollution, childhood underweight, iron deficiency and high blood pressure as the most significant risk factors, responsible for over 16% of all disease conditions.

During the HSSIP, a number of interventions were introduced / scaled up, to improve the services addressing these critical areas. In RMNCAH, virtually all pregnant mothers accessing ANC services at least once. Institutional deliveries are on an improving trend, with better access to Emergency Obstetric and New-born Care (EmONC). Family planning services are also on an improving trend albeit too slowly to achieve country targets. Child health services are also improving, with immunization targets achieved.

The country was able to transition to District Health Information System (DHIS)-2, which is an electronic web based reporting mechanism to ensure timely reporting for decision making. E-health has become a stronger area of focus, with the national e-health technology framework completed and draft e-Health strategy developed. Although a number of surveys and research studies were conducted the sector still faces challenges in health research including; inadequate human resources in all research institutions, low government financial allocation to health research, weak collaboration mechanisms between planners, research institutions, industry and academia and partners.

With health infrastructure, physical access to health facilities (proportion of the population leaving within 5 km of health facility) is currently at 72%. Despite this, there are also still major inequities in availability of facilities, ranging from a low of 0.4 facilities per 10,000 population (Yumbe district) to a high of 8.4 facilities per 10,000 population (Kampala). A number of health facilities were renovated and equipped though we still face challenges of inadequate and poorly maintained medical equipment.

To-date, the pharmaceutical sector has made an improvement in availability of, and access to Essential Medicines and Health Supplies (EMHS) from 43% in 2009/2010 to 63.8% in 2014/2015 . There has been an increase in funding for medicines through both GoU and donor streams from USD 92 million to USD 410 million (including USD 85 million for procurement of Long Lasting Insecticide Nets-(LLIN)) over the same period, resulting into increased public confidence in the health system. However, the greater proportion (81%) of this funding was from Development Partners, and largely skewed to HIV/AIDS, malaria and TB. The Per capita government expenditure on EMHS in the FY 2013/14 was about US$ 2.4 which is below the estimated requirement in the HSSIP of US$ 12.

The health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills, plus retention, motivation, and performance challenges. Efforts by the GoU and Partners have facilitated recruitment of much-needed staff increasing the proportion of approved posts from 56% in 2010 to 69% in 2013/14.

Finally, looking at sector governance, the sector stewardship has been changing at the highest level, leading to frequent changes in stewardship direction. To effectively partner and coordinate with the private sector in health service delivery, the GoU enacted a national policy on public-private partnership in health. Using mTRAC, mechanisms for client feedback / redress were established under the anonymous hotline and U-Report. This has improved on accountability in service delivery.

Strategic Direction

The HSDP seeks to leverage opportunities and honour obligations presented by emerging developments at the national, regional (East African Community (EAC), and the Common African Position of the African Union), and global levels (the Post 2015 Development Agenda). The Plan provides overall strategic direction for the stakeholders in health, together with outlining their expected roles and responsibilities in attaining this strategic agenda. It in addition lays down the implementation and collaboration frameworks within which the stakeholders contribute towards improving the health of the population.

The HSDP goal is to accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life. Thus, the Plan sets key objectives to be attained during the 5 year period. These include: (i) contributing to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.; (ii) increasing financial risk protection of households against impoverishment due to health expenditures.; (iii) addressing the key determinants of health through strengthening intersectoral collaboration and partnerships.; and (iv) enhancing health sector competitiveness in the region and globally. In order to achieve these objectives, the health sector will work towards strengthening the national health system including governance; disease prevention, mitigation and control; health education and promotion, curative services; rehabilitation services; palliative services; and health infrastructure development.

Over this Plan period the sector will focus on attaining the following results: reducing the Infant Mortality Rate per 1,000 live births from 54 to 44 and the Maternal Mortality Ratio per 100,000 live births from 438 to 320/100,000; reducing fertility to 5.1 children per woman; reducing child stunting as a percent of under-5s from 33% to 29%; increasing measles vaccination coverage under one year from 87% to 95%; increasing TB case detection rate from 80% to 95%; increasing ART coverage from 42% to 80%; increasing deliveries in health facilities from 44% to 64; and increasing HC IVs offering CEmOC services from 37% to 50%.

To attain the above outcome targets the health sector will focus on three thematic areas namely: health promotion across the life course (Reproductive Maternal Neonatal Child and Adolescent Health & addressing social determinants); non communicable diseases prevention and control and communicable disease prevention & control.

This Plan prioritizes investment in seven health systems areas including; health governance and partnerships; service delivery systems; health information; health financing; health products and technologies; health workforce and health infrastructure. The health governance and partnerships priority area will focus on strengthening the governance and partnership structures; management and stewardship; Public Private Partnerships and coordination; health legislation and regulation, knowledge translation and improving sector competitiveness. Under service delivery systems, emphasis will be on: delivering the essential health service package; referral system / ambulance service; community health services and supervision and quality of care. Under health information focus will be on building a harmonized and coordinated national health information system covering the routine HMIS; surveillance, vital statistics, research and surveys and innovative e-health solutions. Under health financing the sector will work towards mobilising, and allocating resources to implement planned services in an efficient, effective and equitable manner by introducing reforms in systems for revenue generation, risk pooling and strategic purchasing of services; improving the public financial management system, procurement system and the governance and regulatory system for the National Health Insurance Scheme. Under health products and technologies the focus will be on ensuring the availability, accessibility, affordability and appropriate use of essential medicines of appropriate quality, safety and efficacy at all times. To achieve this the focus will be on; regulation and quality assurance of health products; production of health products and supplies; procurement of health products, warehousing & distribution of health products; and rational use of health products. Under health workforce the focus will be on enhancing effectiveness and efficiency in health workforce development; improving equity in distribution and utilization of health workers; improving health workforce performance at all levels; strengthening Public Private Partnership in development and utilization of the health workforce; and establishing supportive HRH policy environment. Under health infrastructure while new facilities will be constructed and equipped during the implementation of the HSDP priority will be given to consolidation of existing facilities, to provide facilities for them to function effectively (e.g. staff housing, water and energy, theatres, equipment, stores etc) and required ICT and related infrastructure. The consolidation of facilities will also include the upgrading of facilities to higher level facilities specifically, the sector will aim at functionalizing HC IIIs in all sub-counties and piloting the establishment of Community Hospitals. In addition the sector will build capacity and mobilize resources for operation and maintenance of medical equipment and infrastructure. Deliberate efforts will be made to strengthen service delivery in the newly created districts in terms of infrastructure development, equipping and staffing.

To realize the Plan targets, the following core projects are earmarked for implementation: RMNCAH Project - IDA Loan + Global Financing Facility for RMNCAH; Establishment of Uganda National Ambulance and Emergency Service; Capacity Development Plan for Uganda National Malaria Control Program - DFID; Community Health Extension Worker Program; Renovation of 25 general hospitals; Mulago National Referral Hospital; Construction of a Super-Specialized Hospital at Lubowa, Uganda Cancer Institute Development, Uganda Heart Institute Development, Construction of staff houses under the Karaloja Development project, establishment of pilot community hospitals (Maracha, Kaberamaido, Kamwenge), District Health Infrastructure Support Program including functionalization of HC IIIs in all Subcounties, equipping health facilities, E-Health innovations i.e. e-HMIS, telemedicine, HRIS, LMIS, Warehousing and storage, Health Facility Quality of Care Assessment Program and QI, Improvement of Health Service through Health Infrastructure Management - JICA, District Health Services Improvement Project.

Evidence shows that, enforcement of the public finance and accountability regulations, fiscal decentralization, SWAp, introduction of the UNMHCP, centralization of medicines and health supplies procurement, PHC Grant to Private-Not-For Profit (PNFP) health facilities, improved partnership with the private sector, direct transfers of PHC grants to health facility accounts, abolition of user fees in public health facilities, introduction of Output budgeting and reporting tool has facilitated improvements in health service delivery over the last 15 years. The primary motivation of the financing reforms is to transform the financing mechanism from an input focus to a results oriented and to better link the financing to results thus improving decision making and accountability.

The Plan will be financed by both public and private resources, with about 27% being Government contribution, 36% bilateral partners contribution, 7% multi-lateral partners contribution and 30% being private contribution. The overall cost of the HSDP based on the HSDP service coverage targets is estimated at approximately US$ 25.32 billion. The plan would require the per capita health expenditure for Uganda to reach US$ 130 in the first year of the plan rising to US$ 151 in the last year of the plan. Currently the PCHE stands at US$ 53. Funding estimates were projected using commitments from the GoU, with an assumption that GoU would increase it sector funding by at least 10% annually. Total contributions from existing and new foreign partners were assumed to grow by at least 5% annually.

Overall there is a financing gap of about 54% over the Plan period, this gap could be covered through increased revenue efforts and off budget financing. Of the US$ 25.32 billion is wage US$ 1,320.24 billion, US$ 18,258.14 billion is health products and technologies, US$ 1,474.03 billion is health infrastructure development and US$ 1,283.28 billion is for service delivery systems.

Implementation, Monitoring and Evaluation

The HSDP shall be implemented under the SWAp, whereby the MoH shall play its key roles of policy making, providing guidelines, training and capacity-building, monitoring the health sector, and the coordination of partners. This will require having a well functioning governance structures at all levels, having rules that are enforced (such as spending requirements at decentralised levels), joint planning and budgeting, regular performance reviews and commitment to achieving the sector goal and objectives.

The Health Policy Advisory Committee and Technical Working Groups will be strengthened. The roles of the non-state actors such as the private sector, civil society and development partners will need to be clearly articulated; Health Managers will sign performance contracts in line with HSDP results and targets; the ruling party manifesto will be fully aligned to the HSDP; regional-level technical capacity hubs will be established to support implementation of programmes and projects at district level; a Constituency Task Force will be established to discuss progress in the implementation of the service delivery at Health Sub-District level.

To facilitate tracking of planned results, the following reforms will be made in the monitoring and evaluation framework: An M&E Unit will be established to facilitate coordination and more efficient reporting of results. Sector reviews will be conducted at national and sub-national level focusing on performance reporting on the realization of the HSDP results.

1 INTRODUCTION

1.1 Background

Uganda is one of the Countries within the East African Community (EAC). It is a Presidential Republic, with the President both head of state and Head of Government. The State was formed in 1962, following independence from the British. The country practices a multiparty democratic parliamentary system with universal suffrage for all citizens over 18 years. The Government is chosen by popular vote every 5 years, and exercises executive power through a nominated cabinet. Health functions are managed by a Minister for Health. Legislative power is held by the National Assembly, made up of elected Members of Parliament from across the Country. Health functions are managed by a Minister of Health.

Administratively, the country is divided into 111 districts and one city (the capital city of Kampala). The districts are spread across four administrative regions of Northern, Eastern, Central and Western. The districts are subdivided into 181 counties and 22 municipalities and 174 town councils which are further subdivided into 1,382 sub counties, 7,138 parishes and 66,036 villages (Census Report 2014). Parallel with the administration are traditional Kingdoms that enjoy some degree of mainly cultural autonomy.

Demographically, the Country has a population of 34.9 million people in 2014 (Census, 2014), with an average annual growth rate of 3.03%, giving an estimated population of 42.4 million people by 2020. The average household size is 4.7 persons, with a Sex Ratio of 94.5 males per 100 females. An estimated 72% of the population lives in rural areas as compared to 28% in urban centres. 49% of Uganda's population is under the age of 15 and with 18.5% of the total population being under-five. Those aged 65 years and represent 2.3% of the total population in 2015 and should continue to increase as expectation of life improves.

Table 1: Demographic Population in Uganda

Population	Number	%
Total	34.9 million	100%
Children aged 0-59 months (under five years)	6.6 million	18.9%
Women of reproductive age (15-49 years)	7.3 million	20.9%
Population that is 15 years of age/%	17.0 million	48.7%
Population of adolescents (10-19 years of age)	8.6 million	24.5%

Source: National Population and Housing Census 2014

Economically, the country's gross domestic product has steadily been increasing at a rate between 5 – 9% in the recent past. The percentage of Ugandans living below the poverty line decreased from 56.4% in 1992 to 19.7% in 2012 (The state of Uganda population report 2014). However, poverty remains deep-rooted in rural areas, where most of the population lives. The economy is transitioning from an agricultural one, to an industrial, service driven economy with key drivers of the economic growth shifting towards more industrialized activities. Development Aid has played a key role in stabilizing and improving the economy over the past 30 years. In addition, Diaspora remittances increasingly contribute to the country's economy. The per capita income at 2002 constant price grew from Ug. Shs. 680,996 in 2012/13 to Ug. Shs. 688,324 in 2013/14, a growth of 1.1% (Uganda Bureau of Statistics (UBOS) Statistical Abstract, 2014).

The country has made significant improvements in social services, such as health, housing, education, water / sanitation and others. Most social services are provided free at point of use, to reduce financial barriers to their utilization. However, there are still many barriers to uptake of social services, mainly on the demand side (decision making inability for women, household financial status with women having to rely on their spouses, lack of transport among others).

In spite of having made significant progress in improving gender disparities, there are still some hindrances to achieving gender parity, largely associated with the economic make-up. Up to 90% of all rural women work in agriculture, in addition to the responsibility of caretaking within their families. The average woman spends up to 9 hours a day on domestic tasks, meaning women on average work longer an average of 15 hours a day, as compared to men. The poor cannot support their children at school and in most cases, girls drop out of school to help out in domestic work or to get married. Other girls engage in sex work. As a result, young women tend to have older partners and this puts women at a disproportionate risk of getting affected by HIV, accounting for about 57% of all adults living with HIV. Many small entrepreneurial activities have been initiated targeting these women, but they are not able to adequately engage in these because of their heavy workload.

The country is focusing on 5 critical areas to advance women's rights: legal and policy framework and leadership; social and economic empowerment of women; reproductive health, rights and responsibilities; girl child education; peace building conflict resolution and freedom from violence.

Health is a right and thus it is increasingly becoming evident that everybody should have unhindered access to health care. Consequently, attention has been drawn to certain categories of the population such as pregnant mothers, the elderly, children, people with disabilities among others. To this effect the country has developed a national strategic framework aimed at promoting a human rights approach to service delivery. The health sector has also taken steps in mainstreaming human rights and gender at various levels through building capacity for service providers (duty bearers) in programming and implementation. The sector also works in partnership with Civil Society Organisations (CSOs) in promoting the right to health for individuals and communities (rights holders).

Uganda also faces a range of natural and manmade disasters. According to Information from The Office of the Prime Minister (OPM), Uganda in the past two decades has on average more than 200,000 people affected by emergencies every year. Conflict, floods, drought and epidemics constitute the major causes of disaster and emergencies in the country. Efforts have been made on strengthening disaster risk management, emergency preparedness and response. The country has developed and approved its multisectoral National Policy for Disaster Preparedness and Management in 2010 which clearly stipulates the role of the health sector and other partners in disaster risk management and response. The policy also promotes a paradigm shift from a reactive response to disasters to a proactive management of risks.

1.2 Rationale for the Health Sector Development Plan (HSDP)

This HSDP is part of the overall health sector planning framework. It provides the strategic focus of the sector in the medium term, highlighting how it will contribute, within the constitutional and legal framework, to the second National Development Plan (NDP II), and to the second National Health Policy (NHP II) imperatives of the country, and so to the overall Vision 2040. The theme of the NDP II is *"Strengthening Uganda's Competitiveness for Sustainable Wealth Creation, Employment and Inclusive Growth".*

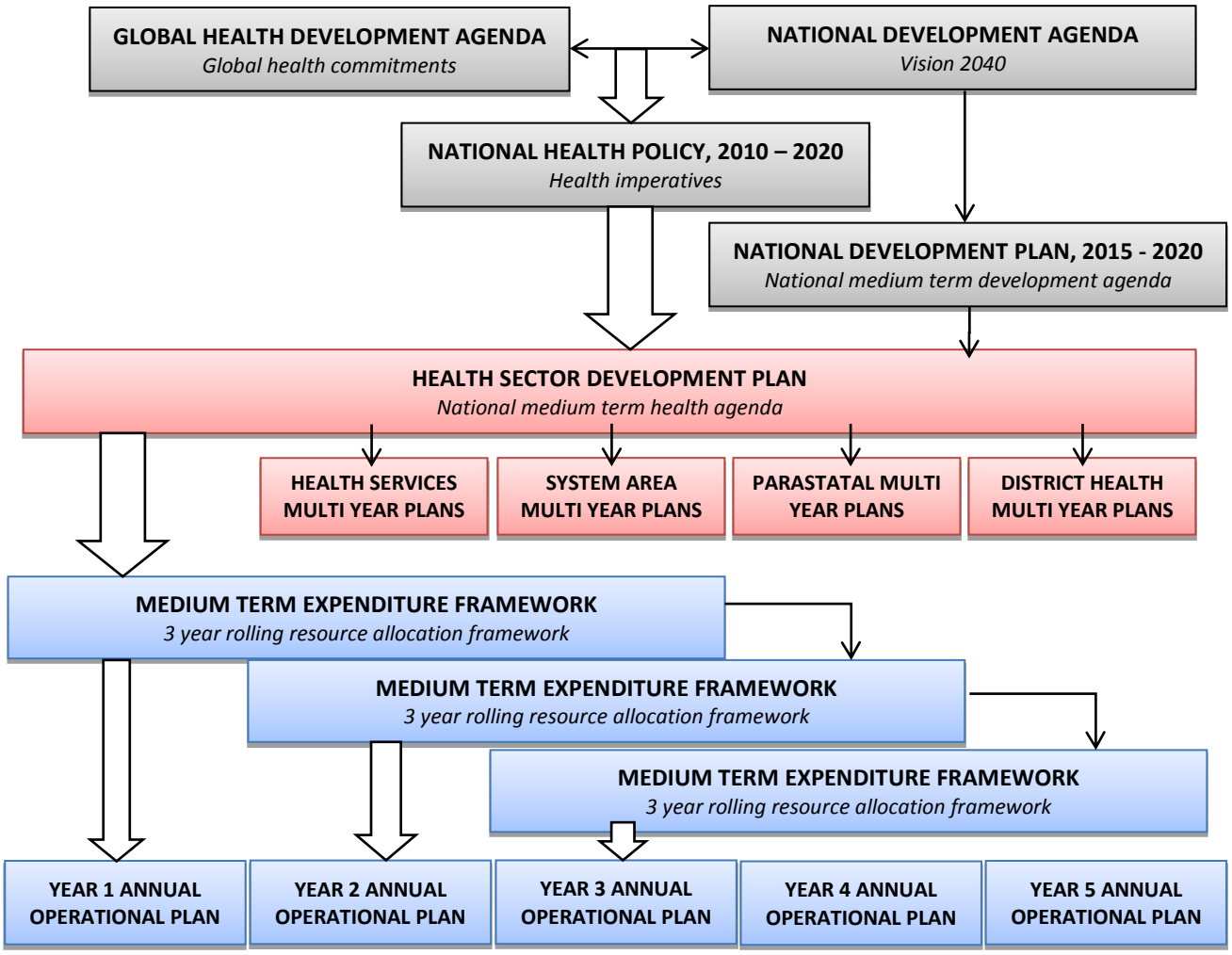
It is a key anchor document in the sector, drawing orientation from the NHP II and the NDP II, and provides orientation to:

- Business / investment plans for health services programs (Malaria, EPI, etc), system areas (human resources, and others), parastatals and districts by providing them with sector targets and priority interventions
- Sector budgeting process by providing this with the key investments that require financing and their related outcomes, and so influencing the operational planning process.

The HSDP provides overall strategic direction for the stakeholders in health, together with outlining their expected roles and responsibilities in attaining this strategic agenda. It in addition lays down the implementation

framework within which the stake holders contribute towards improving the health of the population. Furthermore, HSDP lays down clear coordination mechanisms for the various stakeholders.

Figure 2: Country health planning framework and the HSDP role



1.3 The Global Health Development Agenda

There is global recognition of the key role of health in achieving International Development goals. The HSDP is aligned to support the health sector implement the various global commitments it has entered into. These include;

- Implementation of the International Health Regulations – to guide the country on key actions needed to assure adherence to international health regulations.
- Ouagadougou declaration on Primary Health Care and Health Systems – a re-iteration of the principles of the PHC approach, within the context of an overall health system strengthening approach
- International Health Partnerships(IHP+) on Aid Effectiveness
- The post MDG 2015 agenda – a focus of global efforts in improving health impacts through implementing the Universal Health Coverage (UHC) agenda in health.
- International Human Right agreements such as International Declaration for Human Rights, Convention on the Elimination of All Forms of Discrimination against Women, Child Rights Convention, the

International Conference on Population and Development programme of action and the Beijing Declaration and Platform of Action.

Implementation of these international commitments is well integrated into the strategic focus of the health sector. Regular monitoring and reporting on progress will be carried out. The agenda for global health is changing in a number of important ways which have a bearing on how priorities for development are defined in the future and how they should be measured. Epidemiological and demographic transitions impose a complex burden of infectious diseases alongside Non-Communicable Diseases (NCDs), mental health, injuries and the consequences of violence. Whereas the current set of health-related MDGs focus on priorities for developing countries, the rapid spread of risk factors, such as tobacco use and physical inactivity, unhealthy diets with lots of sugars, fats and salt, and alcohol abuse, along with ageing populations and unplanned urbanization, have a profound influence on health and wellbeing globally. The cost of inaction in relation to NCDs is now recognized as a global risk requiring action in all countries that extends well beyond the health sector alone.

Similarly, emerging infectious disease outbreaks and epidemics constitute a universal threat e.g. the SARS outbreak in 2003 in Southeast Asia, and the H1N1 outbreak in 2010. Many developing countries are faced with inadequate levels of unpredictable funding, limited access to life-saving technologies, lack of financial coverage and a continuing daily toll of unnecessary death and disability from preventable causes. Thus, the common thread for the global agenda is the need to change the focus from developing health systems that deal with selected diseases and conditions. The focus will be ensuring access to services, using innovation to foster efficiency, preventing exclusion (particularly of poor women, girls and other disadvantaged groups) and protecting people against catastrophic expenditure when they fall ill through extending UHC.

In partnership with other nations, international organizations and public and private stakeholders, Uganda will seek to accelerate progress toward a world safe and secure from infectious disease threats and to promote global health security as an international security priority. The focus is on; preventing epidemics, detecting biological threats early, and rapidly responding to disease outbreaks, whether naturally occurring, intentionally produced, or accidentally caused.

In this regard, a human rights-based approach to health is essential. Uganda recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health. Irrespective of where one lives, gender, age or socio-economic status being healthy and having access to quality and effective health care services is of fundamental importance for all people, while at the same time healthy populations are essential for the advancement of human development, well-being and economic growth.

Another element of the approach to the global health agenda concerns the need to address the social, economic and environmental determinants of health, not just the proximal causes of illness and disease. Addressing social determinants has been shown to be an effective way of increasing equity of access and outcome. Similarly, tackling the burden on NCDs will require action in multiple sectors.

One of the main outcomes of the Rio+20 Conference in 2012, was the agreement by member States to launch a process to develop a set of Sustainable Development Goals (SDGs), which will build upon the MDGs and converge with the post 2015 development agenda. As of March 2015, 17 SDGs had been proposed and of these SDG 3: Ensure healthy lives and promote well-being for all at all ages is directly related to the health.

Other SDGs related to health are:

- Goal 1. End poverty in all its forms everywhere.
- Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

- Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
- Goal 5. Achieve gender equality and empower all women and girls.
- Goal 6. Ensure availability and sustainable management of water and sanitation for all.

1.3.1 SDG Goal 3 Targets

Target 1: By 2030 reduce the global maternal mortality ration to less than 70 per 100,000 live births.

Target 2: By 2030, end preventable deaths of newborns and under five children.

Target 3: By 2030, end the epidemics of AIDS, TB, malaria and Neglected Tropical Diseases, and combat hepatitis, water-borne diseases and other communicable diseases.

Target 4: By 2030, reduce by one third premature mortality from NCDs through prevention and treatment, and promote mental health and wellbeing.

Target 5: Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Target 6: By 2020, halve deaths and injuries from road traffic accidents.

Target 7: By 2030, achieve universal access to sexual and reproductive health care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Target 8: Achieve universal health covering, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

Target 9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

Overall, the country has made fair progress with attainment of the MDG targets that have a bearing on health (direct or indirect) as highlighted in Section 2. In order to accelerate the momentum in attaining the MDGs targets post 2015 and work towards the SDGs, Uganda is committed to pursuing the UHC agenda within the framework of the Vision 2040, NHP II and HSDP 2015/16 - 2019/20. Using the multilateral, bilateral, South-South, South-North and Public-Private cooperation, the health sector working with and relevant Ministries, Departments, Agencies (MDAs), will develop a National Global Health Strategy towards policy coherence in relation to the collective action goals.

1.4 The Common African Position (CAP) of the African Union

Recognizing that African stakeholders had played a limited role in shaping the MDGs, the Economic Commission for Africa, the African Union Commission, the African Development Bank (ADB) and United Nations Development Program's Regional Bureau for Africa carried out wide consultations at national, regional and continental levels among stakeholders including Civil Society with the aim of articulating an African common position in the post 2015 development agenda. On the 31st January 2014, the African Union adopted the CAP on the post 2015 development agenda where the Government of Uganda (GoU) was represented.

The CAP recognizes that low life expectancy and lack of equitable access to quality healthcare especially the most vulnerable groups continue to be a major concern in Africa. The emphasis for Africa post 2015 therefore must be according to CAP, to achieve universal and equitable access to quality healthcare.

Priorities identified are:

1. Improved maternal, newborn and child health
2. Enhanced access to sexual and reproductive health and rights including family planning.
3. Special focus on vulnerable groups including children, the youth , the unemployed, the elderly and people with disabilities.

4. Reduced incidence of communicable diseases (HIV/AIDS, Malaria and TB), NCDs (including mental health) and emerging diseases.
5. Strengthened health systems including health financing.
6. Improved hygiene and sanitation.
7. Improved monitoring and evaluation and quality assurance systems.

The CAP also identifies financing, partnerships as a priority area with special emphasis on the need to promote Public Private Partnerships for Health (PPPH), increased funding for research and development, and enhanced utilization of Information Communication Technology (ICT).

1.5 Overview of the Vision 2040

The Uganda Vision 2040 provides development paths and strategies to operationalize Uganda's Vision statement which is ***"A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 years"*** as approved by Cabinet in 2007. It aims at transforming Uganda from a predominantly peasant and Low Income Country to a competitive Upper Middle Income Country. It represents the all-encompassing perspective plan for the thirty years, and acts as a guide to all development plans in Uganda. All MDAs will realign their development priorities with the Vision.

The health related targets outlined in the Vision 2040 are illustrated below.

Table 2: Health related targets in the Vision 2040

No	Development Indicator	Baseline value (2010)	Target (2040)
1	Per capita income (US$)	506	9,500
2	% of the population below the poverty line	24.5	5
3	Income distribution (Gini coefficient)	0.43	0.37
4	% share of national labour force employed	70.9	94
5	% population with access to safe piped water	15	100
6	% standard paved roads to total road network	4	80
7	% level of urbanization	13	60
8	Life expectancy at birth (years)	51.5	85
9	Infant mortality rate per 1,000 live births	54	4
10	Maternal Mortality Rate per 100,000 live births	438	15
11	Under 5 mortality rate per 1,000	90	8
12	Child stunting as % of under 5s	33	0
13	Literacy rate (%)	73	95
14	Gender related Development Index	0.51	0.90

Source: Vision 2040, NPA

1.6 Overview of the National Health Policy

The goal of the NHP II is ***"To attain a good standard of health for all people in Uganda in order to promote healthy and productive lives".*** The priority areas are: Strengthening health system in line with decentralisation; reconceptualising and organising supervision and monitoring of health systems at all levels; establishing a functional integration within the public and private sector; and addressing the human resource crisis.

In pursuance of this goal, the policy is guided by the principles such as Primary Health Care (PHC), decentralisation, evidence based policy making among others. It aims at universal access to the Uganda National Minimum Health Care Package (UNMHCP) which includes promotive, preventative, curative, rehabilitative and palliative care. The policy objectives for health are defined as:

i) To strengthen the organization and management of national health systems.

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

iii) To ensure universal access to quality UNMHCP consisting of promotive, preventive, curative, rehabilitative and palliative services for all prioritised diseases and conditions, to all people in Uganda with emphasis on vulnerable populations.

iv) To build a harmonized and coordinated national Health Information System with the MoH Resource Centre (RC) as national custodian, in order to generate data for decision making, programme development, resource allocation and management at all levels and among all stakeholders.

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

vi) To review and develop relevant Acts and regulations governing health in Uganda and ensure their enforcement.

vii) To ensure adequate and appropriate Human Resource for Health (HRH) service delivery.

viii) To increase motivation, productivity, performance, integrity and ethical behaviour of human resource through the development and efficient utilisation of the health workforce.

ix) To ensure that essential, efficacious, safe, good quality and affordable medicines and health supplies are available and used rationally at all times in Uganda.

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

xi) To mobilise sufficient financial resources to fund the health sector programmes while ensuring equity, efficiency, transparency and mutual accountability.

xii) To effectively build and utilise the full potential of public and private partnerships in Uganda's national health development by encouraging and supporting participation in all aspects of the NHP II implementation at all levels and according to the National Policy on PPPH.

xiii) To strengthen collaboration between the health sector, government ministries and departments and various public and private institutions dealing with health and related issues for instance Universities and Professional Councils.

xiv) To implement the NHP II and the Health Sector Strategic Plan within the Sector Wide Approach (SWAp) and International Health Partnerships (IHP)+ framework, through a single harmonized in country implementation effort, scaled up financial, technical and institutional support for health MDGs and ensuring mutual commitment and accountability.

xv) To ensure that communities, households and individuals are empowered to play their role and take responsibility for their own health and well being and to participate actively in the management of their local health services.

xvi) To create a culture in which health research plays a significant role in guiding policy formulation in order to support evidence-based policy and interventions to improve the health and development of the people of Uganda.

1.7 Overview of the second National Development Plan

The NDP II builds on the progress made in the NDP I. It defines four required objectives as:

1. To contribute towards the production of a healthy human capital for wealth creation through provision of equitable and sustainable health services.
2. To increase financial risk protection of households against impoverishment due to ill health.
3. To address the key determinants of health through strengthening intersectoral collaboration and partnerships, by adopting a health in all policies approach.
4. To enhance health sector competitiveness in the region, including establishing centres of excellence.

These objectives define the health focus, for it to contribute to the National Development Agenda. To achieve these, the health sector development priorities are defined around:

i) Strengthening the national health system including governance
ii) Disease prevention, mitigation and control
iii) Health education, promotion and control
iv) Curative services
v) Rehabilitation
vi) Palliative care services
vii) Health infrastructure development

1.8 Process of Development of the HSDP

The development of this HSDP started with the development of the Health Issues Paper which formed the health sector contribution to the NDP II. This was followed by development of the HSDP concept note which was presented to MoH Senior Management Committee and the Health Policy and Advisory Committee (HPAC) for approval in December 2014. A Taskforce was set up, chaired by the Director General of Health Services (DGHS), and having representation from all MoH departments, the 14 sector technical working groups (TWGs), Local Governments (LGs), Civil society and Non-Governmental Organizations (NGOs), the Private Sector, other Government Ministries, Departments and Agencies (MDAs), Academia, and Health Development Partners (HDPs).

A review of a wide range of international, regional and national policies, plans and frameworks was done to inform the HSDP, and harmonize / align the HSDP with already existing frameworks. These included the proposed UN Social Development Goals (SDGs), resolutions of the World Health Assembly and WHO guiding frameworks on health development, Vision 2040, the NDP II, NHP II, the Health and Nutrition Thematic paper, the MDG progress reports, the mid-term review report of the HSSIP, reports of the deliberations of the Health Committee of Parliament and the committee on the economy of Parliament, other social sector policies and frameworks and sector performance reports, among others. The significant role of other sectors in the social, economic, and environmental determinants of health was taken into account during drafting, as well as gender and human rights mainstreaming of the plan. One of the limitations was that the final evaluation of the HSSIP was not conducted to inform this HSDP.

The respective TWGs developed objectives, strategic outcomes, strategies, key interventions and indicators for the HSDP. A health system building block framework of WHO was utilized to inform the flow of the investment areas in the plan. The process was supported by the HSDP secretariat (Planning Department), and two Consultants kindly supported by the WHO Country office in Uganda. Four validation workshops were conducted with different stakeholders to refine strategies and interventions in the plan. These included a multi-sectoral stakeholders consultative workshop to address the social determinants of health. Presentations were made to the CSOs and HDPs, as well as online circulation of the drafts to members of Senior Management Committee (SMC) and HPAC.

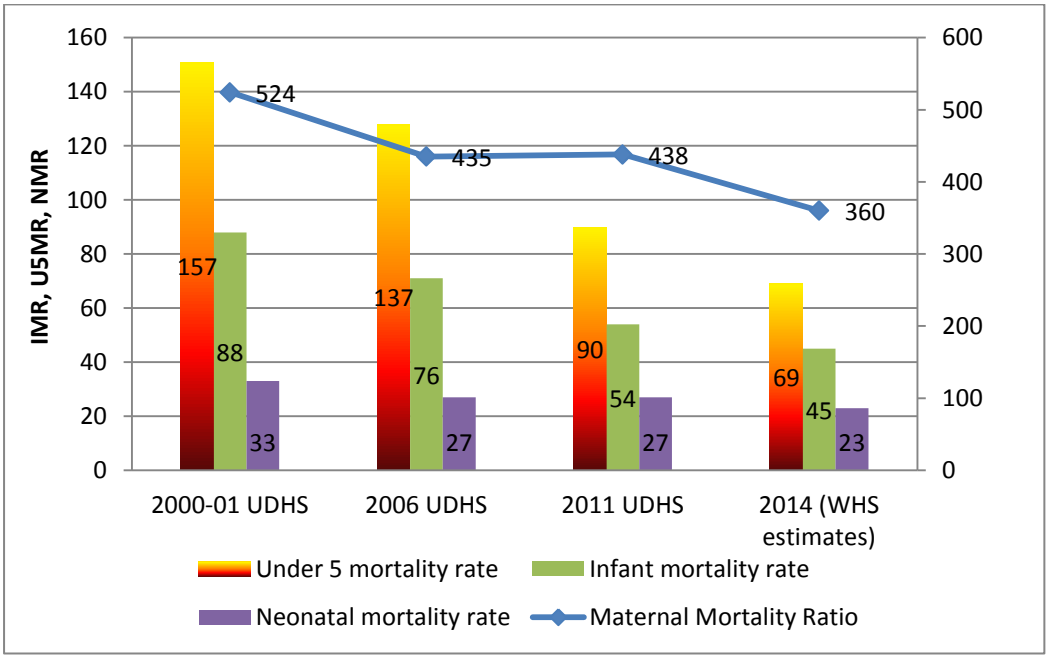
A Joint Assessment of National Strategies (JANS) was conducted by an independent team in September 2015. This was to assess the strengths, weakness along these main categories; situation analysis and programming, process of the strategy development, costs and budget framework, implementation and management; and monitoring, evaluation and review of the strategy. The recommendations were discussed and some were used to further enrich the HSDP draft, while others were noted for action during the implementation. The final HSDP was presented to the MoH SMC and HPAC and finally to Top Management which endorsed it as the as the guiding framework for health sector investment over the next five years, from 2015/16 - 2019/20.

2 SITUATION ANALYSIS

2.1 Progress at impact level

The NHP II had 14 policy objectives defined, all aimed at attaining its vision of a healthy and productive population that contributes to socio-economic growth and national development. While there is no current systematic survey with impact data to show trends in health since the NHP was started, proxy data from the 2014 World Health Statistics report (WHO, 2014) suggest the sector is starting to achieve its targets for a number of age groups, albeit too slowly to attain the Country's impact targets (See Figure 3).

Figure 3: Trends with key impact indicators



Note: 2014 data are latest estimates available, derived from the 2014 World Health Statistics series

Estimates for maternal mortality suggest a value that is at the lower end of the 2011 Uganda Demographic Health Survey (UDHS) confidence limits (351 – 469) continuing a trend of slight reduction in the estimates. However, this is still too far from the country target of 131/100,000 live births by 2015. The child mortality trends however suggest more significant improvements. Whereas Neonatal Mortality Rate is estimated to have achieved the target of 23 deaths per 1,000 live births, it has stagnated at this level for a while.

The impact of all this has been an improvement in the life expectancy at birth in Uganda, from a low of 47 and 45 years in 2000/01 for females and males respectively, to 57 and 54 years by 2011, and estimated to have improved further since then. It however is still too low, when compared to peer countries (63.49 and 61 years in 2012 for Rwanda and Kenya respectively).

2.2 Progress with addressing the disease burden

Looking at the causes of these mortalities, we see from the latest Burden of Disease estimates as produced in the Global Burden of Disease report, 2010 series that HIV, malaria, lower respiratory infections, meningitis and tuberculosis still are estimated to cause the highest numbers of years of life lost in Uganda. These five killers on their own are responsible for just under half (48%) of all mortality in Uganda. Apart from malaria, the mortality due to all these top 5 killers is on a reducing trend, with lower respiratory infections having reduced the most (53%) from the 1990 levels.

In addition to these major causes, the sector has faced challenges with new / re-emerging conditions that cause minimal burden but are significant public health risks that lead to significant resource implications when they occur. These include Polio, where eradication efforts are still ongoing, Ebola Virus Disease, Marburg, and the idiopathic 'Nodding disease'.

Table 3: Top 25 causes of years of life lost in Uganda, and variations from 1990

Rank	Disorder	Years of Life Lost		% change from 1990
		Thousands of years lost	% of total	
1	HIV/AIDS	2733	17.30%	-6
2	Malaria	2257	14.20%	37
3	Lower Respiratory Infections	1004	6.40%	-53
4	Meningitis	838	5.30%	-8
5	Tuberculosis	706	4.50%	-1
6	Preterm birth complications	684	4.30%	40
7	Noenatal encephalopathy	692	4.40%	45
8	Neonatal sepsis	685	4.30%	52
9	Diarrheal diseases	537	3.40%	-74
10	Protein Energy Malnutrition	383	2.40%	-55
11	Road Injury	372	2.40%	98
12	Syphilis	347	2.20%	2
13	Maternal disorders	222	1.40%	16
14	Stroke	222	1.40%	36
15	Interpersonal violence	201	1.30%	148
16	Fire	206	1.30%	-6
17	Congenital anomalies	210	1.30%	-9
18	Cirrhosis	166	1.10%	54
19	Ischaemic Heart Disease	147	0.90%	39
20	Drowning	133	0.80%	36
21	Falls	133	0.80%	50
22	Epilepsy	132	0.80%	71
23	Self harm	97	0.60%	102
24	Measles	112	0.70%	-78
25	Diabetes	88	0.60%	108

Source: Global Burden of Disease Study 2010

Communicable diseases remain the major cause of life lost. As a result of policy interventions though, the life lost due to targeted communicable conditions like measles and diarrhoeal diseases has reduced by 55% or more. Measles burden reduction has been a result of the improve coverage of measles vaccination across the country, though pockets of outbreaks still occur due to build-up of susceptible children.

Diarrhoeal diseases reduction has also been driven by the increases in prevention of the same. The National household latrine coverage is currently 74.8%, (Annual Health Sector Performance Report (AHSPR), 2013/14) compared to the National target of 77%, while hand washing with soap after latrine usage is 32.8% (AHSPR, 2014) compared to the National target of 50% (Annual Environmental Health Data). The rural population with access to safe water is at 64%. Although the number of people with access to safe water and sanitation has improved, there are still many communities (both rural and urban) that rely on contaminated water sources such as streams and open wells. The pupil to stance ratio is 70:1 compared to the target of 50:1 in primary schools and 38% of the primary school have access to hand washing facilities. The Sanitation coverage in urban areas is estimated at 84% compared to the National target of 100% (without Kampala City Council Authority).

On the other hand, NCDs are increasingly becoming a major burden. Life lost due to NCDs is rising significantly, with diabetes, cancer, cardiovascular diseases, self-harm, interpersonal violence and road injuries increasing by about 100% or more since 1990. These conditions are on the increase due to life style changes, increased life expectancy in addition to genetic factors. The baseline survey on NCDs (MoH, 2014) established that there is a high prevalence of hypertension (24%), diabetes (3.4%) and a high prevalence of risk factors; tobacco use (11%), alcohol abuse (5.8%) and overweight. The survey further revealed that over 80% of the population with NCDs are not aware and hence will present with difficult to manage complications like stroke, kidney failure, blindness and impotence. The World Health Organisation (WHO) has in the last decade recognised the significant contribution of mental, neurological and substance abuse disorders to the disease burden globally, with at least one in every four persons experiencing some form of mental disturbance at some point in their life. Depression is the commonest mental health condition affecting up to 25% of people in the community. Over 90% of people who do self-harm or die by suicide have clinical depression or another diagnosable mental disorder. Therefore serious investments will be needed to prevent these complications to keep the population productive. Road traffic accidents especially by the motor cycles (Boda Bodas) have increased and do exert pressure onto the service providers and available resources. Road traffic injuries remain a major cause of death, morbidity and disability ranking number -six as per MoH AHSPR 2013/14. Uganda adopted the UN decade of Action 2010 – 19 for Road Safety and this advocated for reduction of road traffic injuries and accidents (RTI/A) through multisectoral collaboration. As a result of increased prevalence of trauma, NCDs, and elderly persons, the number of persons with disabilities(PWD) is on the increase (20% - UDHS 2011/12).

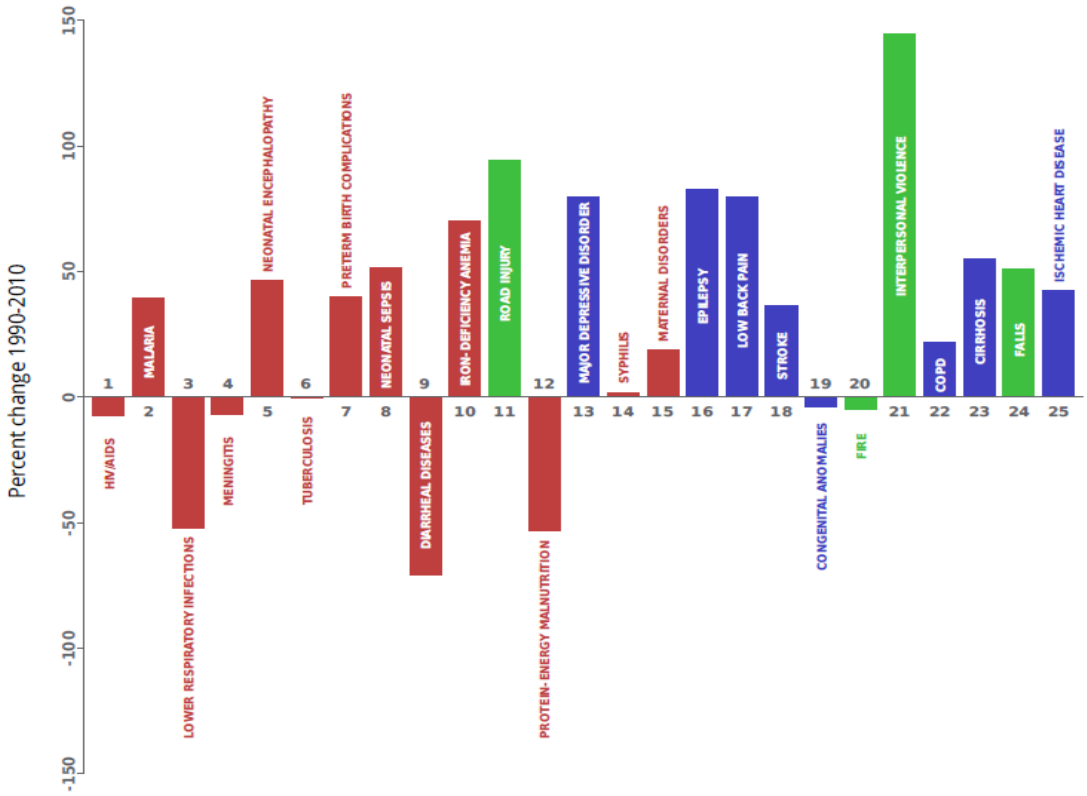
PEM has also reduced, with wasting at 5% among children under 5 (UDHS 1995 - 2011). Malnutrition still remains the underlying cause in nearly 60% of infant deaths (Uganda Nutrition Action Plan (UNAP) 2011 – 2016), and its reduction will further reduce the contribution of malnutrition to overall loss of lives in Uganda. Despite the investments in nutrition education, prevention and reduction of malnutrition over the past years, stunting remains at 33%, underweight at 14% and wasting at 5% among children under 5 (UDHS, 1995-2011). The annual costs (losses) associated with child under nutrition are estimated at UGX 1.8 trillion (5.6% of Gross Domestic Product (GDP)) according to the Cost of Hunger report, 2012. Trends over the years have shown an increase in overweight and obesity among women from 5% in 1995 to 19% 2011. Vitamin A deficiency has worsened from 19% to 38% (UDHS, 1995) and from 20% to 36% (UDHS, 2011) in children and women respectively.

In terms of disability-adjusted life years (DALYs), in Uganda the top three causes of DALYs in 2010 were HIV/AIDS, malaria, and lower respiratory infections. Whereas lower respiratory infections, diarrhoea and PEM declined significantly, there is a rise in malaria, pre-term and neonatal conditions, maternal conditions, iron deficiency anaemia, NCDs and injuries.

Since the early 1980's, the HIV/AIDS epidemic has had great impact on the population with an unacceptably high HIV prevalence among those aged 15 to 49 years of 7.3% (Uganda Aids Indicator Survey, 2011). Mortality has significantly reduced due to interventions to improve uptake and use of Anti-retrovirals (ARVs). The sector achieved near universal coverage of those in need of Anti-Retroviral Therapy (ART) (76% of target based on previous guidelines, which have recently been revised). However, the incidence of new cases remains a challenge, with new populations and changes in the Most at Risk Populations (MARPs) posing ever changing challenges to the HIV/AIDS prevention efforts.

In spite of the significant investments in malaria control, the malaria burden remains high. According to the Health Management Information System (HMIS) records, it is the major cause of outpatient and inpatient attendances accounting for 13.7% (in children under five), 29% among five years and above and 0.72% mortality in the 2013/14 FY. The country is still short of improving identification of malaria, with the proportion of suspected malaria cases tested only at 58.8% (2013) with confirmed malaria positive rate trending from 44.3%in 2011, 58.2% in 2012 and 44.2% in 2013.

Figure 4: Leading causes of DALYs and percentage change from 1990 to 2010 for Uganda



The LRIs, particularly pneumonia, are registering a significant reduction in mortality. This could be attributed to the introduction of vaccines targeting these conditions, particularly the pentavalent (*Haemophilus Influenzae* type B disease) and lately the pneumococcal vaccine. This reducing trend is testament to the success of these efforts and universal coverage with these vaccines should further reduce the burden of these lower respiratory infections till they are not of public health concern.

Anaemia is a leading public health problem in Uganda and is the third leading cause of mortality (Table 4). The current national anaemia prevalence of 50% in children, 6-59 months and 24% in women of reproductive age (UDHS, 2011) which still falls within World Health Organization category of the severe (40%) and mild (20%) public health problem and thus calls for the strengthening and prioritization of the implementation of evidence based cost effective prevention and control efforts.

Table 4: Top ten causes of under 5 inpatient mortality

Diagnosis (2012/13)	%	Diagnosis (2013/14)	%
Malaria	28.0	*Malaria*	28.8
Pneumonia	14.8	*Pneumonia*	13.0
Anaemia	9.7	*Anaemia*	11.6
Respiratory Infections (Other)	8.7	*Perinatal Conditions (in new borns 0 -7 days)*	7.9
Perinatal Conditions	3.9	*Neonatal Septicaemia*	4.4
Septicaemia	2.6	*Respiratory Infections (Other)*	3.1
Diarrhoea – Acute	2.6	*Septicaemia*	2.8

Severe Malnutrition (Kwashiorkor)	2.1	*Perinatal Conditions (in newborns 8-28 days)*	2.6
**Injuries - (Trauma Due To Other Causes)*	1.4	*Diarrhoea – Acute*	2.4
Severe Malnutrition (Marasmus)	1.2	*Severe Malnutrition (Kwashiorkor)*	2.1

**Injuries other than road traffic accidents*

Source: MOH HMIS DATA

The high burden of meningitis is worrying given the availability of effective treatments. It is a condition that is acutely fatal, with the high burden a reflection of the slow speed of detection and inadequate intervention quality. This is a reflection of the access and quality of care challenges that are faced in the health sector.

Tuberculosis (TB) burden has remained high, particularly driven by the HIV co-infection rates. While the sector has managed to achieve a 50% reduction in new TB infections due to scale up of appropriate diagnostics, availability of anti-TB drugs and other community initiatives, the quality of care provided to TB clients is still poor. This is reflected in the rapidly emerging public health challenge of Multi Drug Resistant (MDR) TB, which is increasingly driving the costs, and mortality associated with TB control.

Disease outbreaks from newly emerging or re-emerging disease also contribute to the existing disease burden. Since the first outbreak of Ebola was reported in 2000, additional Ebola outbreaks were reported in Uganda, one in 2011 and two in 2012. Four outbreaks of Marburg were also recorded between 2007 and 2008. Other major outbreaks of public health importance included Yellow fever, Meningitis, Hepatitis E, Hepatitis B and cholera.

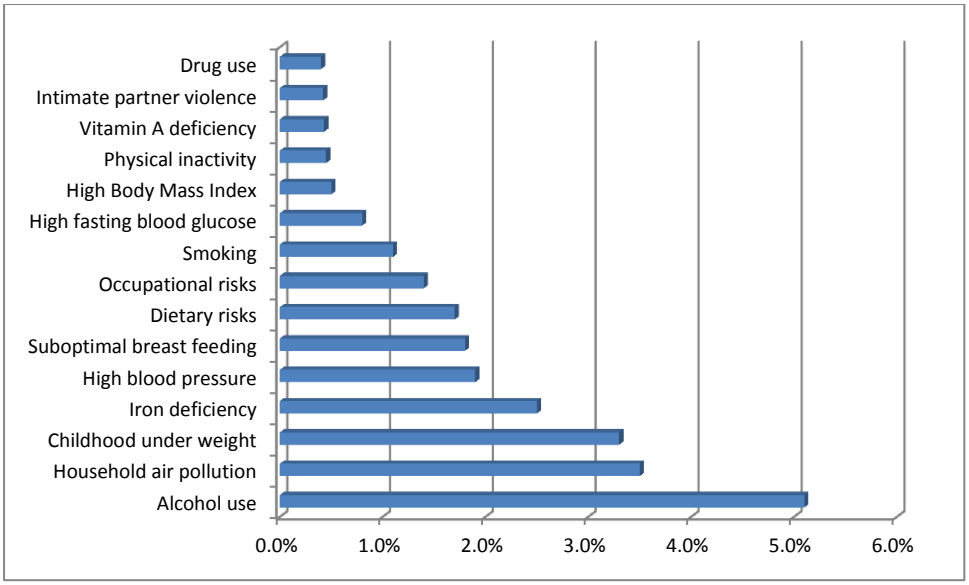
Uganda is also affected by other natural and manmade disasters namely; landslides, floods, associated with extreme weather events and climate change, conflict, drought and the threat of terrorism among the major hazards identified by the various risk assessments in the country. The conflict in the neighbouring countries has remained one of the risk factors for fuelling conflict and a wave of refugees and other forms of migrants into Uganda mainly from South Sudan and Democratic Republic of Congo, and a wave of migrants from Somalia. By end of March 2015, Uganda hosted close to 450,000 refugees from these countries.

In relation to the above, there are also important links between migration and health. Migration is considered a central determinant of health, requiring appropriate policy and programme responses. While migration itself is not a risk factor for ill health, the conditions associated with the migration process can contribute to the vulnerability of migrants and increase risks to their physical, mental and social well-being and result into public health emergencies. Research does show a link between migration and the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs). The circumstances of movement – whether voluntary or forced – directly affect the potential risk of infection for migrants. Moreover, migrants and mobile populations often face difficulties when obtaining care and support for HIV/AIDS and other conditions. Indeed, a number of barriers have been cited that prevent access and utilization of health services by migrants.

2.3 Progress with addressing the risk factors to health

The latest burden of risk factors show alcohol use, tobacco use, household air pollution, childhood underweight, iron deficiency and high blood pressure as the most significant risk factors, responsible for over 16% of all disease conditions. We see that these major risk factors appear to primarily influence the burden of NCDs, highlighting the growing challenge this group of conditions is posing to the health of Ugandans.

Figure 5: Major risk factors and their contribution to total disease burden



Source:- Global Burden of Disease Report for Uganda, 2010

Harmful use of alcohol is associated with many conditions, including HIV/AIDS, road injuries, interpersonal violence, cirrhosis, mental disorders, etc. According to the WHO, the alcohol per capita (15+) consumption is estimated at 9.8L of pure alcohol, a value much higher than the 6L average estimate for the WHO African region. Of this, beer, wine and spirits only contribute 9%, 1% and 2% respectively, highlighting the high amount of un-refined alcohol consumed. The actual alcohol consumed amongst drinkers of alcohol is actually higher, with an estimated 24L consumed by drinkers (26L for males, and 20L for females). Up to 2.5% of the population is classified as alcohol dependent (4.2% males, 0.7% females), a level higher than the 1.4% estimate for Africa. According to the GATS 2013 7.9% of the population above 15 years were using tobacco while 17.3% of the youth were using tobacco (GYTS 2011).A study at Mulago hospital indicated that 1/4 and 1/5 patients at Uganda Cancer Institute diagnosed with cancer of the oesophagus and lung respectively had a history of tobacco use

Household air pollution is a silent killer in the country, contributing significantly to LRIs, cancers and other morbidity and mortality causes.

Table 5: Prevalence of common NCDs in Uganda

	Estimated Prevalence
Hypertension	24% (NCD survey 2014)
Diabetes	3.3%(NCD survey 2014)
Sickle Cell Diseases	2% (SCD prevalence study)
Eye conditions	5.5% (HMIS 2014/15)

Childhood underweight levels are associated with significant childhood mortality, plus developmental challenges that persist into adulthood. Despite the investments in nutrition education, prevention and reduction of malnutrition over the past years, stunting remains at 33%, underweight at 14% and wasting at 5% among children under 5 (UDHS 1995-2011). Vitamin A deficiency has increased from 19% to 38% and from 20% to 36% in children and women respectively. Malnutrition is the underlying cause in nearly 60% and 25% of infant and maternal deaths respectively (UNAP 2011 – 2016). The annual costs (losses) associated with child under

nutrition are estimated at UGX 1.8 trillion (5.6% of Gross Domestic Product (GDP)) according to the Cost of Hunger report, 2012. Trends over the years have shown an increase in overweight and obesity among women from 5% in (UDHS, 1995) to 19% (UDHS, 2011).

2.4 Progress with provision of services addressing major causes of disease burden

The Health Sector Strategic and Investment Plan (HSSIP) 2010/11 - 2014/15 envisioned improved interventions across four cluster areas. These were:

- Health promotion, disease prevention and community health initiatives
- Reproductive, Maternal, Child and Adolescent Health (RMNCAH)
- Communicable diseases control
- NCD prevention and control

During the HSSIP, a number of interventions were introduced / scaled up, to improve the services addressing these critical areas.

Table 6: Performance for health services core indicators in HSSIP

Indicator	Source	2010/11	2011/12	2012/13	2013/14	HSSIP Target
% pregnant women attending 4 ANC sessions	HMIS	32%	35%	31%	32.4%	55%
% deliveries in health facilities	HMIS	39%	40%	41%	44.4%	65%
% children under one year immunized with 3rd dose Pentavalent vaccine	HMIS	90%	85%	87%	93.0%	95.1%
% one year old children immunized against measles	HMIS	85%	89%	85%	86.5%	85%
% pregnant women who have completed IPT_2	HMIS	43%	44%	47%	48.6%	60%
% of children exposed to HIV from their mothers accessing HIV testing within 12 months	EID database	30%	32.3%	46%	53.8%	55%
% ART coverage among those in need	ACP	53%	59.3%	83 % based on 2010 WHO Guidelines (46% based on 2013 WHO Guidelines)	48% (Based on 2013 WHO Guidelines)	75% (based on 2010 WHO Guidelines)
TB Treatment Success Rate	NTLP	71.1%	79%	77%	77%	80%
Functionality of HC IVs (Conducting Caesarean Sections)	HMIS	24%	25%	37%	45%	50%

Source: AHSPR 2013/14

In RMNCAH, the country made good progress in a number of areas. There is currently universal access to Antenatal Care (ANC) services, with virtually all pregnant mothers accessing ANC services at least once. Institutional deliveries are on an improving trend, with better access to Emergency Obstetric and New-born Care (EmONC). Family planning services are also on an improving trend, with adolescent fertility rates, unmet family planning needs and Contraceptive Prevalence Rate (CPR) all improving, albeit too slowly to achieve country targets. Child health services are also improving, with immunization targets achieved (apart from Vitamin A supplementation). However, there are still many challenges faced in improving RMNCAH. Progress in improving the quality of ANC and delivery services is inadequate, in spite of good physical access. This, together with

financial hardships, is contributing to the high dropout rates for the services, with mothers attending all 4 expected ANC visits significantly low. In addition, the quality of service delivery is still a challenge, with facilities facing frequent stock outs of life saving commodities, which is reducing further the confidence of the mothers in using the services. The emergency referral system to send mother and baby from one facility to next remains weak. There is no established referral protocol. There are still inequalities in accessing the services, with rural populations more disadvantaged. Finally, the sector still isn't tacking the major risk factors to RMNCAH, particularly the issue of exclusive breastfeeding.

Looking at communicable disease control, there have been efforts to improve services tackling specific communicable diseases.

- For malaria, there is an increase in children with fever taking antimalarial drugs within 24 hours, Insecticide Treated Net (ITN) possession and use, and laboratory capacity for parasite detection (laboratory, or use of Rapid Diagnostic Tests (RDTs)). These improvements however are not at the level needed to attain the sector goals in malaria control, limiting their impact on the burden of malaria.
- Regarding HIV/AIDS, access to HIV Counselling and Testing (HCT) services increased, particularly amongst women due to the services available in MCH and Prevention of Mother-To-Child Transmission (PMTCT) contacts. HIV testing services also increased amongst exposed infants, improving identification of these. Individuals accessing ART services also significantly increased during the period.
- TB services were able to maintain high Cotrimoxazole uptake amongst TB/HIV clients. Up to 40% of all facilities had TB services, and are able to conduct sputum smear tests, and provide required drugs. However, TB case detection rate all forms remains very low (80%), meaning many cases are not receiving required services. The Treatment Success Rate (78%) is still below the target, with this contributing to the persisting TB burden and emergence of MDR TB as a public health concern.
- With diseases of outbreak potential, the country faced a number of outbreaks during the HSSIP. These included outbreaks of yellow fever (5 districts, 41 deaths), acute hemorrhagic conjunctivitis (26 districts, 8,272 cases), Ebola Virus Disease (2 districts, 21 deaths), Marburg virus disease (2 outbreaks, 4 districts and 15 deaths), plague (2 districts, 3 deaths), cholera (17 districts, 126 deaths), measles (44 districts, 45 deaths) and typhoid. The capacity for surveillance and early detection of outbreaks was strengthened, limiting the potential effects of these diseases.
- Finally, looking at the Neglected Tropical Diseases (NTDs), there has been heightened advocacy, social mobilization, community awareness and vector control efforts that have focused on improving the capacity to detect, and provide required medicines to the affected persons. This has specifically been targeted at Sleeping Sickness and Leishmaniasis. However, the targets of elimination of Onchocerciasis, Trachoma, Lymphatic Filariasis, intestinal worms and Schistosomiasis are still not yet achieved. Rapid assessment of avoidable blindness surveys established that the prevalence of blindness among 50 years old and above is 2%.

Looking at the NCDs and injuries, there were limited interventions introduced to prevent and halt the rising burden of this disease group. However massive community sensitization on NCDs and their risk factors have started and some facilities have been prepared to manage NCDs through training of health workers and supply of basic equipment, These interventions need to be scaled up in this period in order to reverse the worrying trend of NCDs. Service provision through facilities remains low also, with 48%, 44%, and 34% of facilities providing services for chronic respiratory, cardiovascular, and diabetes conditions respectively. In a bid to improve the quality services for mental health conditions, the government invested 21 million USD on development of infrastructure, provision of medical supplies and built human resources for better Mental Health Care. Specialised training in addiction management, child and adolescent mental health as well as programs for empowering users to maintain recovery is ongoing. The Ministry is scaling up Mental Health services through the

implementation of Mental Health Gap Action Program (MHGAP) which is a WHO initiative for increasing access to care for people with common mental, neurological and substance abuse disorders.

The MoH analyzed information on patients referred for treatment abroad over the last five years through the Uganda Medical Board and observed that the leading conditions for referral were End Stage Kidney Failure, Cancers, Heart Conditions, Orthopedic Conditions, Neurological Conditions and Eye Diseases1. Over the five year period, the total cost for treatment is US$ 5,610,029. There is need to develop specialised diagnostic and health care services in the country to reduce on expenditures on referral abroad in view of the growing burden of NCDs.

The HSSIP also put in place measures to improve Emergency and Disaster Preparedness and Response (EDPR). These measures included strengthening the health systems and community capacity and strengthening of the coordination of response. The Integrated Disease Surveillance and Response (IDSR) training guideline was reviewed and updated based on the recent developments. Training of health workers on IDSR was conducted with a coverage of close to 50%. In the course of the implementation of the HSSIP an Emergency Operation Centre (EOC) was also established and is contributing in the management of health related emergencies specially disease outbreaks. Uganda also played a crucial role in the control of the Ebola Outbreak in West Africa in 2014, through the deployment of critical staff for a substantial period of time.

2.5 Progress with Service delivery in the Local Governments and Urban Authorities

The District League Table was used throughout the HSSIP period with the objectives of comparing performance between districts; provide information to facilitate the analysis for good and poor performance at districts and thus enable corrective measures which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision; increase LG ownership of achievements/ performance; and encourage good practices – good management, innovations and timely reporting. There was an improvement in the national average score for the district league table indicators from 58% in FY 2010/11 to 74% in FY 2013/14. This improvement was mainly attributed to the significant improvement in HIV testing in children born to HIV positive mothers from 30% in 2010/11 to 97.5% in 2013/14 and improvement in medicines orders submitted timely from 47% to 99%.

Table 7: District League Table Trends 2010/11 - 2013/14

Financial Year	Population	DPT_3 Coverage (%)	Deliveries in gov't and PNFP facilities (%)	OPD Per Capita	HIV testing in children born to HIV+ women (%)	Latrine coverage in households (%)	IPT_2 (%)	ANC 4 (%)	TB TSR (%)	Approved posts filled (%)	% Monthly reports sent on time	% Completeness monthly reports	% Completeness facility reporting	Medicine orders submitted timely (%)	National Average (%)
2010/11	31,752,300	90	39	1	30	71	43	32	77	52	77	94	85	47	58
2011/12	33,544,573	80	38	1.2	32	68	46	34	61	54	78	89	87	28	57
2012/13	33,568,500	87	39	1.1	45	68	48	30	79	61	80	79	94	35	63
2013/14	36,652,480	93	44	1.0	97.5	72	49	32	80	70	70	74	90	99	74

[1] Summary of the Referrals of Patients abroad for Treatment from FY 2008/09 to 2012/13 by the Medical Board.

Using the league table district were ranked from the best performing in terms of the highest average score to the poorly performing districts. Whereas annual performance awards (plaques) were given to the top performing districts during the annual Joint Review Mission, other follow up activities in terms of resource allocation and targeted support supervision were not explicitly given.

In 2010, the Uganda Urban health profile showed that 15.2% of the population lived in urban areas and of these 60% (2.6 million) lived in slums. With the growth in urban centres over the last 5 years the urban population has grown with changing lifestyles and living conditions for this population. The health risk factors like alcohol consumption, violence, obesity, HIV/AIDs are higher in the urban than rural population. Other growing challenges are related to food hygiene and safety due to the poor food handling practices. This calls for need to strengthen regulation of urban health services and access to safe water.

2.6 Progress with private sector engagement

In order to improve the health status of the people of Uganda, to increase the geographical access to health care, government is addressing is 'partnerships' among the private sector stakeholders and providers. The Private Health Sector in Uganda is varied and diverse. The following categorisation has been agreed upon during discussions with the various stakeholders in Uganda in the articulation of the PPPH policy: Private Not For Profit health providers (PNFP), Private Health Practitioners (PHP) and Traditional and Complimentary Medicine Practitioners (TCMP). In addition to the above recognized categories , a number of individuals, often without formal health training, are also engaged in treatment of patients and illegal sale of drugs. These informal providers cannot be considered part of the legitimate private sector unless they regularise and register themselves under one of the recognised categories of private sector providers described above (PNFP, PFP, TCM), and comply with the laws, regulations and standards that apply to their practices.

The PNFP sub-sector currently employs approximately 34% of the facility-based heath workers in the country, while it operates 40% of all hospitals and 20% of all lower-level health centres. In spite of employing less staff than the public sector, attrition of qualified staff from PNFPs to public facilities and private practice continues to be a problem, increasing the unbalance between sub-sectors. The human resource inputs of the NFB-PNFP sub-sector include capacity building, in service training, community empowerment and community-based service delivery. However to date these inputs have not been well quantified.

The human resource contribution of the TCMP sub-sector is also not clearly quantified and requires more research. A recent WHO report, however, estimates that the ratio of traditional medicine practitioners to population in Uganda is between 1:200 and 1:400 compared with a doctor to population ratio of 1:18,000, which implies a potentially significant contribution of this sub-sector to human resources for health services.

One of the major challenges under this partnership is the poor reporting and non-inclusion of data from private sector hospitals and clinics in the National HMIS. As a result their contribution to the sector outputs and outcomes is not captured.

2.7 Progress with human rights and gender

Progress has been made in ensuring that key sector policies, strategies and guidelines are cognisant of how men and women are affected and at the sometime addressing the issues of health as right and progressing recognising progressive realisation. In addition to strengthening the human rights and gender desk, the sector has improved coordination and collaboration with key CSOs and MDAs in the field of human rights and gender.

The health sector has also contributed and actively participated the Country's reporting of the progress regarding the right to health and gender obligations at national, regional and international levels such as EAC, AU and the UN. The recommendations therein have been adopted and used to inform the right to health and gender responsive planning programming and service delivery.

During the HSSIP period the sector has developed a male involvement strategy, guidelines for managing Gender Based Violence (GBV) centres, human rights and gender manual for service providers and policy makers, as well as creating awareness on the right to health at national and district levels. The sector has also been able to address and periodically report on the key International Treaties and recommendations. The main challenge has been being the consistent in addressing issues that pertain to the structural and financial commitments to addressing human rights and gender issues in the health sector. To address the human rights needs of people living with mental illness, the Mental Bill (2014) was drafted and approved by cabinet and awaiting presentation to parliament for enactment into law.

2.8 Progress with attainment of MDGs

Overall, the country has made fair progress with attainment of the MDG targets that have a bearing on health (direct or indirect). The status as reported in the most recent MDG status report (2013) is highlighted in table 8 below.

Table 8: Status of MDG targets in Uganda

Goal	Target	Progress
Goal 1: Eradicate extreme poverty and hunger	Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	ACHIEVED
	Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	NO TARGET
	Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	ON TRACK
Goal 2: Achieve universal primary education	Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	SLOW
Goal 3: Promote gender equality and empower women	Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	ON TRACK
Goal 4: Reduce child mortality	Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	ON TRACK
Goal 5: Improve maternal health	Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	SLOW
	Target 5.B: Achieve, by 2015, universal access to reproductive health	SLOW
Goal 6: Combat HIV/AIDS, malaria and other diseases	Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	REVERSAL
	Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	ON TRACK
	Target 6.C: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	ACHIEVED
	Target 6.D: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	ON TRACK
Goal 7: Ensure environmental sustainability	Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	SLOW
	Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	SLOW
	Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	ON TRACK

Goal	Target	Progress
	Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	NO TARGET
Goal 8: Develop a global partnership for development	Target 8.B: Address the special needs of the least developed countries	SLOW
	Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	ACHIEVED
	Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	ON TRACK
	Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	ON TRACK

First, the report recognises that no one factor is sufficient to influence the attainment of the goals. Indeed many factors are necessary to attain the goals.

Factors that could improve the attainment of the goals:

- the importance of **government spending on health** and other social services, particularly for health system components like infrastructure.
- the need for **improved efficiency** of government spending in the health sector was emphasized as an important driver for attaining health related goals.
- and the **importance of other social determinants of health** such as household income, infrastructure/ transport.

2.9 Progress with making required health investments

In the previous years, the health sector has been making significant investments aimed at improving its capacity to provide health services for the people in Uganda. The HSSIP envisioned investments across the following areas:

- Planning, supervision, quality improvement, Monitoring and Evaluation (M&E)
- Health information, research and evidence generation
- Financial management and procurement
- Health infrastructure
- Management of health inputs
- Human Resources
- Partnership, and sector governance

2.9.1 Progress with planning, supervision, quality improvement and M&E

Looking at planning, supervision, M&E, the sector made some progress. Various policies and strategy documents were developed, across different program and system areas. Annual operational plans and reports were consistently produced for the health sector. Districts continued to develop their operational plans, though these are not comprehensive enough to cover their services due to inadequate methods for making available information on off budget resources.

Integrated and internal support supervision was conducted at all levels however, this was erratic due to budget and staff availability challenges, with limited follow up of emerging issues. The sector reviewed the supervision, monitoring and inspection mechanism in the health sector and developed a draft Comprehensive Supervision, Monitoring and Inspection (Regulatory) Strategy. In addition the support supervision guidelines and tools are under review.

The MoH developed and disseminated the Health Sector QI Framework and Strategic Plan 2010/11 - 2014/15 to provide a common framework for all public and private health institutions, partners and stakeholders to

coordinate, plan, mobilize resources, implement, monitor and evaluate Quality Improvement (QI) initiatives in Uganda. QI Coordination structures were established at national level (National QI Coordination Committee), Rwenzori region (Regional QI Team), district level (District QI Teams) and most Hospitals and Health Center (HC) IVs (Health Facility QI Teams and Work Improvement Teams). All districts were supported to implement various QI interventions mainly through partner support and they are at varying levels of implementation. Areas of focus were mainly HIV/AIDS Care and treatment, Safe Male Circumcision, Immunization, RMNCAH Health, Medicines and Health Supplies Management, Laboratory Management and Health Care Waste Management. Standardized the In-service QI training package and about 900 health workers were trained in QI and 5S methodology.

The following guidelines / manuals were revised or developed and disseminated; Infection Prevention and Control Guidelines, 5S guidelines and Handbook for health workers; Performance standards for male circumcision for HIV prevention, Patient and Family Centered Care Guidelines, draft nutrition assessment guidelines and QI Manual for Health Workers. Developed the Health Facility Quality of Care Assessment Program Manual and tools to be implemented as a step towards accreditation in the health sector. The MoH also reviewed the Health Sector Service Delivery Standards and Service Standards. To be finalised in FY 2015/16. Conducted a national client satisfaction survey, HIV service assessment 2014, Performance assessment of safe male circumcision, and Baseline Health Facility Quality of Care Assessment in 14 districts (Jinja, Mitooma, Busia, Budaka, Bududa, Bukwo, Bulambuli, Butaleja, Kapchorwa, Kween, Manafwa, Mbale, Pallisa and Sironko.

The M&E Plan for HSSIP 2010/11 – 2014/15 was developed and disseminated aiming at establishing an M&E system that is robust, comprehensive, fully integrated, harmonized and well coordinated to guide monitoring of the implementation of the HSSIP and evaluate impact. With support from the Global Fund for TB, HIV/AIDs and Malaria (GFTAM), 12 Regional Performance Monitoring Teams were established to strengthen the decentralized capacity for active performance monitoring and surveillance of program outputs and support the performance management of implementing agencies at all levels. Community feedback mechanism - mTRAC and U-Report was rolled in all districts. On annual basis AHSPRs were compiled and disseminated. Annual Sector Performance Reviews were conducted in addition to biannual reviews at national level. Quarterly performance reviews were conducted at sub-national levels. Programme review conducted for Malaria Program in 2011, TB program in 2013 and HIV/AIDS program review to be conducted in 2015.

The M&E Structure for the MoH is not defined to streamline the M&E functions at national level. Comprehensive program reports are not compiled to feed into the overall sector performance reports. This affects timeliness and completeness of national level reporting. There are still irregular program and sub-national performance reviews due to inadequate funds. Evaluations for most programs not conducted due to inadequate funding and as a result impact of interventions is not well documented. The low reporting rates from the private sector limits the ability to appropriately monitor overall sector outcome performance. Finally, the utilization of data for decision making is still minimal and technical guidance needs to be given and enforced from the MoH to the lower levels and Partners.

2.9.2 Health information

With health information, research and evidence generation, the country was able to transition to District Health Information System (DHIS)-2, which is an electronic web based reporting mechanism and revised reporting tools to ensure information disaggregation. The inadequate supply of the revised HMIS tools in all facilities is still hampering data collection and reporting. A data quality manual was developed and data validations were conducted in a number of districts. Surveys and facility assessments specific for some high burden conditions (HIV, TB prevalence, malaria, NCDs, etc) were successfully initiated / conducted. The mechanisms for evidence

generation and oversight however, need to be streamlined and strengthened to avoid scenarios where data generation is resource driven, as opposed on need driven.

E-health has become a stronger area of focus, with the national e-health technology framework completed and draft e-Health strategy developed. Several local innovation programs exist and can be leveraged to build country ownership and reduce the total cost of ownership. The Government has maintained strong stewardship over this developing area, to ensure the emerging e-health architecture is aligned to the pillars of e-health house of value and are contributing to the National Health Record Program.

2.9.3 Research and evidence generation

Health research is very crucial in the provision evidence based interventions. The Uganda National Health Research Organization (UNHRO) Act was operationalized and the Health Research Policy in Uganda 2012 - 2020 and UNHRO Strategic Plan 2010/11 - 2014/15 have been developed. Currently health research is conducted at the national research institutions and academic institutions. Uganda Virus Research Institute (UVRI) Polio laboratory was fully accredited in January 2014. UVRI carried out baseline studies to determine epidemiological patterns for malaria transmission on Lake Victoria in Kiimi and Nsazi Islands; routine surveillance for HIV, Syphilis, Acute Flaccid Paralysis and Aborvirus; Insecticide resistance studies in the malaria and monitored immune responses for plague, yellow fever and other out-breaks due to viral haemorrhagic fevers; and trained 50 staff in bio- safety and bio- security.

The Natural Chemotherapeutic Research Institute (NCRI) is mandated to conduct research in Natural Products in the management and treatment of Human Diseases. Currently research in medicinal plants used for treatment of various ailments in Uganda has been ongoing. The institute has documented medicinal plants in 90% of all the district in Uganda and established medicinal plant demonstration gardens in the four regions in the community centres for traditional medicine in Uganda. Scientific chemical and pharmacological analyses have also been conducted to validate their quality, safety and efficacy. In order to enhance sustainable use of medicinal, NCRI has conducted trainings among community members, farmer groups, herbalists and Village Health Teams (VHTs) in conservation, processing and value addition. At policy level, NCRI has spear headed a bill on indigenous and complimentary that is in Parliament.

The major challenges in health research are inadequate human resources in all research institutions, low government financial allocation to health research, weak collaboration mechanisms between planners, research institutions, industry and academia and partners. Others are, lack of mechanisms for dialogue with relevant partners for research. This hampers ownership of the research agenda and research capacity to develop quality products to be patented and capacity to commercialize several remedies which are developed by NCRI.

2.9.4 Health infrastructure

With health infrastructure, physical access to health facilities (proportion of the population leaving within 5 km of health facility) is currently at 72%. All the 112 districts in Uganda either have a hospital or HC IV or both. This however includes some old and dilapidated infrastructure mainly at General Hospitals (GHs) and some lower level health facilities. There were limited improvements in facility infrastructure. A summary of health facilities by region is as indicated in the table 9.

Table 9: Health facilities (public and PNFP) by region in 2015

Region	Population	Clinic	HC II	HC III	HC IV	GH	RRH	National Referral Hospital	Total
Central		645	1,065	318	51	53	3	2	2,137
Eastern		34	618	324	48	30	3	0	1,057

Northern		32	484	271	31	27	4	0	849
Western		120	774	376	67	34	4	0	1,375
Total		**831**	**2,941**	**1,289**	**197**	**144**	**14**	**2**	**5,418**

Source: DHIS2, 2015

At present, only five Regional Referral Hospitals (RRHs) - (Mbarara, Mubende, Masaka, China Uganda Friendship Hospital (CUFH) - Naguru and Lira) have Accident & Emergency Units, with construction ongoing in a further three (Kabale, Hoima and Moroto). On the other hand, three GHs (Tororo, Masafu and Bududa) have Accident & Emergency Units while eight more are under construction (Entebbe, Mityana, Nakaseke, Iganga, Kiryandongo, Anaka, Nebbi and Moyo). Only three RRHs have intensive care units (Jinja, Mbarara and Lira) though these are not fully functional due to lack of health workers trained in intensive care.

There are only four Regional Blood Banks (Mbarara, Fort Portal, Gulu and Mbale), complementing the Nakasero Uganda Blood Transfusion Services (UBTS) and the 2 National Referrals (Mulago and Butabika plus CUFH Naguru).

Only 66% of HC IVs have anaesthesia services available; critical care/ intensive care services are available in only 37.4% of the hospitals, hospice and palliative care services are being offered in only 4.8% of the hospitals. A number of hospitals lack functional basic equipment e.g. adult weighing scales, otoscopes, ophthalmoscopes, ECG machines, cardiac monitors, defibrillators, ventilators and ambubags. Oxygen cylinders or functioning central oxygen supply are available at 57% of the RRHs, 41% of the GHs, 33% of the speciality hospitals and 13% of HC IVs. Ultrasound services were available in only 46.9% of the health facilities surveyed. Only 37% of the health facilities had a budget line item for routine maintenance and repair of medical equipment. Schedules for maintenance of any medical equipment were observed in 13.4% of the facilities surveyed. (Draft Report Hospital and HC IV Census 2015)

Infrastructure investments were not well coordinated, limiting their full potential as a result. There is lack of a comprehensive picture of the availability and functionality of critical medical equipment, and transport facilities hampering adequate planning in this area. Facilities may have equipment, but no space, or staff adequately trained for their use. There are also still major inequities in availability of facilities, ranging from a low of 0.4 facilities per 10,000 population (Yumbe district) to a high of 8.4 facilities per 10,000 population (Kampala).

However, since the establishment of the Capital development budget for RRHs, rehabilitation of the existing physical infrastructure has begun and replacement of essential medical equipment has progressively been undertaken. For equipping, the focus has been on replacement of essential medical equipment because of the poor maintenance condition of the available equipment as shown in Table 10.

Table 10: Medical Equipment Inventory and Maintenance Condition

Health Facilities	Equipment Condition					
	A	B	C	D	E	F
Average for RRHs (11)	44%	6%	24%	10%	8%	8%
Average for General Hospital (39)	33%	5%	32%	8%	11%	12%
National Average HC IV (45)	52%	23%	11%	5%	6%	3%
National Average HCIII (32)	63%	15%	10%	4%	4%	4%

Source: MoH/JICA Inventory 2009

***Key**: A: Good and in use, B: Good but not in use, C: In use but need repair, D: In use but needs replacement, E: Out of order but repairable, F: Out of order and should be replaced*

Additionally, procurement of medical equipment for specialised diagnostics, treatment and care has remained limited because of underfunding. Due to the above reasons, hospitals have a number of equipment related challenges:

i) The few health facilities providing specialised diagnostics, treatment and care (e.g. Cancer Institute, Uganda Heart Institute, Mulago National Referral Hospital) are overloaded and therefore incapable of meeting the growing demand for specialised health care and diagnostics.
ii) Diagnostic equipment are lacking in most referral facilities. This leads to inappropriate diagnosis, treatment and wastage of medicines. At RRH level, important diagnostic and treatment equipment that would be required include; Magnetic Resonance Imaging (MRI), Computerised Axial Tomography (CAT) scan, cardiology diagnostics, renal dialysis, cancer diagnostics and treatment including the cobalt 60 and linear accelerator radiotherapy equipment for cancer treatment.
iii) Medical equipment is poorly maintained due to lack of funds and absence of local technical expertise to provide after sales support.
iv) Some of the old equipment is obsolete technology that is hazardous to health workers and patients.

2.9.5 Pharmaceutical Supplies and health products

On the other hand, there has been a steady improvement in the availability of health products, as measured by the tracer commodities. Improvements in the National Medical Stores (NMS) capacity to procure and supply required commodities is contributing to this. To-date, the pharmaceutical sector has made an improvement in availability of, and access to Essential Medicines and Health Supplies (EMHS) from 43% in 2009/2010 to 63.8% in 2014/2015 surpassing the 2015 HSSIP target of 60%. There has been an increase in funding for medicines through both GoU and donor streams from USD 92 million to USD 410 million (including USD 85 million for procurement of Long Lasting Insecticide Nets-(LLIN)) over the same period, resulting into increased public confidence in the health system. However, the greater proportion (81%) of this funding was from Development Partners, and largely skewed to HIV/AIDS, malaria and TB. Human Resource production increased from coverage of 1.1 pharmacists/ 100,000 populations to 1.6 pharmacists/100,000 population currently with the number of training institutions increasing from one to three for pharmacists. Regulation for medicines has also been strengthened through National Drug Authority (NDA).

Despite increased funding for health commodities by government, the amount available is still inadequate to meet the country's EMHS requirements. The Per capita government expenditure on EMHS in the FY 2013/14 was about US$ 2.4 which is below the estimated requirement in the HSSIP of US$ 12. There is over dependence on donor financing for procurement of EMHS and associated activities, inadequate skilled and professional pharmaceutical human resources in the health sector, mismatch of resource allocation among public health sector facilities and inadequate funding to NDA to carry out its regulatory function.

2.9.6 Human Resources

The health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills, plus retention, motivation, and performance challenges. Efforts by the GoU and Partners have facilitated recruitment of much-needed staff increasing the proportion of approved posts from 56% in 2010 to 69% in 2013/2014. There is improvement in recruitment of health workers, largely driven by efforts in 2012 to improve staffs at HC III and IVs. There are however variations by district, facility type and by cadres. Only 45% of positions at HC II are filled, as compared to 70% / 71% at HC II and IV respectively. The effort to improve availability of health workers at HC III and IV is commendable, though it may have had the unintended consequence of reducing attraction and motivation of staff at HC IIs and the general hospitals. Additionally, there are still variations in staffing levels by district with only 28% of positions filled in Kiruhura district, compared to 91% of posts in Iganga district. Plus, the current numbers per level are still too low for the health care delivery

needs. There are an estimated 1.55 health workers per 1,000 persons, which is below the WHO cut off of 2.28 / 1,000 persons below which the country is considered as having a critical shortage. Nurses and midwives are staffed to 83% and 76% respectively. The following health cadres are severely in short supply: Pharmacists (8%), Anaesthetic staff (30%), Health administrator (33%) and Cold Chain Technicians (40%). Considering government investment in Mental Health Regional Referral Units, the current staffing structure does not address the prerequisite staff for those units, for example there are no positions for clinical psychologists, psychiatric social workers, occupational therapists and general counsellors to form the required multidisciplinary teams at that level. Overall, staffing is slewed in favour of specialized health institutions and larger health facilities (RRH 81%; GH 69%, HC IV 85%, HC III 75% and HC II 49%).

Table 11: Staffing by level, 2015

Name	No. of units	Total approved (Norm)	Positions filled	Vacant	Filled	Vacant
Mulago NRH	1	2,801	1,880	581	67%	34%
Butabika NRH	1	424	359	63	85%	15%
UBTS	1	242	215	27	89%	11%
UCI	1	213	122	91	57%	43%
UHI	1	190	134	56	71%	29%
RRH	14	4,744	3,820	924	81%	19%
Sub-Total Central Level	**19**	**8,272**	**6,530**	**1,742**	**79%**	**21%**
Total district staffing	111	46,851	31,357	15,494	67%	43%
Health facilities in KCCA	17	3,933	2,792	1,141	71%	29%
Municipal Councils	22	176	111	65	63%	35%
Sub-total LG	**150**	**50,960**	**34,260**	**16,700**	**67%**	**33%**
Total National	**169**	**59,232**	**40,790**	**18,422**	**69%**	**31%**

Source: MoH HRH Biannual Report , April 2015

Several reasons explain the inadequacy of the health workforce in Uganda. Generally, production of health professionals do not adequately match health services needs and demands. There is underproduction of some priority cadres (e.g. anaesthetists, pharmacy technicians, theatre attendants, environmental health officers and cold chain technicians, etc). Inadequate and unpredictable funding further undermines the capacity to fill approved positions. There is also concern over the quality of the graduates. The situation is compounded by low staff retention and motivation, particularly in rural of hard-to-reach areas.

2.9.7 Partnership and Sector Governance

With regard to sector partnerships, most of the existing structures for partnership engagement are largely moribund, and not providing the needed forums for sector engagement. Some partners are therefore sidestepping these structures, and providing support that is not coordinated and harmonized. The SWAp process and the Health Policy Advisory Committee (HPAC) functionality are therefore compromised, with current focus primarily on statutory actions (e.g. endorsing proposals) as opposed to being forum for dialogue. The Technical Working Groups (TWGs) and Intersectoral coordination functionality are sub optimal, and there is limited real engagement of some stakeholder groups. Merit however needs to be given to the tenacity of the partnership and coordination structures, like HPAC and Health Development Partners (HDPs) forum which have largely continued to exist in spite of this environment.

Most of the targets for Aid Effectiveness (Paris Declaration and IHP+ indicators) assessed in 2014 showed significant progress on the country performance (Table 10).

Table 12: Progress in implementation of the IHP+ commitments

	Issue monitored	Government Indicator	Achievement	Associated DP indicator	Achievement
1.	Health development co-operation is focused on results that meet developing countries' priorities	A sector results framework in place	100%	Development Partners use the country results framework	98%
2.	Civil Society operated in an environment which maximized its engagement in and contribution to development	Government supports meaningful participation of CSOs in health sector policy processes – including planning, coordination & review mechanisms.	80%	Development Partners support meaningful engagement of CSOs in	78%
3.	Health development cooperation is more predictable	Government funds disbursed predictably	Not available	DP funds disbursed predictably	76%
		Projected government expenditure on health provided for 3 years.	100%	Government has information on DP expenditure plans for three years ahead	34% (Most HDP indicative expenditure is for annual)
4.	Health aid is on budget	A national health plan in place that has been jointly assessed.	100%	DP Cooperation reported on budget	49%
5.	Mutual accountability among health development cooperation actors is strengthened through inclusive reviews	Mutual assessment mechanisms in place.	100%	DPs use mutual assessments mechanisms	76%
6.	Effective institutions: developing countries' systems are strengthened and used; • Financial Management System • Procurement Systems	Quality of country public financial management systems (score)	3.26 out of 6	DPs use country public financial management systems	43%

Source: IHP+ Country Score Card, 2014

Finally, looking at sector governance, the sector stewardship has been changing at the highest level, leading to frequent changes in stewardship direction. There has been high turnover at Senior and Top management of the MoH during the HSSIP period. There were also some gaps in technical departments that were limiting capacity to provide comprehensive guidance. The MoH developed and disseminated guidelines for the Governance and Management structures at the national level, Guidelines for Referral Hospital Boards and Hospital/Health Unit Management Committees (HUMC), Client charter for MoH and Referral hospitals and guidelines for developing client charters in the health sector. Most of the RRH Boards were inducted and oriented on their roles and responsibilities. At the district level, the functionality of the management and stewardship structures like the Social Services / Health Committee, District Health Management Teams (DHMTs), District Health Teams (DHTs)

in some districts was supported through projects like Strengthening Decentralization for Sustainability (SDS), though many persons managing the districts lack the necessary skills and expertise.

To effectively partner and coordinate with the private sector in health service delivery, the GoU enacted a national policy on public-private partnership in health. This framework, and the accompanying implementation guidelines, outlines the strategies that public and private sector stakeholders embrace in to achieve the goals of the health system. The MoH desires to increase access to health services by exploiting private sector geographical reach, efficiency, work ethic, financial mobilization expertise, personnel and physical facilities. A PPPH Coordination Unit that acts as secretariat and the coordinating arm of all resolutions from the PPPH TWG and HPAC that concern the public-private collaboration in health was established in the MoH.

Using mTRAC, mechanisms for client feedback / redress were established under the anonymous hotline (Service delivery complaints toll-free number for people to call or SMS to express opinions about health service-related issues, e.g. good service, HCs closed during working hours, stock-outs of essential medicines in facilities) and U-Report (U-Reporters participate in weekly SMS dialogue on community issues, are informed about services in their areas, and provide regular feedback on developmental issues). This has improved on accountability in service delivery.

2.10 Progress with financing for health

The NHP II framework asserts the provision of good health as a necessary condition for a productive population that contributes to economic growth and national development. The policy framework is to be attained through mobilizing sufficient financial resources to fund the health sector programmes while ensuring equity, efficiency, transparency and mutual accountability. The sector is addressing these policy issues by investing in a health system that:-

- Guarantees efficient use of available resources;
- Ensures universal access to a basic health care package; and
- Supports a strong and viable public-private partnership for health; and, an equitable and sustainable financing mechanism.

Healthier is wealthier. In addition to the fact that there is an intrinsic value of health and that health is a human right, the economic case for investing in health is robust. Good health is not only an outcome of, but also a foundation for, development. Healthy individuals are more productive, earn more, save more, invest more, consume more, and work longer, all of which have a positive impact on the GDP of a nation.

Health is an economic good and there is a need to explore a paradigm shift in financing, production and consumption of health services with a focus on making healthcare financing more accountable to the public, particularly in regards to inefficiencies and better utilization of public funds and resources. Therefore Investing in health is vital for sustainable economic and social development.

Better health also reduces the financial costs of health care for the family, the community, the private sector, and the government. There are several potential consequences for households related to the costs of health care. First, costs could be prohibitively expensive, which may mean that the individual has to forego treatment. Second, to pay for health care, households may sell productive assets or incur debt. Third, health care costs can have a catastrophic impact and push households into, or more deeply into, poverty.

These challenges are especially relevant in Uganda where; health expenditure per capita is below the WHO recommendation, share of the health sector as a proportion of the national budget of 6.4% is less than the Abuja target of 15%, and the availability of risk pooling mechanisms such as health insurance is not yet available. At

the macro level, societies as a whole benefit from healthy populations, which reduce the cost to companies and the government of health care provision, lost productivity, high turnover rates, and unemployment benefits.

Uganda's per capita spending on health was US$ 53 per capita in 2011/12 which is low compared to WHO recommended minimum level of 60 US$. In addition, the Total Health Expenditure (THE) as % of GDP is only 1.3%, against the target of 4%. The primary sources of health care financing are households (37%), donors (45%) and government (15%) - (NHA, 2013), while the private insurance constitutes a small proportion of THE. The 37% contributed by household is majorly out of pocket spending which is far above the recommended maximum of 20% Out of Pocket (OOP) expenditure by households recommended by WHO if the households are not to be pushed into impoverishment. Development partners contribute 45% of THE—most of it being off budget. The General Government Expenditure (GGE) on health was $9 per capita (NHA 2013) compared to the HSSIP target of $17 per capita and WHO Commission of Macro Economics on Health recommendation of $34. The Government Public financing is still below the WHO CME and HSSIP recommendations. The % of the total government budget allocated to the health sector reduced from 9.6% in 2009/2010 (AHSPR, 2013/14) to 8.7% in 2014/15 (National Budget 2014).

With financial management and procurement system, in the past five years, health service delivery was financed by the government, private sources and development assistance under the SWAps. Development assistance continues to play a major role in financing health services but a bigger proportion of this is off-budget. The MoH has information on general budget support and project support to the health sector but not sufficient information on off-budget support. Most of the funds from partners are directed towards the three disease areas; HIV/AIDS, TB, and Malaria. There still exist many donor 'projects' – bilateral, multilateral and global initiatives – which need to be integrated fully into strategic and operational planning and budgeting, even if the finances do not flow through the Ministry of Finance.

Procurement and disposal plans were developed as required, and the procurement process is improving with additional recruitment and capacity building in the Procurement Unit of MoH. Nevertheless, challenges remain:

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

Table 13: Financing trends 2003 – 2014

FY	GOU funding	Donor projects	Total	Per capita expenditure UGX	Per capita exp. In U$	GOU expend. on health as a % of total govt. exp.
2009/10	435.8	301.80	737.60	24,423	11.1	9.6
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.10	799.11	25,142	10.29	8.3
2012/13	630.77	221.43	852.2	23,756	9	7.8
2013/14	710.82	416.67	1127.48	32,214	12	8.7

Source: HSSIP 2010/11-2014/15, AHSPR 2013/14

2.11 Recommendations moving forward

Given the situation at the end of the HSSIP, there are a number of issues the sector needs to strategically focus on, in order to move towards achievement of the HSDP objectives and so play its role in the UHC attainment.

i) **A comprehensive package of essential health services.** As seen, many new / re-emerging health threats are constantly coming up such as NCDs and disease outbreaks. A focus only on a minimum package primarily providing communicable disease prevention and control interventions will mean the sector focus is not aligned with the changing needs on the ground. The essential package of services needs to address conditions of public health importance (either due to their burden, cost, and / or perceived importance) covering prevention, promotion, curative, rehabilitative and palliative services. Uganda already has an essential health care package of services, the UNMHCP. It will require revision to suit the parameters agreed following stakeholder consultations, and as appropriate reviewed periodically to ensure it is adapted to the changing country context and aspirations of Ugandans.

ii) **Further analysis of the district performance trends and provide more support to poorly performing districts using corrective measures** which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision.

iii) **More emphasis on neglected age cohorts, particularly the new-born, adolescents and elderly.** As seen in the burden of disease, there are still many conditions affecting these age cohorts that don't have effective interventions in place. The efforts at RMNCAH are beginning to bear fruits and so need to be scaled up further, while strategic interventions addressing these above-mentioned age cohorts are put in place.

iv) **Establishing comprehensive programs (with dedicated budgets) targeting the disease conditions with the highest rise in burden.** These include diabetes, self-harm, intimate partner violence, and road injuries, whose burden has increased by about 100% or more since 1990.

v) **Establishing comprehensive programs (with dedicated budgets) targeting the major risk factors contributing to the disease burden.** These include alcohol/drug abuse, household air pollution, childhood underweight (nutrition – already existing but needs better funding), iron deficiency, high blood pressure, sub optimal breastfeeding, dietary risks, occupational risks and smoking.

vi) **Long-term Commitment.** The success of UHC requires sustained commitment by political leadership. The right to health must be enshrined in the regulatory framework (Constitution) of the country. This is critical for actions taken at all levels and for citizen engagement.

vii) **Broad government wide buy-in** of the key sectors of the economy in assuring the attainment of health outcomes. This calls for the development and implementation of a multisectoral plan for health, Nation-wide consensus on reforms that might be crosscutting. The key sectors include: Finance, Planning and Economic Development; Education and Sports; Gender, Labour and Social Development; Local Government; Works and Transport; Water and Environment; and Energy, among others. The MoH will be responsible for providing stewardship, but other sectors as explained above are critical for UHC success by addressing the social determinants of health.

viii) **The comprehensive re-definition of the service delivery system from community to national level is needed**. This should provide guidance on expected structures, roles / responsibilities, functions, and Operating Procedures to operationalize these functions for each level of care. It will be important to ensure that services are organized around the needs and expectations of the population in terms of holistic long-term health to help them better understand their own health-care needs and properly integrated so that the population is able to receive a continuum of health promotion, disease prevention, diagnosis, treatment,

disease-management, rehabilitation and palliative care services, through the different levels of health services in the country. This will also require having in place an appropriate referral system.

ix) **Scale up efforts to attract, recruit, align skills with needs, and improve retention / motivation of health workers in a comprehensive manner**. A skilled and motivated health workforce in adequate numbers is critical for the realization of the vision of UHC. A focus on specific cadres (e.g. Medical Officers, midwives, nurses) or facility types (e.g. HC IVs) leads to imbalances, with key services being affected in the drive to improve other services. By having a comprehensive approach to addressing HRH challenges, this should be minimised.

x) **Holistic investment in health infrastructure with a focus on reducing existing inequities**. This should focus on reducing disparities in physical infrastructure, medical equipment including diagnostics, transport and ICT across districts, and ensuring availability, functionality and readiness of infrastructure in facilities of the same level. In line with this the Uganda Health Facility Atlas will be published and regularly updated using Geographic Information Systems to show spatial location of health facilities nationally and sub-nationally.

xi) **More efforts in improving capacity for health products management**. The investments in availability of products are not having the required effect due to disruptions in the supply chain and irrational use of products due to gaps in capacity for management of the health products at all levels of the health system.

xii) **Prioritisation of definition, and operationalization of a more comprehensive health information system.** The sector needs to have clear and comprehensive strategies for data generation, validation, analysis, dissemination and use addressing systems of routine HMIS, vital statistics (birth / death and cause of death information), disease surveillance, research, and health surveys. At present, there are still many gaps in these various systems. Coordination therefore should be strengthened at national and sub national levels for routine HIS, disease surveillance including processes for data collection and validation and Civil Registration and Vital Statistics (CRVS).

xiii) **Re-invigorating the partnership and coordination mechanism to ensure that better harmonization and alignment is being practiced**. The entire framework, and instruments need to be reviewed to ensure they are able to guide movement towards attainment of Aid Effectiveness indicators.

xiv) **Improved capacity for comprehensive costing, budgeting, financing and financial management is needed.** This is most acute at all levels of the health sector, where financing and financial management capacities are hindering the ability to effectively prioritise and budget funds and ensure value for money in funding identified priorities. Attention needs to be paid to raising sufficient funds, minimizing out of pocket payments through prepayment and pooling, and using all available funds efficiently and equitably. In addition, institutional arrangements related to financing and governance for health have to be clearly understood and requisite changes made in order to realize UHC.

xv) **M&E Plan for the HSDP.** As part of the HSDP implementation, the MoH will develop a M&E Plan with key indicators and targets to monitor overall sector performance.

3 THE STRATEGIC AGENDA

3.1 HSDP Mission, Goal and Objectives

The overall thrust of the health sector during this HSDP period has been elaborated in the NHP II and the NDP II. The NHP II defines the sector vision and mission guiding the HSDP.

HEALTH SECTOR VISION	HEALTH SECTOR MISSION
To have a healthy and productive population that contributes to economic growth and national development'.	***To facilitate the attainment of a good standard of health by all people of Uganda in order to promote a healthy and productive life.***

3.1.1 HSDP Goal

The HSDP goal is ***'To accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life'.***

UHC makes it possible to ensure that ***all people receive essential and good quality health services*** they need ***without suffering financial hardship***.

3.1.2 Specific Objectives

Focus will be on the four specific objectives as defined in the NDP II:

Specific Objective 1: To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.

Strategic Interventions

i) Health promotion across the life course (RMNCAH and elderly).
ii) Provision of Non Communicable Disease Prevention and Control services
iii) Provision of Communicable Disease Prevention and Control Services

Specific Objective 2: To address the key determinants of health.

Strategic Interventions

i) Strengthen intersectoral collaboration and partnerships for effective implementation of the following program areas;
   - Safe water
   - Environmental health and sanitation
   - Food and nutrition services
   - Environmental pollution control
   - Housing and urbanization
   - School health
   - Road safety
   - Veterinary services
   - Energy
   - Gender and human rights

Specific Objective 3: To increase financial risk protection of households against impoverishment due to health expenditures.

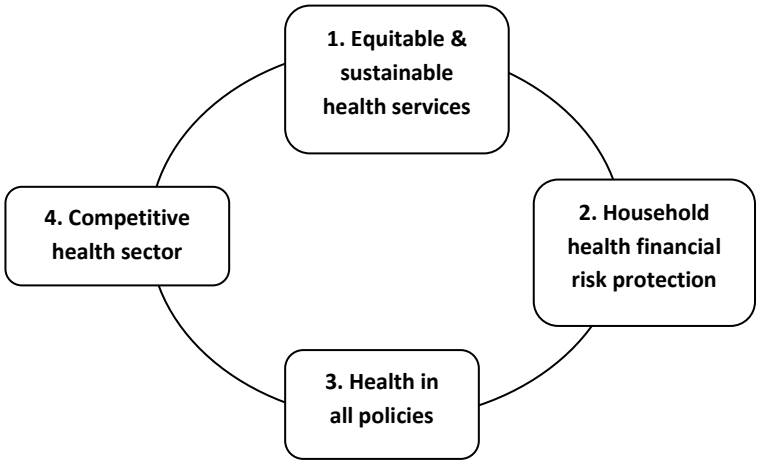
Strategic Interventions

i) Establishment of systems for revenue generation
ii) Establishment of systems for risk pooling
iii) Establishment of systems for strategic purchasing of services
iv) Improve financial and procurement management systems

Specific Objective 4: To enhance the health sector competitiveness in the region and globally.

i) Health Systems strengthening by addressing
    a. Health governance and partnerships
    b. Service delivery system
    c. Health information and technology
    d. Health financing
    e. Health products and technologies
    f. Health workforce
    g. Health infrastructure

Figure 6: Interrelationship of the Health Sector objectives for the HSDP



These objectives define the health sector focus, for it to contribute to the National Development Agenda. To achieve these, the health sector development priorities are defined around strengthening the national health system including governance; disease prevention, mitigation and control; health education and promotion, curative services; rehabilitation services; palliative services; and health infrastructure development. These will be achieved through attainment of strategic targets at the impact, outcome, process, and input levels.

3.2 Health Sector Key Performance Indicators and Targets

The health sector aims to ensure a maximum possible level and distribution of health is achieved. The key sector performance indicators and targets are shown in table 14 below.

The baseline targets for the impact indicators are drawn from the Human Development Report (World Bank and WHO, 2014) and these will be adjusted after the UDHS 2015 results are available. The annual targets were set based on computations that include the likely availability of funding, on how this can be translated into intervention access and coverage, and ultimately on health impact in addition to taking the international targets of UHC into consideration.

NB: Additional indicators will be required for programme and project management and these will be included in the programme and project specific M&E Plans.

Table 14: Health Sector Key Performance Indicators and Targets for the HSDP

Specific Objective	Key Result Area	Indicator	Baseline		Target 2019/20
To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.	**HEALTH IMPACT**				
	Health impact trends	Maternal Mortality Ratio (per 100,000)	438 (UDHS 2011)	360 (WHS 2014)	320
		Neonatal Mortality Rate (per 1,000)	26 (UDHS 2011)	23 (WHS 2014)	16
		Infant Mortality rate (per 1,000)	54 (UDHS 2011)	45 (WHS 2014)	44
		Under five mortality rate (per 1,000)	90 (UDHS 2011)	69 (WHS 2014)	51
		Total Fertility Rate	6.2 (UDHS 2011)		5.1
		Adolescent Pregnancy Rate	24% (UDHS 2011)		14%
	HEALTH & RELATED SERVICES OUTCOME TARGETS				
	Communicable disease prevention & control	ART Coverage	42% (HMIS 2013/14)		80%
		HIV+ women receiving ARVs for PMTCT during pregnancy & delivery	72% (HMIS 2013/14)		95%
		TB Case Detection Rate (all forms)	80% (HMIS 2013/14)		95%
		Intermittent Presumptive Treatment (IPT) 3 or more doses coverage for pregnant women	50% (HMIS 2013/14)		93%
		In patient malaria deaths per 100,000 persons per year	30 (HMIS 2013/14)		5
		Malaria cases per 1,000 persons per year	460 (HMIS 2013/14)		198
		Under-five Vitamin A second dose coverage	26.6% (HMIS 2013/14)		66%
		DPT3Hib3Heb3 coverage	93% (HMIS 2013/14)		97%
		Measles coverage under 1 year	87% (HMIS 2013/14)		95%
	Essential clinical and rehabilitative care	Bed occupancy rate (Hospitals & HC IVs)	59% (HMIS 2013/14)		90
			50% (HMIS 2013/14)		75
		Average length of stay (Hospitals & HC IVs)	Hospital 4 (HMIS 2013/14)		3
			HC IV 3 (HMIS 2013/14)		3
		Contraceptive Prevalence Rate	30% (UDHS 2011)		50%
		Couple years of protection	4,074,673 (HMIS 2013/14)		4.7 M
		ANC 4+ coverage	32.4% (HMIS 2013/14)		45%
		Health Facility deliveries	44.4% (HMIS 2013/14)		64%
		HC IVs offering CEmOC Services	37%		50%

Specific Objective	Key Result Area	Indicator	Baseline	Target 2019/20
			(HMIS 2013/14)	
	HEALTH SYSTEMS OUTPUT TARGETS			
	Health Infrastructure	New OPD utilization rate	1.0 (HMIS 2013/14)	1.5
		Hospital (inpatient) admissions per 100 population	6 (HMIS 2013/14)	10
		Population living within 5km of a health facility	75% (MoH Inventory)	85%
	Medicines and health supplies	Availability of a basket of commodities in the previous quarter (% of facilities that had over 95%)	To be determined	100%
	Improving quality of care	Facility based fresh still births (per 1,000 deliveries)	16 (HMIS 2013/14)	11
		Maternal deaths among 100,000 health facility deliveries	132 (HMIS 2013/14)	115
		Maternal death reviews conducted	33.3% (HMIS 2012/13)	65%
		Under five deaths among 1,000 under 5 admissions	17 (HMIS 2013/14)	16.1
		ART Retention rate	79.7% (HMIS 2013/14)	84%
		TB Treatment Success Rate	80% (2013 Cohort)	90%
	Responsiveness	Client satisfaction index	69% (USSP Survey 2014)	79%
	Human Resources	Approved posts in public facilities filled with qualified personnel	69% (AHSPR 2013/14)	80%
		Number of health workers (doctors, midwives, nurses) per 1,000 population	Doctors 1:24,725 (HSSIP MTR 2013)	1:23,500
			Midwives 1:11,000 (HSSIP MTR 2013)	1:9,500
			Nurses 1:18,000 (HSSIP MTR 2013)	1:17,000
To increase financial risk protection of households against impoverishment due to health expenditures.	Health Financing	Out of pocket health expenditure as a % of Total Health Expenditure	37% (NHA 2011/12)	30%
		General Government allocation for health as % of total government budget	8.7% (AHSPR 2013/14)	15%
To address the key determinants of health through strengthening intersectoral collaboration and partnerships.	Social and economic determinants of health	Children below 5 years who are stunted	33% (UDHS 2011)	29%
		Children below 5 years who are under weight	14% (UDHS 2011)	10%
	Health promotion & environmental health	Latrine coverage	73% (AHSPR 2013/14)	82%
		Villages/ wards with a functional VHT, by district	72% (AHSPR 2013/14)	85%

3.3 Specific Objective 1: To contribute to the production of a healthy human capital for wealth creation.

3.3.1 Health promotion across the life course (RMNCAH and Elderly)

This HSDP prioritises RMNCAH, in line with the Third Global Forum of 2013 and other global initiatives such as ***Every Woman, Every Child***, which focuses on improvement in women's and children's health outcomes; ***Family Planning 20/20 initiatives***—which aims at expanding access to family planning information, services, and supplies in the world's poorest countries.

With the increasing life expectancy and the number of elderly persons increasing there is need to improve the quality of life in old age by preventing and treating diseases and disabilities in older adults. This can be strengthened through health promotion and prevention policies, especially those directed to older people. The life course approach allows the sector to identify, and focus interventions needed at the different stages of life. The focus will be on prioritising high burden geographical areas and population groups with the highest disease burden for each cohort, with a focus on high impact interventions needed.

The program areas corresponding to the life cohorts and are:

- Reproductive, Maternal (15 - 49 years) and New-born Health (up to 28 days of life)
- Child Health (29 days – 5 years)
- School age and adolescent health (6 – 24 years)
- Adult health (25 – 59 years)
- Elderly health (over 60 years)

The program areas and key interventions for health promotion across the life course are shown in table 15.

Table 15: Program areas and key interventions for health promotion across the life course

Programs / service areas	Key interventions	Lowest Level of Provision[2]
Reproductive, Maternal and New-born Health	Provide comprehensive ANC services that include malaria prevention, HCT, eMTCT and nutrition supplementation.	2
	Provide standardized quality Basic Obstetric and New-born Care (BeMONC).	3
	Provide standardized quality Comprehensive Obstetric and New-born Care (CeMONC).	4
	Improve knowledge and skills of health workers in post abortion care.	3
	Provide required post natal care for mothers and new-borns .	3
	Implement the costed plan for family planning services at all levels of care.	2
	Empower male partners with knowledge about reproductive, maternal and newborn care services.	1
Child Health (29 days – 5 years of life)	Sustain universal coverage of available routine immunization services, with a focus on identifying high risk populations and hard to reach (exposed, or uncovered areas).	2
	Scale up and sustain effective coverage of a priority package of cost-effective preventive child survival interventions (breast feeding, cord care, Vitamin A supplementation, ORS-Zinc for diarrhoea, oral amoxicillin for	2

[2] *Levels of provision are: 1 = Community; 2 = Dispensary / Health Centre 2; 3 = Health Centre 3; 4 = primary hospitals (general / Health Centre IV); 5 = secondary hospitals (regional); 6 = tertiary hospitals (national)*

Programs / service areas	Key interventions	Lowest Level of Provision[2]
	pneumonia, de-worming, LLINs, HBB Plus, etc).	
	Promote ECD, Early stimulation and play at household and community levels.	1
	Promote Infant and Young child feeding practices.	1
	Strengthen Integrated Management of Childhood Illnesses (IMCI) interventions	2
	Ensure adequate capacity for provision of timely interventions required for child survival.	2
	Design and implement the Prevent, Protect and Treat (PPT) strategy for diarrhea and pneumonia as recommended by the Global Action Plan for Diarrhea and pneumonia.	MoH
	Scaling up Integrated Community Case Management (iCCM) to expansion districts including designing and implementing iCCM referral and using computer based training in iCCM.	3
School age and adolescent health (6 – 24 years of life)	Establish / functionalize adolescent friendly corners at all levels of care.	2
	Promote good nutrition, sexual and reproductive health education in schools and communities.	1
	Ensure all girls aged 9 to 13 years are vaccinated against Human Papilloma Virus.	2
Adult health (25 – 59 years of life)	Ensure universal access to all preventive, promotive, curative and rehabilitative services while ensuring quality.	3
Elderly health (over 60 years / post retirement)	Build capacity of health workers in elderly care / geriatric medicine.	4
Community ownership and demand creation	Social marketing to increase demand for life saving commodities especially in the private sector.	1
	Strengthen VHTs for community based reporting (feedback) of MPDR (including verbal autopsies.	1
	Collective action and mutual accountability for ending preventable maternal, newborn and child deaths.	1

3.3.2 NCD Prevention and Control

The increased contribution of NCDs to the Burden of Disease (BoD) is being recognized globally. In Uganda, emerging evidence from empirical studies estimates that NCDs account for 11-13% of our burden of disease. The health sector will therefore implement enhanced programmes for prevention and treatment of diseases of lifestyle, as well co-ordinated intersect oral interventions to reduce intentional and unintentional injury. The strategic approach will focus on containment of these conditions, through addressing the risk factors associated with them, and managing them where they arise.

The program areas aimed at achieving these targets are:

1. NCD prevention
2. Capacity building
3. NCD management

For each, the strategic outcome and key interventions are shown in table 16.

Table 16: Program areas and key interventions for NCDs control across the life course

Programs / service areas	Key interventions	Lowest Level of Provision
NCD Prevention and Control	Develop and implement communication strategies for NCD prevention and control and for MNS disorders.	MoH
	Institutional screening for NCD risks.	2
	Strengthen the regulatory framework - Develop and implement the Alcohol Control policy, Tobacco Control Policy, and the Drug Abuse Control Policy.	MoH
	Develop a NCD policy and guidelines on diet and physical activity.	MoH
Capacity building	Improve health worker skills to manage NCDs, management of common mental neurological and substance use disorders including rehabilitative healthcare workers at all levels of care including the community and households.	4
Management of common NCDs	Develop a NCD policy and guidelines on NCD management.	MoH
	Ensure availability of NCDs drugs.	3
	Ensure availability of basic equipment for screening, management and monitoring of NCDs.	2
	Ensure availability of rehabilitative appliances (orthopedic, visual and hearing devices)	5
	Establish functional surveillance, monitoring and research to support prevention and control of NCDs.	2
	Management of NCDs including conditions related with drug abuse and harmful use of alcohol at all levels of care	2
	Scale up services for management of NTDs (blinding diseases/conditions, hearing impairment and deafness, osteoarthritis, osteoporosis, muscle weaknesses, dementia).	5
	Conduct advocacy and communication for behaviour change aimed at injury prevention, eliminating gender and disparities that negatively impact public health and development.	1
	Provide Psychosocial interventions to people affected by violence, conflicts and disasters.	1

3.3.3 Communicable Disease Prevention and Control

The communicable diseases of major public health importance include: the top 20 causes of mortality (HIV/AIDS, malaria, LRIs, meningitis, TB, neonatal sepsis, diarrheal diseases, syphilis, and measles), plus major causes of public health concern (NTDs, emerging and re-emerging diseases, and conditions of epidemic potential).The strategic approach will focus on eradication (zero cases), elimination (no longer a public health concern) or control (reduction in burden) of these different communicable conditions as highlighted in the table 17.

Table 17: Strategic approach addressing different communicable conditions

CONDITIONS TARGETED FOR ERADICATION	CONDITIONS TARGETED FOR ELIMINATION

1. Polio 2. Guinea Worm Infestation	1. Mother to Child HIV transmission 2. Maternal and Neonatal Tetanus 3. Measles 4. Malaria 5. Leprosy

CONDITIONS TARGETED FOR CONTROL	
1. HIV/AIDS 2. Malaria 3. Tuberculosis 4. Syphilis 5. Meningitis 6. Viral haemorrhagic fevers (VHFs) and other epidemic diseases (Ebola Virus Disease, Marburg and others)	7. Diarrheal diseases including cholera 8. LRIs (Pneumococcal, Haemophilus) 9. Diphtheria 10. Pertussis 11. Hepatitis B 12. NTDs

The program areas under Communicable Disease Prevention and Control are:

- HIV/AIDS prevention and control
- Malaria prevention and control
- Tuberculosis and Leprosy prevention and control.
- NTD control and elimination (Lymphaticfilariasis, Onchorcerciasis, trachoma, soil transmitted helminths, jiggers, visceral Leishmaniasis, human African Trypanosomiasis, Buruli Ulcers, etc).
- EPI (Vaccine Preventable Diseases).
- Epidemic disease prevention and control including emerging and re-emerging diseases control (including Nodding syndrome, Hepatitis B).

The program areas and key interventions for communicable disease prevention and control are shown in table 18.

Table 18: Program areas and key interventions for communicable disease prevention and control

Programs / service areas	Key interventions	Lowest Level of Provision
HIV / AIDS prevention & control	Scale-up access to ART for all with CD4 count 500 cell/ul and below	3
	Test and treat children (<15 yrs.) and pregnant women, sero-discordant couples, and people with TB/HIV co-infection.	3
	Implement TB/HIV interventions to decrease the burden of HIV among patients with presumptive and diagnosed TB.	3
	Scale-up HIV prevention interventions: HCT, Safe male circumcision, targeted behavioural change communication for risk sexual behaviours, and condom availability and access.	1
	Manage STIs (syphilis, gonorrhoea and others).	2
Malaria and integrated vector management & control	Scale-up and sustain indoor residual spraying (IRS) in 50 malaria epidemic prone districts.	1
	Sustain universal access to LLINs.	1
	Build capacity for larval source management, including urban malaria control.	MoH
	Scale up of diagnosis and treatment of malaria cases at all levels of care including public, private and village levels.	1

Programs / service areas	Key interventions	Lowest Level of Provision
	Address community practices hindering correct malaria prevention and management .	1
Tuberculosis and Leprosy control and prevention	Early detection, treatment initiation and adherence in all diagnosed TB patients.	3
	Early detection and improve DR-TB patient management (including infection prevention, and home based care).	5
	Improve access to and utilization of quality laboratory network and radiology services for TB diagnosis.	3
	Empower patients, their families and communities in TB care through referral of presumptive TB patients to diagnostic facilities, supporting treatment adherence and conducting contract tracing.	1
	Scale-up implementation of the one-stop model for co-infected TB patients in ART accredited facilities.	3
	Ensure universal access to leprosy surveillance and management services in endemic districts, including medical and social rehabilitation.	1
NTD control	Mass deworming for schistosomiasis and soil transmitted helminths.	1
	Mass screening and prevalence assessments of NTDS (*Kalar Azar, Schistosomiasis, Drucunculosis, Leishmaniasis).*	1
	Mass treatment and rehabilitation for trachoma .	1
Vaccine Preventable Diseases control	Active surveillance for eradication of polio.	1
	New vaccines introductions ; • Inactivated Polio Vaccine • Rota virus vaccine introduction with 2 oral doses • Human papillomavirus vaccine introduction	2
	Strengthen routine immunization services with focus on low coverage districts, high drop out rates	
	Supplementary immunization activities for routine vaccines .	2
	Immunization against Hepatitis B.	2
Epidemic disease prevention & control	Surveillance and response to communicable conditions of epidemic importance including cholera, typhoid, Emerging Viral Diseases, etc.	1
	Build local capacity for managing emergencies and building resilience to major hazards.	1
	Ensure the attainment of the International Health Regulations 2005 core competencies.	2
	Cross border collaboration and community empowerment to emergency preparedness and response including refugees and other migrant and vulnerable population.	1

3.4 Specific Objective 2: To address the key determinants of health

The Health Sector will work with responsible MDAs, Private sector, CSOs DPs and the community, to target achievement of critical interventions needed to assure good health for productivity of the people of Uganda.

3.4.1 Strengthen intersectoral collaboration and partnerships

The program areas aimed at addressing the key determinants of health are:

- Safe water
- Food and Nutrition
- Environmental pollution and control
- Climate change and human health
- Housing and urbanization
- School health
- Road infrastructure and Transport
- Veterinary services
- Energy
- Gender and human rights

The program areas and key interventions to address the key determinants of health are shown in table 19.

Table 19: Strategic outcome and key interventions to address the key determinants of health

Programs / service areas	Key interventions	Lowest Level of Provision
Partnerships	Establish and monitor the functionality of a mechanism of inter-sectoral and inter-ministerial collaboration for engaging with health related sectors.	District
Safe water	Community sensitization on safe water use.	1
	Ensure water quality testing and surveillance	4
Environmental health and sanitation	Promote improved hygiene and sanitation at household level and in public places.	1
Food and Nutrition services	Create awareness at community level on right foods to eat for good nutrition status and promote their production.	1
	Screen for malnutrition in all age – groups and ensure appropriate care and rehabilitation for the identified individuals.	1
	Support growth promotion and monitoring in the first two years of life at community level.	1
Environmental Pollution control	Awareness creation on indoor air pollution prevention, proper liquid, solid and gaseous waste management.	2
Housing and urbanization	Enforcement of standards on housing.	District
	Develop urban health programs targeting slums and public places.	District
School health	Operationalise the School Health Strategic guidelines.	4
Road safety	Active involvement in road safety campaigns and interventions.	District
Veterinary services	Screening and management of zoonotic conditions.	4
Energy	Plan and advocate for provision of reliable power supply to health facilities.	District
Gender and Human Rights	Develop a Gender and Human Rights Policy and guidelines in health	MoH
	Sensitize communities to address gender disparities that make specific groups more vulnerable to certain disease conditions such as TB, HIV/AIDS, Malaria, Depression, alcohol and drug abuse, suicide, malnutrition, failure to immunise.	1

3.5 Specific Objective 3: To increase financial risk protection of households

Most Ugandans pay for their health care as direct OOP which is estimated at around 37% of Total Health Expenditure (THE). The health sector will work towards mobilising, and allocating resources to implement planned services in an efficient, effective and equitable manner. Given the importance of the health sector in the life of the country and the funds involved, it is imperative that health service organisation and agencies have financial processes that are efficient, modern, transparent, geared towards service provision and based on value for money principles.

The strategic outcome for HSA 4 and key interventions are shown in table 23.

Table 20: Service areas and key interventions for increasing financial risk protection of households

Program / Service areas	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
Establish revenue generation systems	Increase evidence-based advocacy for increased government revenue and donor/partner funding for health through sector-budget support.	National Health Accounts (NHA)	NHA of two Years back conducted	NHA of one Years back conducted	NHA of one Years back conducted
		Efficiency studies	-	1 study	2 studies
		Studies on Fiscal Space	-	1 study	2 studies
	Introduce pre-payment mechanisms for household's contribution to health.	NHIS established	NHIS Bill	NHIS implementation modalities developed	SHI Operational
	Formulate the required legislation, such as the NHI Bill.	NHI Bill. formulated	Draft NHIS bill	NHIS Act in place	NHIS operational
	Establish a National Health Insurance Authority.	NHIA established	0	NHIA	NHIA
	Establish high level coordinating mechanisms for health financing.	Uganda AIDS Trust Fund Board of Trustees established	0	UATF Board of Trustees	UATF Board of Trustees
		NHI Board	0	NHI Board	NHI Board
	Conduct resource mobilization based on national health strategic plans and priorities.	Investment Cases developed	HIV/AIDS Investment case, Malaria strategy, HSDP Investment case	Investment Case for RMNCAH	Invest Cases in Major causes in morbidity (other funding proposals)
Risk pooling	Study and establish modalities for the Joint Action Fund for pooling of government and partner funding.	Joint Action Fund established	-	Joint Action Fund	Joint Action Fund
	Establish a fund for social health insurance that incorporates formal and	Fund for social health insurance	Community and Private HI schemes	SHI operational with formal sector	SHI that incorporates formal and

Program / Service areas	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
	informal enrolments plus mechanisms for government support to the poor and indigent.			enrolments	informal enrolments.
Strategic purchasing	Institutionalize result based financing	RBF institutionalized	Draft HFS	RBF strategy developed and disseminated	RBF strategy rolled out
Financial management	Improve the capacity for budgeting, financing and procurement at all levels.	IFMS portal functional across users	IFMS portal installed	IFMS fully functional	IFMS fully functional
		Finance Committees functional	10% functionality	Fully functional	Fully functional
	Strengthen mechanisms for financial transparency and accountability to encourage higher sector budget support mechanisms.	Transparency and accountability mechanisms functional	Mechanisms in place	Full adherence to established mechanisms	Full adherence to established mechanisms
	Conduct comprehensive resource mapping of public and donor funds.	Resource Mapping Tool that includes Off budget Funding	Report of 100% Public & 30% Donor funds	Report of 100% Public & 60% Donor funds	Report of 100% Public & 80% Donor funds
	Review the resource allocation criteria and formula to ensure rational and equitable distribution.	Resource allocation criteria and formula reviewed & disseminated	4:2:1 allocation formula	Revised allocation formula used	Revised allocation formula used

3.6 Specific Objective 4: To enhance health sector competitiveness in the region and globally

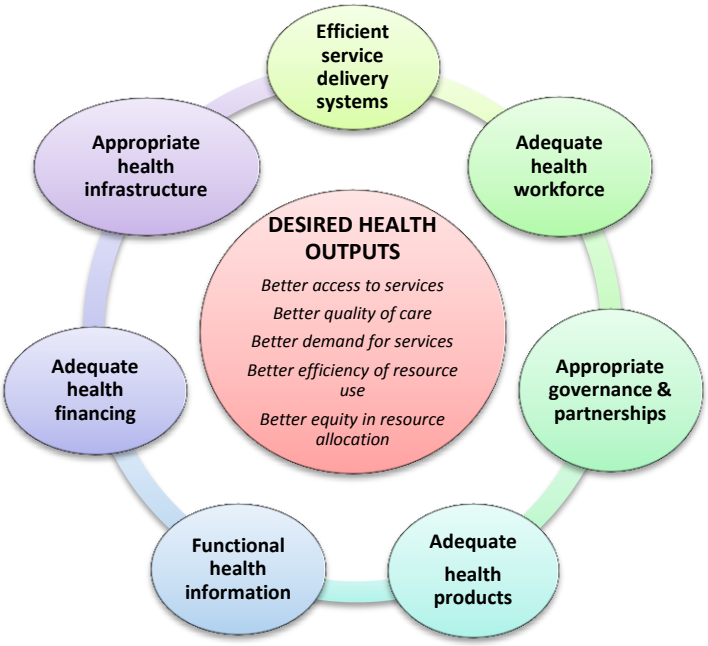
In order to enhance the health sector competitiveness in the region and globally, there is need to attain improvements in access to services, quality of care, demand for services, efficiency and equity in delivery of services as the key outputs from investments it is making. A health systems approach will be used to address the current challenges in health service delivery and leverage this to enhance the health sector competitiveness in the region and globally.

These Health Systems Areas are:

1. Health governance and partnerships
2. Service delivery systems
3. Health information
4. Health financing
5. Health products and technologies
6. Health workforce
7. Health infrastructure

These are all inter-connected, and work together to attain the desired sector outputs.

Figure 7: Health systems areas inter-relationships



3.6.1 Health governance and partnerships

Health governance is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public in order to protect the public interest" (WHO, 2008). Good governance is central to maximize the outputs and deliver services to the people of Uganda. Improvement in coordination and management of the delivery of health and health related services is therefore a key strategic deliverable. Governance will be provided through the governance, management and partnership structures at all levels. The existing partnership instrument – the compact – will serve as the formal instrument to guide the functioning of the partnership in health and is guided by the principles of the 2005 Paris Declaration on Aid Effectiveness.

Effective and sustainable partnerships are important for optimal health system functionality, to improve service coverage, access, quality, safety, and financial risk protection. Strengthening partnerships with MDAs; HDPs; the private sector, CSOs, and households will support holistic planning, implementation, M&E of strategic interventions in the HSDP. The SWAps will be used to ensure benefits over bilaterally- agreed support mechanisms between development partners and MoH, including: better coordination of activities, better and more participative decision-making, transfer of ownership to MoH, improving MoH leadership abilities, and improving government contracting and procurement mechanisms (to the extent they are used).

Appropriate legislation and its enforcement provide an enabling environment for operationalization of the policy and the HSSIP and are essential for an effective health service delivery system. The sector will work towards strengthening the capacity of the regulatory bodies to perform their responsibilities.

The health sector intends to have comprehensive governance and partnerships from community to national levels, ensuring appropriate voice, accountability, rule of law, control of corruption and involvement of stakeholders is effectively practiced and the health sector is globally recognized for excellence.

The sector intends to achieve the above by focusing on the following program areas:

- Appropriate governance and partnership structures
- Management & stewardship
- Public Private Partnerships and coordination
- Health legislation and regulation
- Knowledge translation of research findings and use of evidence based for decision making

The program areas and key interventions for governance and partnership are shown in table 19.

Table 21: Program areas and key interventions for governance and partnership

Program / Service area	Key Interventions	Measures of success			
		Milestone	Baseline	Midterm target	End term target
Governance and partnership structures	Review and strengthen functionality of health governance and management structures (Top Management, HPAC, SMC, TWGs, Boards).	Functional governance and management structures	Guidelines in place	50%	75%
	Revival of the Health Partnership Fund (PF) mechanism to support the SWAp processes including monitoring, joint reviews, TA, technical studies, capacity building	PF mechanism established	-	PF mechanism in place	PF mechanism in place
	Improve governance through streamlining / harmonising systems, PFM, accountability, procurement, assuring compliance and enforcement.	Improved and harmonized PFM	-	Mechanism established	Reputable PFM in place
	Develop a National Global	National Global	0	1	1

Program / Service area	Key Interventions	Measures of success			
		Milestone	Baseline	Midterm target	End term target
	Health Strategy.	Health strategy			
	Technical and other resource support is strategically planned and provided in a well-coordinated manner.	TA and other resources is well coordinated	NA	100%	100%
	Review, develop and disseminate client charters.	Client Charters (Key message) updated	MoH and 14 RRHs	MoH and 14 RRHs	MoH and 14 RRHs
			56 districts	85 districts	112 districts
	Promote and facilitate joint (involvement of DPs, CSOs and private sector) planning at all levels	Comprehensive annual sector plans developed	1	1	1
	Implement the NDP, NHP II, HSDP in line with the SWAps, the Compact and IHP+ framework and guidelines	Compact developed and signed and implementation monitored	Annual report on implementation of the compact	Annual report on implementation of the compact	Annual report on implementation of the compact
		GoU and DPs participation in the IHP+ assessments	2014 assessment	2016 assessment	2018 assessment
	Taking Joint Actions on Regional Health Priorities in line with the EAC strategic plan 2015-2020 especially on cross border health challenges.	Resolutions with actions taken	NA	100%	100%
Management & Stewardship	Capacity building of DHMTs, DHTs, HUMCs	Functionality of DHMTs, DHTs, HUMCs	50%	80%	85%
		Mid-level managers trained in leadership and management	90	180	300
		Guidelines for district management structures developed & disseminated	0	Guidelines developed	Disseminated to all districts
	Establishment of Uganda National Hospital Authority (UNHA)	UNHSA established	-	-	Bill developed
	Improve accountability at community level through Constituency (HSD) Health Assemblies	Constituency (HSD) Health Assemblies held at least twice a year	-	All HSDs	All HSDs
Public Private Partnerships	Introduction of the Medical Credit Fund in Uganda Operationalize the PPPH Policy to all districts	Allocated funds disbursed	NA	100%	100%
		PPPH functional	Policy developed	Guidelines disseminated in all districts	PPPH policy operationalized in at all levels

Program / Service area	Key Interventions	Measures of success			
		Milestone	Baseline	Midterm target	End term target
	Develop PPP advocacy strategy both internal and external to MoH	PPP advocacy strategy developed	0	1	1
Health legislation & regulation	Develop a national accreditation system	Accreditation system developed	-	Institutional accreditation system developed	Accreditation of hospitals
	Regulatory bodies and legal frameworks strengthened & functional	Regulatory bodies strengthened / functional	-	National Drug and Food Authority Established	-
			-	-	HPA established
Knowledge translation and use for decision making	Develop a comprehensive knowledge management framework for Uganda.	Knowledge management framework developed	0	1	Health research publications shared with decision makers
	Support the solidarity, partnership, knowledge exchange and identification of leadership and opportunities of cities through the strengthening of Healthy Municipalities / Cities Networks in the East African Region.	Regional meetings held / attended	NA	2	4

3.6.2 Service Delivery Systems

Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources. The sector aims at improving the service organize, management capacity, patient transport and communication, basic emergency infrastructure, supplies and equipments, finance and human resources and referral systems. With the development of new technologies, treatment and management plans, availability of new evidence and the changing needs of service users, the health sector needs to adapt to these changes in a managed way. Over the last five years, new services have been introduced and a number of these essential services will be rolled down to lower level units.

For universal access, the HSDP prioritises functionalizing health facilities as defined in the MoH Service Standards, to ensure that clinical, rehabilitative and palliative care services are available at all levels of health care delivery. Deliberate efforts will be made to strengthen service delivery in the newly created districts in terms of infrastructure development, equipping and staffing. In order to address the service gap between HC IV and

GHs, the HSDP will introduce and operationalize the concept of a 60-bed community hospital. The range of services and staffing requirement for the community hospital will be determined in future in the revised Essential Health Care package. The HSDP has prioritised Emergency Medical Services / ambulance services as key intervention areas for introduction and scale up. To ensure delivery of quality services, up to date guidelines and Standard Operating Procedures (SOPs) must be available and easily accessible in addition for a functional supervisory system and referral system.

There is strong emphasis on health promotion, underlined by the introduction of "Alert Villages" and "model homes" through the Community Health Extension Workers (CHEW) Program.

The sector intends to achieve this by focusing on the following service areas:

1. Essential health service package
2. Referral system / Ambulance Service
3. Community health services
4. Supervision and Quality of care
5. Specialized services

The program areas and key interventions for service delivery systems are shown in table 21.

Table 22: Program areas and key interventions for service delivery systems

Program / Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
Essential health service package	Review and roll out the health service essential care package by level of care.	Revised EHS Package rolled out to all health levels	0	50%	100%
	Implement the essential health services package	Essential health service package implemented	All levels	All levels	All levels
	Develop a project to support new districts in terms of infrastructure development, equipment and staffing	Project to strengthen new districts established	-	Project funding identified	Project implementation initiated
	Strengthen Consultant technical outreaches and mentorship to General Hospitals and HC IVs	Consultant Technical outreaches and mentorship conducted to GHs and HC IVs	-	All GHs and HC IVs	All GHs and HC IVs
Laboratory services	Strengthen laboratory services at all levels to provide basic, complementary, referral and specialist laboratory services	Laboratory services strengthened	Laboratory Quality Management System in hospitals Regional TB Reference Lab. established	National Public Health Laboratory Services established	
Imaging services	Improve basic non-invasive radiology services (Ultra sound	Basic non invasive radiology services available at all	60%	80%	95%

Program / Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
	scan, X-ray), basic Invasive radiology services (Endoscopy, laparoscopy)	hospitals			
	Improve advanced non-invasive radiology services (Computerized Tomography Scan, Magnetic Resonance Imaging, EEG) and advanced invasive radiology services (angiography, Radio-isotope scanning)	Advances non-invasive radiology services available in Referral hospitals	1%	20%	30%
Specialized therapy / care	Strengthen specialized services delivery e.g. Cardiovascular diseases, Diabetes, ENT, Ophthalmic care, optics, oral surgery and care, geriatrics, endocrine and metabolic disorders, genetic disorders, haematology, skin, neurological conditions, etc)	Specialist hospital constructed	UCI UHI	1	2
	Establishment of other institutes / Centers of Excellence	National TB Reference Laboratory	-	Oncology and diagnostic Centres	-
Referral system / Ambulance Service	Operationalize the National Ambulance Service	National Ambulance Service operationalized	Draft National Ambulance Policy and structural framework	Ambulance Service for Kampala Metropolitan Area	National roll-out
	Operationalize the referral framework from community to national levels.	Revised referral framework operationalized	0	1	1
Community services	Finalize and disseminate the CHEW policy and strategy	CHEW policy and strategy disseminated	Draft	CHEW policy and strategy disseminated	
	Establishment of CHEW Program in 7,500 parishes in the Country	CHEWs trained	0	6,000 CHEWs trained	15,000 CHEWs trained
		CHEWs functional	0	3,000 parishes	7,500 parishes
	Promotion of model households / families through the VHTs	Model households certified		100,000 model households certified	300,000 model households certified
	Provision of integrated	All LLUs	NA	100%	100%

Program / Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
	routine outreaches that cover all key RMNCAH services	conducting integrated outreaches			
	Engage and mobilize communities to actively participate in maintaining good health and adopt positive health practices	Radio programs	0	36	72
Supervision and Quality of care	Finalize and disseminate the supervision, monitoring and inspection strategy	SMI strategy disseminated	Draft strategy	SMI strategy disseminated	100%
	Strengthen Supervision, monitoring and inspection at all levels	SMI guidelines and tools developed and disseminated	Concept note developed	SMI guidelines and tools disseminated	
		DHTs trained in supervision skills	-	50%	75%
		Districts conducting quarterly support supervision of LLHFs	30%	60%	100%
		Private clinics inspected and licensed	50%	75%	100%
	Institutionalization of a regional supervisory structure	Regional Supervisory Structure institutionalized	RPMTs under GF support	Institutionalization process initiated	Regional Structure Institutionalized
	Review, develop and disseminate standards and guidelines and SOPs for quality service delivery.	Assorted Standards, guidelines & SOPs reviewed/ developed & disseminated	QI Manual IPC PCC Governance	SDS S/S Patient Safety Public Health Standards	Assorted standards and guidelines
	Roll out of the Health Facility Quality of Care Assessment Program to all districts and use findings to implement QI Projects.	Health facilities attaining at least 75% score under the facility assessment	0%	20%	30%
	Institutionalise QI systems in private and public facilities including standards based case management	Functional district QITs	40% (45 districts)	58% (65 districts)	68% (85 districts)
		Hospitals and HC IVs with functional QITs	75%	85%	90%
	Strengthen dynamic interaction and feedback mechanisms between health care providers	Districts with a functional feedback mechanism	10%	30%	50%

Program / Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
	and consumers				

3.6.3 Health Information

A comprehensive knowledge management approach is needed in the sector. The health sector will continue building a harmonized and coordinated national health information system with the Resource Centre as national custodian in order to generate data for decision making, programme development, resources allocation and management at all levels and among all stakeholders. During the HSDP period special focus will be on establishing a functional Community Information System, including vital statistics in collaboration with UBOS. The use of innovative e-health technologies will be applied in all aspects of the health information system.

The sector intends to achieve this by focusing on the following program areas:

- Routine HMIS
- Surveillance
- Vital statistics
- Research
- Health surveys
- Innovative e-health solutions

The program areas and key interventions for health information are shown in table 22.

Table 23: Strategic outcome and key interventions for health information

Program / Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
Routine HMIS	Develop a National Health Information System Framework (NHISF) to create a reliable and accessible environment for managing health data.	NHISF developed	0	1	1
	Develop and scale up e-HMIS to incorporate the community HMIS and private service providers	e-HMIS scaled up to community and private service providers	DHIS 2 at district and hospital level	DHIS 2 extended to HSD level mTRAC integrated with national platforms	e-HMIS rolled up to community
	Strengthen the HR capacity of the RC to effectively manage the design, development and roll-out of HMIS tools and all related e-Health Solutions and Information Services.	HR capacity of RC strengthened	0	1	1
Surveillance	Transform the current epidemiological and surveillance infrastructure into a National Public Health Agency with an EOC and effective laboratory capacity.	National Public Health Agency established	0	National Health Surveillance and Response system established	1
Vital statistics	Improve operational capacity for birth and death registration in collaboration with Uganda Registration	Births and deaths registered	5%	20%	50%

Program / Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
	Services Bureau.				
Health Research	Develop a knowledge translation framework to evaluate and manage research findings	Knowledge translation and evaluation framework established	NA	1	1
	Strengthen national research organizations and institutes for enhanced innovations and inventions on health products and technologies	Research organizations and institutes strengthened	0	2	5
	Conduct operational research (for priority interventions (e.g. RMNCAH, HIV/AIDS, HSD Concept, etc) to inform the HSDP review process	Operational research conducted	-	4	8
Health surveys	Conduct surveys for in depth information on the health system and impact trends for targeted diseases and conditions.	Surveys conducted	MIC	AIS SARA	NCDs SARA
Innovative e-health solutions	Finalize the e-Health Policy and Strategy	e-Health strategy finalized	0	e-Health policy and strategy disseminated to all districts	Operationalization of e-Health strategy

3.6.4 Health Products and Technologies

The sector intends to contribute to the attainment of the highest standard of health for the population of Uganda by ensuring the availability, accessibility, affordability and appropriate use of essential medicines of appropriate quality, safety and efficacy at all times.

The sector intends to achieve this by focusing on the following program areas:

- Regulation and quality assurance of health products
- Production of health products and supplies
- Procurement of health products
- Warehousing & distribution of health products
- Rational use of health products

The program areas and key interventions for health products and technologies are shown in table 24.

Table 24: Program areas and key interventions for health products and technologies

Program / Service area	Key Interventions	Measures of success			
		Milestone	Baseline target	Midterm target	End term target
Regulation and quality assurance of health products	Review and strengthen policy and regulatory framework for quality assurance of medical products, health technologies and food safety	National Food and Medicines Authority Policy	0	1	1
	Strengthen post-marketing surveillance and pharmacovigilance for medicines and health supplies	Sampled pharmaceutical products failing NDA quality tests	4% (2013/2014)	<1%	<1%
Production of health products	Promote local production and procurement of domestically produced essential medicines of good quality and competitive price	Local production and procurement of domestically produced medicines (financial value) to overall market of essential medicines[3]	10%	30%	50%
Procurement	Develop capacity of health facility staff to quantify and forecast medicines and health supplies needs	Hospitals and HC IVs making reliable procurement plans	10%	50%	80%
	Procure sufficient amounts of medicines and health supplies including laboratory commodities	Availability of a basket of 41 commodities[4] based on all reporting facilities in the previous quarter	63.8%[5] (2014/2015)	85%	90%
Warehousing and distribution	Improve the national Logistics Management and Information System	Hospitals and HC IVs reporting using electronic LMIS	0%	50%	85%
	Improve the infrastructure for storage at the central and	Pallet locations[6]	10,500	34,500	40,500
		Cold chain storage	307	560	811

3 Medicines will be defined according to the range of products manufactured domestically
4 Baskets of 41 commodities - there are 5 baskets under the following categories Essential Medicines and Health Supplies (15 medicines); ARV (8 medicines); TB (2 medicines); LAB (7 health supplies and diagnostics); and RMNCH- 9 Medicines
5 Current statistics for stock out indicator for the six tracer medicines 2014/2015- Baseline for 41 items TBD
6 Pallet location - measure of warehouse space in terms of number of pallets

Program / Service area	Key Interventions	Measures of success			
		Milestone	Baseline target	Midterm target	End term target
	peripheral levels	Cubic metres			
	Strengthen systems for distribution	Average lead time from ordering to delivery at the facilities	39 days	<60 days	<60 days
Rational use	Monitor and support adherence to treatment and dispensing guidelines	Adherence to treatment and dispensing guidelines monitored and supported	Quarterly reports	Quarterly reports	Quarterly reports
	Regularly update treatment and dispensing guidelines and essential medicines list	Updated UCG & EMHSLU	UCG 2012	UCG 2016	UCG 2019
	Strengthen Medicines and Therapeutic Committees (MTCs) in hospitals	Functional hospitals (public and PNFP) MTCs (hold bimonthly meetings)	NA	50%	75%

3.6.5 Health Workforce

In order to respond adequately to future health service needs and demands, the workforce will grow at annual rate of 5% to at least 80% of the current staffing norm by midterm, prioritising critical cadres. At mid-term, the structure of the whole health workforce will be reviewed. It is assumed that no community hospital will be constructed during the first 3 years. At mid-term, the structure of the health workforce will be reviewed. The HSDP prioritizes issues of health worker motivation and accountability.

The sector intends to achieve this by focusing on the following service areas:

- Enhance effectiveness and efficiency in Health Workforce development
- Improve equity in distribution and utilization of health workers
- Improve health workforce performance at all levels
- Strengthen Public Private Partnership in development and utilization of the health workforce
- Establish supportive HRH policy and work environment
- Strengthen capacity for HRH recruitment

The program areas and key interventions for health workforce are shown in table 25.

Table 25: Program areas and key interventions for health workforce

Objective	Key Interventions	Milestones	Measures of success		
			Baseline	Midterm target	End term target
Enhance effectiveness and efficiency in development of the Health Workforce	Support the scaling up of production of priority health professionals and super specialized cadres (Cardiology, Oncology, Neurologists, Plastic Surgeons, Nephrology, Diagnostics).	Annual number of graduates, per cadre and health education institution (Midwives, Anesthetic officers, Lab, Pharmacy technicians)	Midwives = 1,954	3,118	4,141
			Pharmacy Technicians = 55	55	163
			Anesthetic officers = 26	47	53
			Theatre Assistants = 15	57	78
			Lab = 1,699	2,542	2,702
			Environmental Health= 185	387	417
			Doctors = 250	250	434
			Public health nurse	20	40
			Biomedical technicians	100	120
			Ambulance Officers = 0	200	500
			Clinical psychologists = 30	120	240
		Annual intake of trainees per health training institution and cadre (for priority cadres- Midwives, Anesthetic officers, Lab, Pharmacy technicians)	Midwives = 3,681	4,281	4,681
			Pharm. Tech = 144	234	294
			Anesthetic officers = 40	60	80
			Theatre Assistants = 35	100	200
			Lab = 2,462	2,702	2,862
			Environ. Health = 210	236	236
			Doctors = 364	484	534
			Public health nurse	61	61
			Biomedical technicians	120	120

Objective	Key Interventions	Milestones	Measures of success		
			Baseline	Midterm target	End term target
		Super specialists trained	NA	10	20
	Work with MoES to review and harmonise education standards and monitoring tools for both public and private health Training Institutions	Harmonized education standards and monitoring tools	0	1	1
	Streamline and design mechanisms for coordinating and expanding access to CPD programmes	Mechanism in place	0	1 (IST Section at HRDD / MoH & HMDC)	1
Improve equity in distribution and utilization of health workers	Restructure the whole health workforce (norms and skill mix) to conform to the revised Expected Standard of Practice	Approved positions for qualified health workers in public sector	58,501	To be reviewed	TBD
	Design strategies for attracting and retaining health workers	Health worker-population ratio	1.55 per 1,000	2 per 1,000	2.2 per 1,000
Improve health workforce performance at all levels	Institutionalize individual performance planning, monitoring and appraisal for health workers at all health facilities and national institutions	Districts with the revised PM guidelines and tools	0	30%	50%
		Health facilities and institutions conducting individual performance planning, monitoring and appraisal	NA	50%	65%
	Strengthen strategies for Rewards and Sanctions of health worker performance	Functional rewards and sanctions committees	NA	40%	60%
	Design and implement strategies for monitoring and reducing absenteeism at health facilities	Health facilities using effective monitoring mechanisms e.g. sms, attendance registers, clock in	NA	39%	50%
	Performance management training for health managers	Health managers trained in performance management	100	250	500
Strengthen Public Private Partnership in	Enhance the capacity of private health training institutions to produce	Mechanism for providing targeted logistical support to	2	5	10

Objective	Key Interventions	Milestones	Measures of success		
			Baseline	Midterm target	End term target
developing the health workforce	priority health cadres	private TIs to produce priority cadres			
Establish supportive HRH policies and work environment	Initiate and support policy development on recruiting and seconding HW to PNFP facilities at the district level	Policy developed	0	1	-
	Initiate and support policy development on recentralising the management of all DHOs and ADHOs	Policy on recentralizing DHOs and ADHOs developed	0	1	-
	Provision of appropriate Personal Protective Equipment (PPE) for all HWs including uniforms	PPE provided	Uniforms for nurses and midwives provided	Uniforms for all HWs provided	Uniforms for all HWs provided
Strengthen capacity for recruitment of HRH	Development of a resource centre and information management system for the Health Service Commission (HSC)	Functional information management system	-	1	1
	Construction of office space for the HSC	Office space for HSC	-	1	1

3.6.6 Health Infrastructure

Health Infrastructure comprises buildings - both medical & non-medical; Equipment - medical equipment, furniture and hospital plant; Communications (ICT equipment); and Ambulatory systems (ambulances, cars. pickups, vans, trucks, etc as required for healthcare delivery at different levels). While new facilities will be constructed and equipped during the implementation of the HSDP priority will be given to consolidation of existing facilities, to provide facilities for them to function effectively (e.g. staff housing, water and energy, theatres, equipment, stores etc) and required ICT and related infrastructure. The consolidation of facilities will also include the upgrading of facilities to higher level facilities specifically; the sector will aim at functionalising HC IIIs in all sub-counties and piloting the establishment of Community Hospitals. In addition the sector will build capacity and mobilize resources for operation and maintenance of medical equipment and infrastructure.

The sector intends to achieve this by focusing on the following service areas:

- Health Infrastructure development and rehabilitation
- Medical Equipment
- Maintenance

The program areas and key interventions for health infrastructure are shown in table 26.

Table 26: Program areas and key interventions for health infrastructure

Service area	Key Interventions	Milestones	Measures of success		
			Baseline	Midterm target	End term target
Development & Rehabilitation	Renovate and consolidate the existing health infrastructure for effective service delivery.	Mulago Hospital rehabilitated & upgraded	30%	100%	100%
		Mbarara Hospital rehabilitated and upgraded	50%	75%	100%
		GHs fully rehabilitated	2	20	31
		RRHs fully rehabilitated	0	5	8
		Number of new hospitals constructed (Kawempe, Kiruddu, Rubaga, KCCA Central Division)	2	3	4
	Develop and upgrade health infrastructure based on need to promote equitable access to quality health care.	HC IIIs established or HC IIs upgraded to HC III	0	150	317
		HC IV upgraded to Community Hospital	0	15	35
		RRH and GHs along highways with Accident & Emergency Units	5	17	22
		RRH with ICU	3	8	13
		Regions with Regional Blood Banks	3	8	13
		Staff houses	0	2,500	5,000

Service area	Key Interventions	Milestones	Measures of success		
			Baseline	Midterm target	End term target
		constructed			
		Oxygen / medical gas plants established at RR Hospitals	0	6	13
		Centre of excellence with established homes	0.5 Cancer Institute	2 UCI & UHI	3 Renal Services Institute
	Completion of unfinished health facilities	HC IVs fully consolidated	0	80	169
Medical Equipment	Procure, distribute and maintain appropriate medical equipment at all levels of health service delivery.	Health facilities equipped	60%	75%	85%
		Centres of Excellence and National Referral Hospitals equipped	30% Mulago, 0% for Gulu & Mbarara, 20% UHI and 20% UCI	50% Mulago, 0% for Gulu & Mbarara, 40% UHI and 40% UCI	70% Mulago, 30% for Gulu & Mbarara, 50% UHI and 50% UCI
	Procure, distribute and maintain appropriate means of transport at all levels based on need.	Hospitals and HC IVs with functional multipurpose vehicles	10%	50%	100%
Build capacity for operation and maintenance of medical equipment and infrastructure	Training of Biomedical Engineers	Biomedical Engineers trained	0	15	32
	Construction of Workshops in RRHs	Maintenance workshops constructed	5	8	13
	Conduct user training	Number of health workers who received user training	16 National Trainers	150 users	250 users
	Establishment of a National Medical Equipment Maintenance Service	National Medical Equipment maintenance Service established	0	Policies and guidelines developed	Service established
Waste management engineering	Provision of efficient, safe & environmentally friendly health care waste management facilities	Regional Specialized Healthcare waste management centres established	1 Eastern Uganda	2	2

4 FINANCING OF THE HSDP

The sector Health Financing strategy 2015/16 - 2024/25, has a detailed health financing model that best fits Uganda's Health Sector Aspirations. The overall goal of the health financing reform strategy is to facilitate attainment of UHC through making available the required resources for delivery of the essential package of services in an efficient and equitable manner.

Uganda's health financing policies are premised on key international covenants and broad government frameworks provided by the Constitution, political commitments and National Development plans and the health sector strategic plans. These frameworks assert the provision of good health as a necessary condition for a productive population that contributes to economic growth and national development. The sector is expected to address the current health challenges by ensuring a strong health system that;

1) Guarantees efficient use of available resources
2) Ensures universal access to a minimum health care package
3) Supports a strong and viable public-private partnership for health; and, an equitable and sustainable financing mechanism.

Evidence shows that, enforcement of the public finance and accountability regulations, fiscal decentralization, SWAp, introduction of the UNMHCP, centralization of medicines and health supplies procurement, PHC Grant to PNFP health facilities, improved partnership with the private sector, direct transfers of PHC grants to health facility accounts, abolition of user fees in public health facilities, introduction of Output budgeting and reporting tool has facilitated improvements in health service delivery over the last 15 years. The primary motivation of the financing reforms is to transform the financing mechanism from an input focus to a results oriented thus improving decision making and accountability.

4.1 Health Financing Mechanisms

Funds for health care are derived from: 1) general tax revenues; 2) Development Partner contributions; 3) health insurance (private and social health insurance); 4) OOP / direct payment by patients; and, 5) community financing and 6) Global Health financing initiatives. A combination of all mechanisms is used by the Government. Ability to mobilize general revenues depends on the level of economic development—associated with per capita income which determines ability to demand and pay for services; fiscal capacity—the level of taxable economic activities; and, administrative capacity.

The size of the formal sector determines how much can easily be raised for social health insurance—the larger, the better. Private insurance can only mobilize funds from those who can pay and are willing to be insured. Community financing can raise revenues from small farmers and the informal sector. Direct OOP funds play a big role in financing health even in countries with extensive tax-funded public health services however, this can be catastrophic if there are no pre-payment arrangements. The DPs contribution to the health sector is substantial and any pull out may massively affect health service delivery and distort the health financing systems.

4.1.1 Key Health financing features

The resource tracking studies provide evidence to monitor trends in health spending for all sectors- public and private, different health care activities, providers, diseases, population groups and regions in a country. The National Health Accounts (NHA) provides evidence for developing national strategies for effective health financing and raising additional funds for health. Evidence from all the four NHA rounds show that the primary sources of health care financing are households, donors and government and that private insurance constitutes a small proportion of THE. Public financing mainly through taxation is the dominant prepayment financing in the

country. The outstanding short coming with the current mode of health financing is the high OOP of 37% is deemed catastrophic (pushing households into poverty).

Estimating the cost of delivering future services encompasses a certain level of uncertainty as overall cost of provision of services depends on both clients and providers' behaviours, government strategic focus which themselves are affected by policy options, and derived incentives. A health strategy with a strong focus on families, the poor, vulnerable communities and community based interventions with a strong prevention component is cheaper than a strategy that focuses on high technology. It is therefore not always accurate to infer future costs from current funding in the health sector.

However, current expenditure per capita is US$ 53 on health from all sources and Government spends US$ 13 per capita on health. With an average of 5% inflation annually cost projections can be extrapolated for the 10 years. It is a conservative cost estimate based on a number of assumptions and calculated only for the public network, composed of government and selected PNFPs. Using the health systems building blocks, this cost may be shared as follows based on the NHA report;

1. Leadership and Governance **17%** (reviews, regulations, oversight, evaluations, capacity building networking and collaboration, communication, M&E, office supplies, logistics, maintenance, stewardship, supervision
2. Human Resources for Health 30**%** (remuneration and extra allowances).
3. Health Financing **3.5%** (reviews, financing mechanisms, SHI, Studies, research, PER).
4. Medical Products, Vaccines and Technologies **12%** (EMHS, EPI, RH, CH, HIV/AIDs, LLINs, Lab Reagents/supplies, Vaccines, safe blood).
5. Strategic information **3.5%** (Development of HMIS and maintenance, printing, capacity building, surveys, ICT).
6. Improve Access to quality and Equitable Services **34%** (buildings, equipments, non medical and medical, ambulance, maintenance, ISC).

4.1.2 Principles for financial sustainability

- Strong leadership, vision, and regulatory framework to foster short- and long-term sustainability.
- Independent controls and quality checks essential for M&E of health facility performance to ensure efficiency.
- Cultural and social factors, particularly solidarity within communities is emphasized.
- Key reforms including provisions for financial protection and other support for indigent populations is one of the key interventions.
- Aid coordination and harmonization is critical to ensure aid is used effectively and aligned with national priorities.
- The ability of the sector to adapt strategies, in light of the changing macro- and health sector environment has been provided for in the 10 year HFS.

4.2 Costing the HSDP

The MoH in collaboration with stakeholders in the health sector undertook the costing of the Plan to determine the resources needed to achieve the above objectives. This was done a through a consultative process with a wide range of key players.

4.2.1 Methodology

The costing of the Plan was undertaken using the One Health Tool (OHT). This is a tool for medium term strategic health planning (3 -10 yrs) at national level. It is used to support costing, budgeting, impact financial

space analysis, and disease and health systems programming in the development of strategies for the Health Sector. The OHT runs under software that incorporates among others epidemiology impact models to demonstrate the achievable health gains; with LiST, Goals AIMS, TB Estimate & Impact tools.

The tool has in-built modular interfaces; the costing and modeling interfaces. The costing interface allows costing for two major areas: health services; and the health systems. The health services cover the disease programs such as the RMNCAH, HIV/AIDs, Tuberculosis, Malaria, NCDs, Environmental Health, Mental neurological and substance abuse disorders, etc. The health systems cover the health platforms necessary to facilitate the provision of health services. These include the health infrastructure, HRH, Governance, health financing, logistics management the Health information systems, etc.

The health services module was configured to determine costs within each program. The costing of the health services of the HDSP was undertaken using the program mode. The program mode permitted investments inputs to be captured by delivery channel for each program. Therefore the investments for the various disease program could be derived at the various levels of service delivery.

4.2.2 The Costing Approach

The costing approach used the ingredients approach. This approach identified the inputs necessary for an activity or service, the quantities of the inputs and the unit costs for each input are imputed to the inputs and a total cost for the input is determined according to the equation:

$$\textbf{\textit{Cost of services}} = \text{Number of service } X \text{ } \textbf{\textit{Unit cost of the service}}$$

Where the number of services required in the tool are determined using the formula:

$$\textbf{\textit{Number of services} = \textit{Target population X Population in need X Coverage}}$$

The planning aspect of the tool requires the process to be driven by evidence based programming, explicit analysis of the current health system, and what can realistically be achieved in the short, medium and long term. This process called for progressive integration of the disease specific plans, costs and the funding mechanism. Any resources constraints envisaged in the planning process called for prioritization of interventions so as to yield given set of health outputs. In addition the model was used to estimate the likely effects of any changes in the planned interventions coverage with any changes in the resources available. Bottlenecks identified would mitigated with implementation of proposed strategies.

4.2.3 Data and assumptions

a) Unit costs:
   These were derived through a concerted process that included: review of relevant literature on program expenditures from MoH, key implementing partners, costing studies and reports, as well as consultations with key implementing agencies.
   - Medicines and Supplies costs were based on the essential drug suppliers list, and other key procurement mechanisms such as UNICEF, GF and other major supplier's related procurement overheads costs.
   - HR related costs where based on the Uganda Public service pay structure.
   - Programmatic intervention costs were based on the most recent past expenditures.

b) MTEF was used for projections.
c) The allocation of 10 % to 15% of the national budget is used for the next 5 years.
d) Household expenditure, and external financing spending projections is based on the NHA results of 2012.
e) Population for the base year (2014) estimated at 34,347,550.
f) Service coverage for year 2013/14 considered as baselines for the costing process.

g) With the exception of the Programme management cost, Governance and HIS that were calculated using Activity Based Costing.
h) HR estimation for Service Providers
    - 10% of Staff time was allocated to task other than training or service delivery.

4.2.4 The scenario analysis

Three scenarios were developed to guide in the impact analysis and also to determine the most effective set of interventions. The scenario was derived by alternating various sets of key service coverage. The scenarios included: the plan scenario, the moderate scale up scenario and the Ambitious scale up scenario.

1) Plan Scenario

This was based on the service coverage targets as proposed in the HSDP. The plan assumed major infrastructural developments would take place during the first half of the plan period. Scale up of the HR is assumed to be minimal.

2) Moderate scale up scenario

This assumed the service coverage scale up will be gradual over the life of the plan. Intervention would be scaled up cognizant of the HR and other infrastructural constraints in the health sector.

3) Ambitious scale up scenario

This represented a very ambitious scale up of intervention. It also assumed that many of the HR and other infrastructural constraints would have been addressed to enable the rapid scale up of interventions.

4.3 Presentation of the results

4.3.1 Costing results

The resources required to implement the HSDP based on the Plan scenario was estimated at US $ 15.58 billion over the life of the plan. This would grow from an annual cost US $ 2.23 billion in the first year to US$ 3.79 billion in the last year. Table 27 shows the summaries of the costs for this scenario.

Table 27: Summary Costs according to Plan Scenario 1

Investment domain	Resource requirements (US $ Millions)					
	2015/16	2016/17	2017/18	2018/19	2019/20	TOTAL
Health Products & technologies	1,242.73	1,466.88	1,775.42	1,911.30	2,117.46	**8,513.79**
Health workforce	242.32	251.63	265.43	275.69	285.17	**1,320.24**
Health infrastructure	38.59	126.84	491.71	414.76	402.12	**1,474.02**
Logistics Management	478.81	490.94	513.95	524.84	543.4	**2,551.94**
Health governance	0.23	0.23	0.23	0.23	0.23	**1.15**
Health information	5.81	3.31	6.28	7.89	6.74	**30.03**
Health financing	26.53	61.4	78.43	110.45	131.99	**408.80**
Service delivery systems	210.47	231.97	255.52	283.1	302.22	**1,283.28**
TOTAL	**2,245.49**	**2,633.20**	**3,386.97**	**3,528.26**	**3,789.33**	**15,583.25**

4.3.2 Per Capita Health Expenditure

The plan would require the per capita health expenditure for Uganda to reach US $ 64.5 in the first year of the plan rising to US $ 96.6 in the last year of the plan. Currently the PCHE stands at US $ 53 (2013/14) as shown in table 28.

Table 28: Per capital health expenditure for the plan scenario

Period	Projected Per Capita (USD)				
	2015/16	2016/17	2017/18	2018/19	2019/20
Plan Scenario HE Per capita	64.52	73.44	91.68	92.7	96.63
Current HE Per Capita (2013/14)	53	55	56	58	60
Funding Gap	11.52	18.44	35.68	34.7	36.63

The cost summaries according to program area (Table 29) show that health service costs are 59.7% and health system costs 40.3% of the total costs. Among the disease program areas HIV/AIDS is 17.4% of the total budget and 61.9% of this is towards treatment. NCDs have a share of 17% of the total budget and 59.9% of this is towards prevention. Child health services have 12.3% of the budget with 96.9% of this going towards treatment.

Table 29: Cost summaries according to program areas - Plan scenario. In US $ Millions

Programme	Prevention (US$ millions)	Treatment (US$ millions)	Health services costs (US$ millions)	Total (US$ millions)	% Prevention	% Treatment	% health service costs	% Total
RMA Health	126.02	134.23	1.97	262.21	48.1%	51.2%	0.8%	1.7%
Child Health	10.45	1,858.49	48.27	1,917.21	0.5%	96.9%	2.5%	12.3%
Immunization	110.90	-	1.81	112.72	98.4%	-	1.6%	0.7%
Malaria	338.27	411.01	27.95	777.24	43.5%	52.9%	3.6%	5.0%
TB	8.05	13.18	15.44	36.67	22.0%	35.9%	42.1%	0.2%
HIV/AIDs	1,023.88	1,676.19	8.54	2,708.61	37.8%	61.9%	0.3%	17.4%
Nutrition	140.25	40.14	4.29	184.67	75.9%	21.7%	2.3%	1.2%
Environmental Health	499.28	-	3.23	502.51	99.4%	-	0.6%	3.2%
NCDs Diseases	1,588.20	1,058	3.08	2,649.28	59.9%	39.9%	0.1%	17.0%
Mental, Neurological and substance abuse disorders	1.21	142.83	0.89	144.93	0.8%	98.6%	0.6%	0.9%
Total Health services costs	***3,846.51***	***5,334.07***	***115.48***	***9,296.05***	***41.4%***	***57.4%***	***1.2%***	***59.7%***
Health System	1,270.13	4,978.93	38.13	6,287.18	20.2%	79.2%	0.6%	40.3%
Total HSDP Cost	**5,116.64**	***10,313.00***	**153.61**	***15,583.23***	***32.8%***	***66.2%***	***1.0%***	***100.0%***

4.3.3 The Financial Gap Analysis

The financial gap analysis presents a comparison between the current and committed funding vis a vis the current and future resource needs. A financial gap analysis was generated to determine the unmet funding need for the plan over the life time of the plan. Funding estimates were projected using commitments from the GoU, with an assumption that GoU would increase it sector funding by at least 10% annually.

Multilateral, Bilateral, the Private sector and household OOP were estimated and projected over the years based on the NHA results 2012. Total contributions from existing and new foreign partners were assumed to grow by at least 5% annually. Table 30 shows the financial gap analysis for the Plan Scenario.

Table 3021: Funding gap analysis for the HSDP in accordance with the Plan scenario

Investment domain	Resource requirements (US $ Millions)					
	2015/16	2016/17	2017/18	2018/19	2019/20	TOTAL
Resources Requirements	2,245.49	2,633.19	3,386.97	3,528.26	3,789.32	15,583.23
Funding Commitments						
GOU	489.662	504.3519	519.4824	535.0669	551.1189	2,599.682
Bilateral Partners	766.64	804.97	845.22	887.48	931.85	4,236.16
Multilateral Partners	140.77	147.81	155.2	162.96	171.1	777.84
Private Foreign donors	10.44	10.96	11.51	12.08	12.69	57.68
Private sector						0.00
*Household Out of Pocket	557.64	568.79	580.16	591.77	603.6	2,901.96
*Private firms	105.45	107.56	109.71	111.91	114.15	548.78
Total Commitments	**2,070.60**	**2,144.44**	**2,221.28**	**2,301.27**	**2,384.51**	**11,122.10**
Funding Gap	**174.89**	**488.75**	**1,165.69**	**1,226.99**	**1,404.81**	**4,461.13**
Funding Gap %	**7.79%**	**18.56%**	**34.42%**	**34.78%**	**37.07%**	**28.63%**

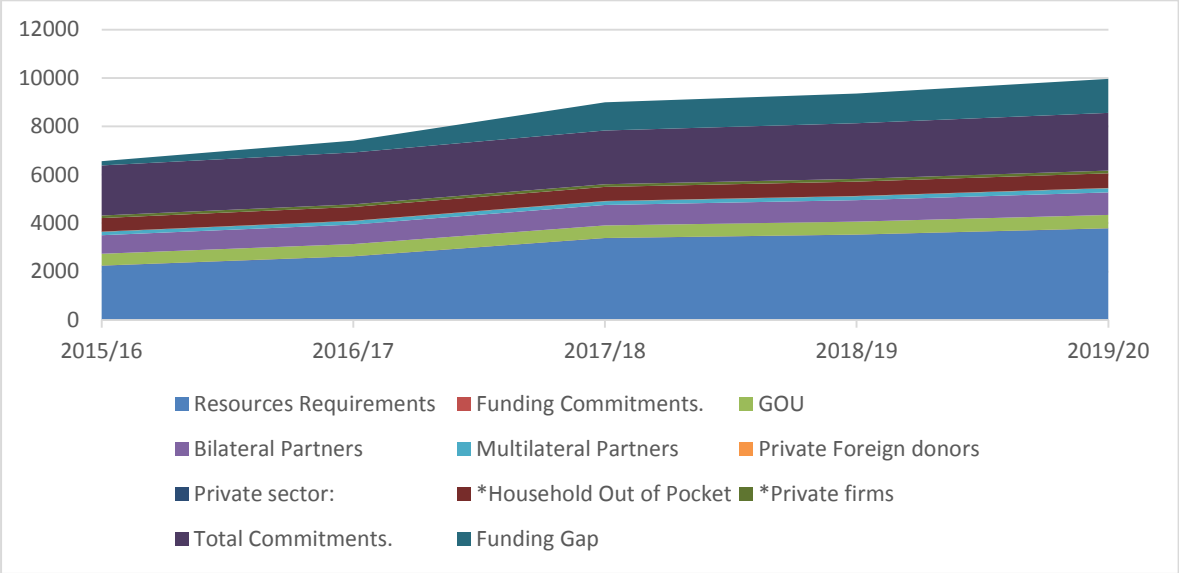
As can be seen from the table above, the funding gap for the total strategic period is 28.63% under the assumptions mentioned above. The first FY seems to be well funded save for a funding gap of 8%. This gap steadily increases over the strategic period up to 37% in the last year. This is likely because of the fact that donor commitments are largely predictable for 2 - 3 years in advance. Figure 8 below graphically shows the same findings.

4.3.4 Strategies for financial sustainability

The sector plans to address this funding gap by;

a) Advocating for increase in the health sector budget from the MTEF and making health a higher priority in existing government spending.
b) Generating efficiency gains and equity in the way funds are used through minimizing waste and investing in high impact interventions.
c) Consolidating the existing pooling mechanisms with the vision of creating a Health Fund in a phased manner.
d) Providing adequate levels of financial risk protection through the NHIS.
e) Mobilizing private resources from the private sector under the PPPH arrangements.
f) Exploring grant opportunities by writing feasible proposals.

Figure 8: Financial Gap analysis for the HSDP



4.4 Impact Analysis

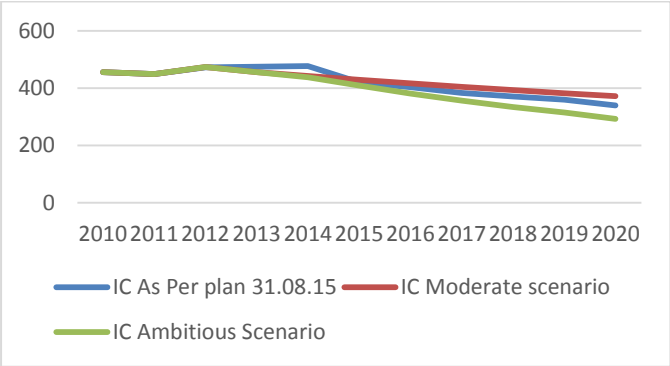
An assessment of the impact of the scale up of key interventions in the strategic plan on key health indices was done. This was done to demonstrate the likely return of investment if all the required resources are mobilized.

The figures below demonstrate the likely impact of implementing the strategic plan. The key assumptions that drive the results include:

a) The resources needed for 100% implementation of the plan are mobilized and used in a timely manner.
b) 100% uptake of the services offered by the community.
c) That all social determinants of health and health care access are tackled.

Figure 9 shows the impact of the RMNCAH interventions on maternal mortality.

Figure 9: Projected trends in Maternal Mortality by Scenario

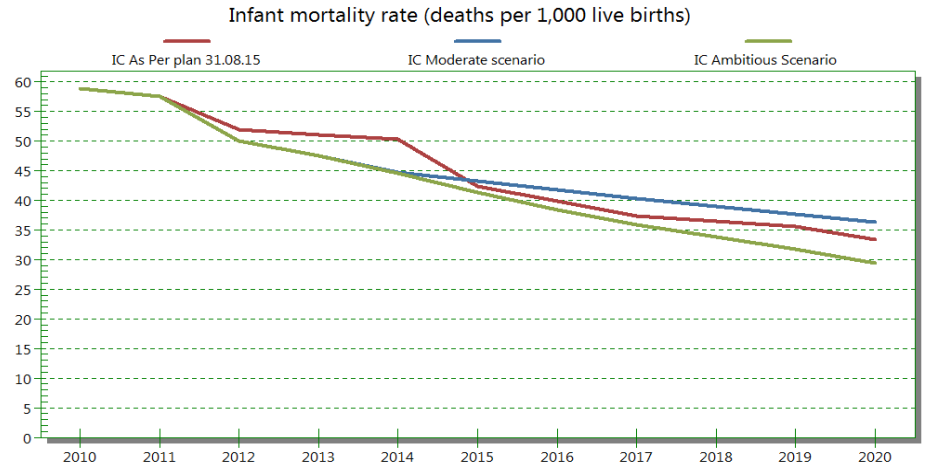


The HSDP has targeted that by 2020 MMR will be reduced from 438 to 320 deaths per 100,000. According to these projections, as the plan currently is, the likely achievement will be 338 deaths per 100,000 live births. This will exceed the goal that has been set by the health sector and therefore a more ambitious scale up plan is

unnecessary. The moderate plan also achieves the HSDP target and therefore in the absence of adequate resources a less ambitious plan than the current one (configured as the moderate scenario) would enable the sector to achieve its MMR goal.

Infant mortality rates were also modelled in the OHT for the strategic period. As seen in the figure below, all the scenarios result in reductions in IMR below 40 deaths per 1,000 live births. The HSDP targeted IMR is 27 deaths per 1,000 live births. The ambitious scenario achieves the greatest reduction resulting in a reduction to 29 deaths per 1,000 live births, while the "'as per plan" scenario achieves a reduction to 33 deaths per 1,000 live births. If the plan is implemented as planned the sector is likely to realize significant reductions in IMR albeit less than anticipated.

Figure 10: Infant Mortality rate Modelling



The HSDP target for Under 5 Mortality rate is 51 deaths per 1,000 live births. All three scenarios modelled result in significant reductions in Under 5 mortality rates. They however, fall short of the target for the HSDP with the exception of the ambitious scenario. The most ambitious scenario achieves a reduction to 47.69 deaths per 1,000 live births. The planned scenario achieves a reduction to 53.1 deaths per 1,000 live births.

The Figure 11 below shows the projected trends in TFR given the interventions for FP that have been included in the Strategic Plan. As can be seen all scenarios result in a significant reduction in TFR by almost half. The plan as it is results in a TFR of 3.1 by 2020. This less than the target of 5.1 in the HSDP. This implies that if well implemented and resourced the planned interventions are likely to supersede the HSDP target for TFR.

Figure 11: Projected trends in Total Fertility Rate

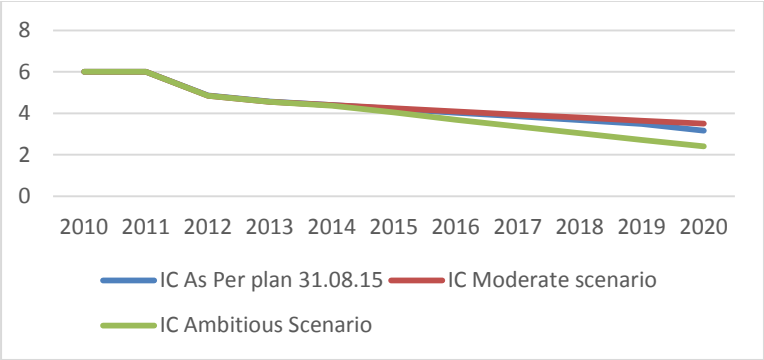
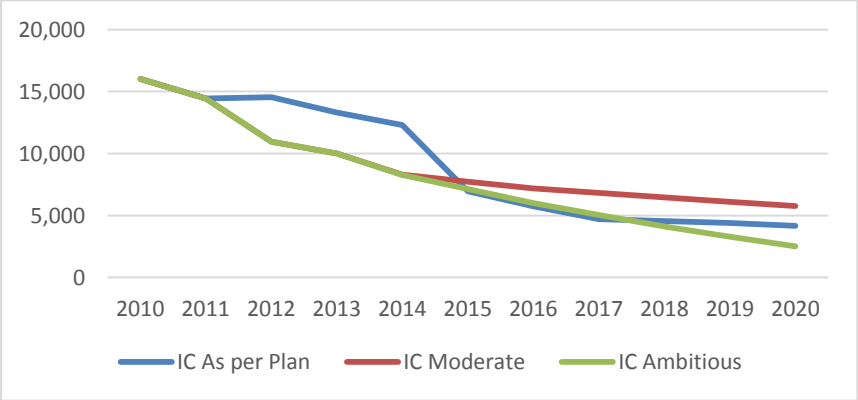


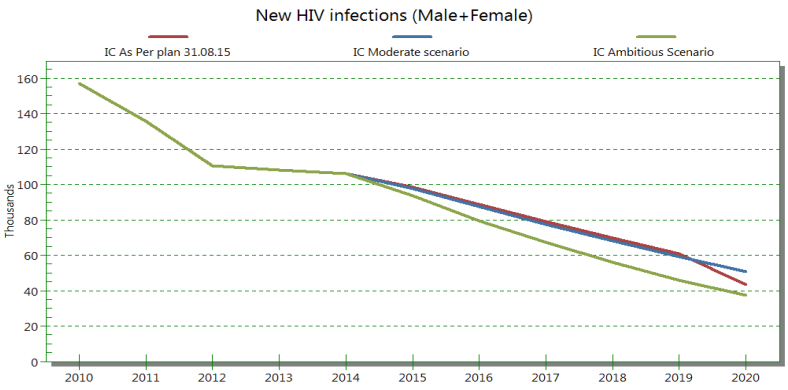
Figure 12 shows projected reductions numbers of annual deaths in children due to malaria. As can be seen all scenarios result in significant reductions in deaths due to malaria. Given that this is a key cause of morbidity and mortality amongst children in Uganda, adequate investment and implementation of malaria interventions is key.

Figure 12: Projected reductions in deaths due to childhood malaria



Lastly, figure 13 shows the projected trends in new infections due to HIV/AIDS. As can be seen from the figure below, all investment scenarios result in significant reductions in incident cases of HIV/AIDS.

Figure 13: New HIV infections modelling



4.5 Conclusion

In general, the investment case demonstrates that there will be significant investments in financial and human resources required to implement the HSDP. However, as the impact analysis above shows, the likely returns on investment in the health sector are great. This is because of the significant reductions in mortality (of all forms), new infections and deaths that are probable.

These gains are largely dependent on the availability of the required resources, efficiency in the allocation and use of resources mobilized and lastly, the uptake of the services by the communities.

5 IMPLEMENTING THE HSDP

The HSDP shall be implemented under the SWAp, whereby the MoH shall play its key roles of policy making, providing guidelines, training and capacity-building, monitoring the health sector, and the coordination of partners. In other words, the main role of the central MoH is to support the decentralized levels in the implementation of the HSDP by ensuring that SWAp funds are allocated equitably, sent to the service providers (districts and health facilities) and accountability strengthened. This will require having a well functioning MoH structure, having rules that are enforced (such as spending requirements at decentralised levels), joint planning and budgeting, regular performance reviews and commitment to achieving the sector goal and objectives.

5.1 Governance, Management and Partnership Structures in the sector

Better coordination of service delivery is a key element required to maximize the outputs the health sector is able to deliver to the people of Uganda. Improvement in coordination and management of the delivery of health and health related services is therefore a key strategic deliverable for the MoH.

Guidance on coordination and governance is provided through three oversight structures;

- ***The management structure:*** This guides internal Ministry coordination, to guide implementation of defined interventions and activities at the different levels.
- ***The governance structure:*** This looks at defining the guiding strategic direction and following up on the operation of interventions. It is largely defined through formal legislation, with members and functions formally gazetted by the Government.
- ***The partnership structure:*** This guides external coordination of service delivery by all stakeholders at the respective levels of care. All partners providing services at a given level of care engage with each other through this structure.

The governance, and partnership structures described in this chapter intend to establish a substantive sector-wide governance mechanism, to foster agreement on other common procedures for consultation and decision – making. Among the measures are annual planning, procurement and disbursement mechanisms, M&E. Others are audits, financial management and the exchange of information (communication) in this collaboration.

The existing partnership instrument – the Memorandum of Understanding (Compact) – will serve as the formal instrument to guide the functioning of the partnership in health. It is guided by interpretation of the principles of the 2005 Paris Declaration on Aid Effectiveness.

5.2 Management Structure for Stewardship

The key oversight functions of the health sector will be managed through the Minister and the Ministers of State. Duties of these have been defined by Government.

5.2.1 Office of the Permanent Secretary

The Permanent Secretary coordinates resources for effective management of Health Funds. The work of the Permanent Secretary will be supported through the following units: Administration, Internal Audit, Finance and Accounting, Procurement. The PS will work through the Office of the Director General Health Services (DGHS) for guiding technical direction.

5.2.2 Office of the DGHS

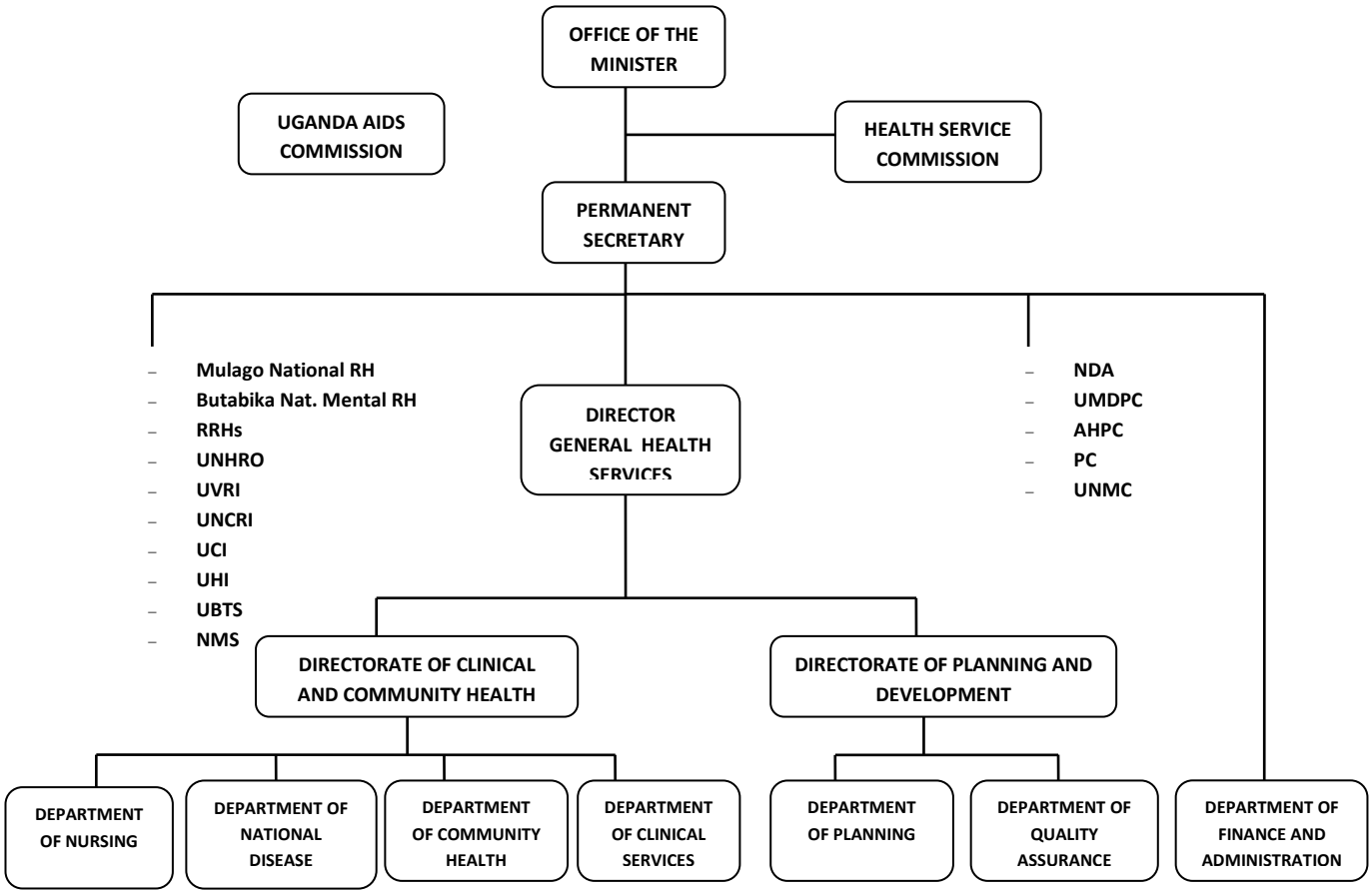
The DGHS coordinates technical functions for delivery of Health. The work of the DGHS will be coordinated through two directorates: Directorate for Planning & Development and Directorate of clinical & Community Health services.

Several semi autonomous government agencies complement the work of the Ministry in discharging its core functions through service delivery, research and training, and procurement and distribution of drugs. These include both parastatals, and statutory institutions responsible for quality control.

These are:

- ✓ Health Services Commission
- ✓ National Drug Authority (NDA)
- ✓ National Research, and Teaching hospitals– Curative services and teaching
- ✓ National Medical Stores (NMS) – Procurement and distribution of commodities
- ✓ Uganda National Health Research Organization (UNHRO)
- ✓ Uganda Virus Research Institute (UVRI) – Research
- ✓ Uganda National Chemotherapeutics and Research Institute (UNCRI)
- ✓ Joint Clinical Research Centre (JCRC)
- ✓ Uganda Blood Transfusion Services (UBTS)
- ✓ Uganda Medical and Dental Practitioners Council
- ✓ Pharmacy Council
- ✓ Uganda Nurses and Midwives Council
- ✓ Allied Health Professionals Council

Figure 14: Macro Structure of the Ministry of Health



5.2.3 The Governance Structure

The governance structures for coordination of the sector will be made functional, to guide implementation of the HSDP. These are illustrated in the figure below.

1) **Cabinet / Parliament**

The Sector shall close with the Cabinet and relevant committees of Parliament for overall political and policy oversight to the sector. Its key role is political and policy coordination, ensuring the sector is working towards the country's presidential manifesto, its policy objectives as set out in the National Health Policy, and the country's NDP. This function includes:

- Articulating the policy direction for the sector, taking broader Government objectives into consideration.
- Monitoring adherence to the policy direction of the sector.
- Mobilizing resources for achievement of the sector policy direction.

The health sector shall interface with Cabinet and Parliament whenever necessary but in any case, during the JRM of the Health Sector, during government planning meetings and retreats as and when called upon.

2) Top Management Committee

Chaired by the Minister, is responsible for providing overall policy direction, making higher level policy decisions, approving policy proposals and giving general oversight to the health sector as a whole.

3) Health Policy Advisory Committee (HPAC)

The HPAC is a forum for the Government, HDPs, CSOs and other stakeholders to discuss health policy and to advise on the implementation of the national strategic plan. It is chaired by the PS and co-chair is the Head of the HDPs. It provides a forum for information and experience sharing, and resolution of disagreements or conflicts among health sector stakeholders. HPAC identifies tasks that need to be undertaken through special assignments and approves terms of reference for each such assignment.

4) Senior Management Committee (SMC)

The SMC Chaired by the DGHS provides strategic leadership in overseeing policy development and planning, as well as oversight of technical programmes and assuring coordination of the activities and overall functioning of the Ministry. Intermediate management decisions are made at this level. SMC also examines and prepares the necessary position papers on matters to be referred to HPAC and TMC.

5) Technical Working Groups (TWGs) and (sub)committees

Actual technical coordination will be through the TWGs, each focused on specific technical areas. These will be the forum through which technical issues are debated and agreed and specific recommendations and actions are implemented. The committees shall be both standing, and ad hoc. Standing committees exist all the time, while the ad hoc ones will be formed to address a particular task, then disbanded when the task is completed. Standing committees shall primarily relate to health services, while the ad hoc ones shall focus on different health system challenges.

All the technical working groups and committees will report through the Senior Management Committee and reports from these shall be a standing HPAC agenda. Furthermore, HPAC and MoH Senior Management may task TWGs with specific issues to resolve. Two or more technical stakeholder committee can cooperate to address particular issues that cut across them. In such instances, they will define the modalities of cooperation.

One functioning example is the Global Fund Country Coordinating Mechanism (CCM), which brings together Global Fund related issues from the malaria, TB and HIV technical stakeholders committees.

6) Regional Management Committee

An institutionalized regional level structure is being discussed to ease coordination, quality assurance and support for health service delivery at the decentralized level. During the HSSIP period 12 RPMTs were established with support from GFTAM to strengthen the capacity for active performance monitoring and surveillance of program outputs in order to support the performance management of implementing agencies at all levels. Once the regional team is fully institutionalized it will work within the existing structures i.e. the RRHs and be members of the Regional Management Committee. The purpose of the Regional Management Committee is to provide technical guidance, coordination, supervision and monitoring of health service delivery at regional level.

7) District Health Management Team (DHMT)

The purpose of the DHMT is for effective co-ordination between all health related players in the district. It is responsible for planning, organizing, M&E of services in the whole district using available information.

8) HSD Management Team

Like the DHMT, the HSD Management's purpose is effective co-ordination between all health related players in the HSD. It is responsible for planning, organizing, M&E of services in the HSD using available information as well as ensuring provisions of quality primary health care health services, supervise monitor and train lower level health workers e.g. VHTs.

9) Health Unit Management Committee (HUMC)

The HUMCs or Hospital Boards are composed of various stakeholders from the health facility, local administration and community and are responsible for planning, M&E, reporting and playing an advisory role for quality health service delivery.

5.2.4 Health Development Partner Coordination

1) HDP Group

The HDP Group meets monthly, with the overall purpose of coordinating development partners in Uganda. The group's aim is to strengthen the partnership between GoU and the HDPs to ensure more effective implementation of the national strategic plan and to reduce transaction costs for both agencies and Government. The HDP Group chooses one agency to be their coordinator for each GoU FY. The coordinator chairs the monthly meetings and acts as a contact point between group members and MoH.

2) Inter-Agency Coordination Committees

Inter-Agency Coordinating Committees are fora for those working in particular disease or program areas to coordinate their activities.

5.2.5 Private Sector Coordination (CSOs, PHPs, TCMPs)

The role of the private sector in health includes;

- Providing priority services to the communities within which they operate.
- Contributing towards policies development, planning, monitoring and evaluation.

- Resource mobilisation for health care from households, organisations both local and international.
- Providing or participating in research, community and social mobilisation, advocacy, capacity building including human resources development, logistical support, technical assistance and other services at all levels.
- Ensuring proper utilisation of resources and accountability.

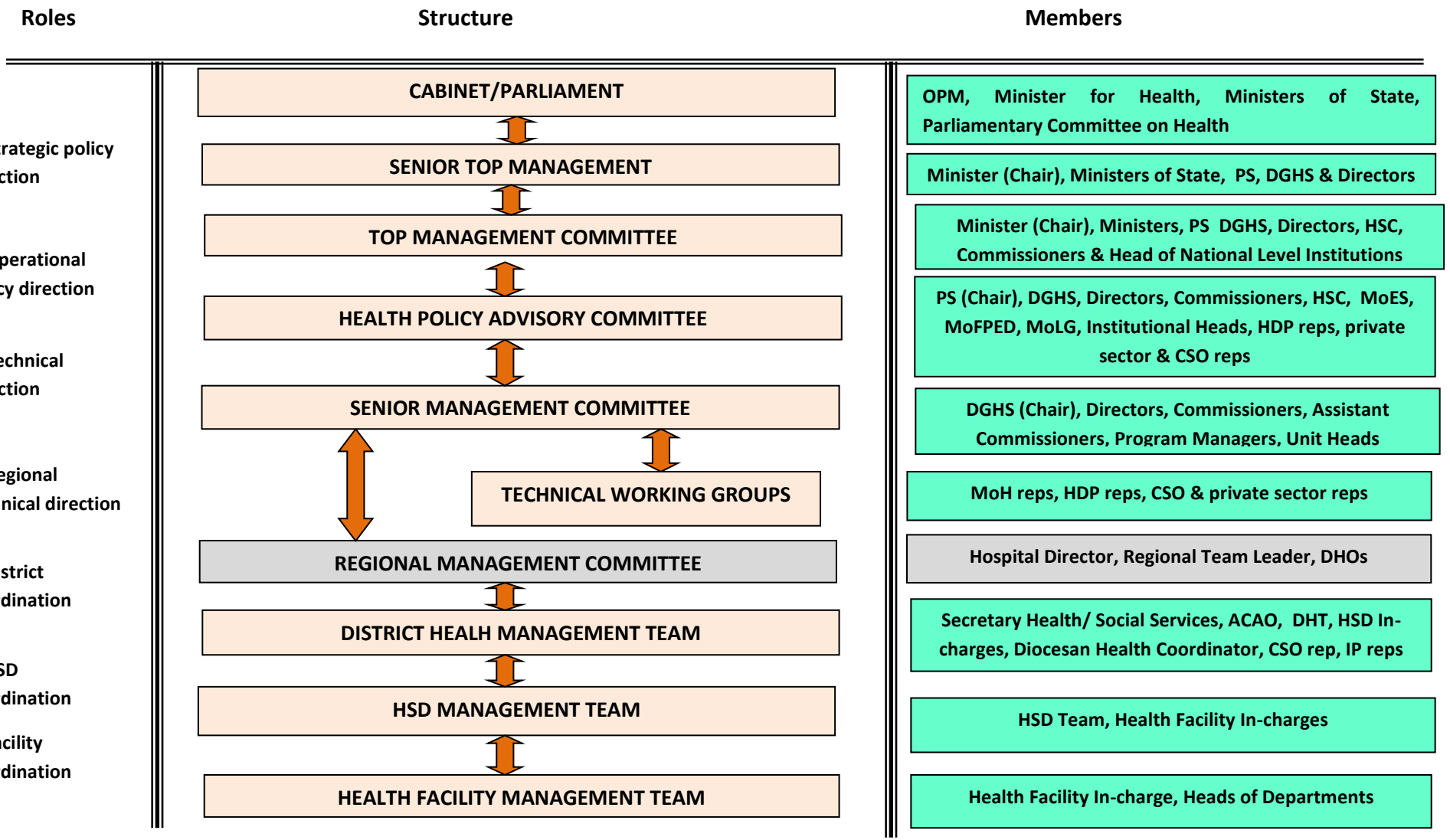
At MoH headquarters, the PPPH Coordination Unit and acts as secretariat and the coordinating arm of all resolutions from the PPPH TWG and HPAC that concern the public-private collaboration in health.

1) Umbrella Organizations (PNFP, PHP, TCMP).

The role of the umbrella organisations is;

- To represent their members and promote partnership initiatives.
- To coordinate the different health providers from each sub-sector and promote professional development and ethics.
- To provide support services and accredit the member facilities and providers.

Figure 15: Governance and Partnership Structure in the health sector



5.3 Roles and responsibilities of the sector constituents

Table 31: Roles and responsibilities of sector constituents

Constituency	Stakeholders	Roles and responsibilities in HSDP
State actors	Ministry of Health	• Overall stewardship of the sector, and provision of policy and strategic guidance • Development of operational tools and processes for implementation of HSDP
	Uganda AIDS Commission	• Stewardship of the HIV/AIDS prevention and Control agenda
	National Drug Authority	• Oversight, regulation and management of health products
	National Medical Stores	• Management of procurement and warehousing of all health products
	Uganda Blood Transfusion Services	• Coordination of provision of blood and blood products
	Uganda National Health Research Organization	• Coordinating health research activities in Uganda
	Natural Chemotherapeutics Research Institute	• Conduct research in natural products and traditional medicine in management and treatment of Human diseases
	Uganda Virus Research Institute	• Coordination of evidence generation and knowledge management relating to viral conditions
	National and RRHs hospitals	• Provision of tertiary and secondary referral health services, pre-service and in-service training, and medical research
	District Health Offices	• Coordination, planning, supervision and monitoring the implementation of the health agenda
	Health facilities	• Front line provision of agreed health services • Reporting on service delivery
	Ministry of Finance, Planning and Economic Development	• Create enabling environment for the implementation of the NDP II towards achievement of health goals under vision 2040 • Provision of adequate financial resources for implementation of the HSDP • Provide data that is required to inform health planning (e.g. UDHS, vital statistics) • Promote sustainable population growth
	Ministry of Public Service	• Maintenance of payroll of health workers • Restructure the HRH in line with changing tasks and new technologies • Performance based contracting of HRH • Inspection of health service delivery
	Ministry of Local Government	• Enforcement of the Public Health Act • Recruitment of health workers for general hospitals and lower level health units • Supervision and monitoring of health service delivery

Constituency	Stakeholders	Roles and responsibilities in HSDP
		• Support health infrastructure development • Passing of by-laws
	Ministry of Education and Sports	• Support education of men and women in order to enable them to increase control over the determinants of health and thereby improve their health. • Promote sport and physical exercise • Implementation of the School Health Program • Ensure quality training of health workers.
	Ministry of Water and Environment	• Development of safe water sources (drilling bore holes, provision of piped water, protection of springs, rain water harvesting) • Provision of sanitation services in rural growth centres & urban areas and communal toilets. • Control and enforce sustainable use of the environment (EIA, avoid pollution, ensure sustainability use of wetlands)
	Ministry of Agriculture, Animal Industries and Fisheries	• Ensure food (both plant and animal sources of food) security for the whole population • Control of zoonotic diseases
	Ministry of Internal Affairs	• Have fair justice systems, particularly in managing access to food, water & sanitation, housing, work opportunities, and other determinants of wellbeing • Ensure wellbeing of refugee populations • Ensure all visitors comply with regulation with respect to required vaccinations and sharing of critical information concerning their health status under special circumstances e.g bird flu
	Ministry of Defence	• Ensure security (a major determinant of access to health)
	Ministry of Gender, Labour and Social Development	• Ensure youth and gender is mainstreamed in all sector policies • Advocacy and prevention of gender based violence • Develop social policies for protection of vulnerable groups • Ensure development and enforcement of proper regulation of cultural institutions. • Promote progressive workplace and safety policies that safeguard the health of workers
	Ministry of Works and Transport	• Construction and maintenance of roads for accessing health facilities and referral of patients e.g. express lanes for ambulances. • Ensure availability of infrastructure to incentivise and support physical activity (cyclists, pedestrians) • Enforcing standards for all buildings
	Ministry of Lands, Housing and Urban Development	• Promote urban and housing designs and infrastructure planning that take into account health and wellbeing of the population • Strengthen access to land, and other culturally

Constituency	Stakeholders	Roles and responsibilities in HSDP
		important resources, in particular for women
	Ministry of Information Communication and Technology	• Facilitate data and voice communication within health sector and with other sectors
	Ministry of Energy	• Ensure that all health facilities have access to affordable energy • Promote use of alternative sources of energy e.g. solar • Educating health institutions on energy saving
	Ministry of Trade and Industry	• Ensure work and stable employment and entrepreneur opportunities for all people across different socio economic groups • Ensure importation of goods that meet the quality standards
	Development Partners	• Provision of demand driven technical assistance and inputs into implementation of the different HSDP priorities • Complement financing of the HSDP priorities with earmarked or un earmarked funds • Actively participate in joint sector monitoring and review
	Philanthropic agencies	• Complement the financing of the HSDP priorities with earmarked funds
Non state actors	Private for profit	• Provide complementary health services, in areas with populations having higher capacity to pay • Reporting on service delivery
	NGOs / PNFPs	• Provide complementary health services, in underserved areas with large indigent populations in line with the sector standards and guidelines • Reporting on service delivery
	CSOs	• Advocacy • Support implementation of non-facility based health service priorities in line with the sector standards and guidelines • Provide a link between health services and households in articulating health issues of importance • Participate in joint sector monitoring • Reporting on service delivery
	Traditional and Complementary Medicine Practitioners	• Provide tested locally produced health services and products • Carry out research on local medicines
	Village Health Teams	• Mobilize and link community with the formal health service • Provide community based services approved by MoH • Reporting on community health data
Clients	Households / Individuals	• Take care of their health, and practice appropriate health seeking behaviours

5.4 HSDP implementation risks and their mitigation

The main risks that may influence the attainment of the HSDP priorities, with their mitigation strategies and contingency plans are shown in table 32.

- Several HDPs reduce their contributions due to austerity back home.
- Most resources remain off-budget; harmonization and alignment remain rhetoric intentions.
- Poor stewardship or corruption may cause the deterioration of the strategy credibility and push the health sector in different directions.
- Emergencies (within and outside) draw attention and resources away from the sector or require substantial reallocation of resources from the planned interventions.
- Proliferating, competing priorities, including donor preferences and political pressures, can compromise the enforcement of this strategy and implementation of the plan.
- Global Health security issues such as drug trafficking, epidemic outbreaks, and child abuse.
- Inadequate monitoring due to resource constraints results in the sector plan becoming a collection of dead documents that may sometimes be referred to but not be used consistently to guide decisions.

Table 32: HSDP risks, their mitigation and contingencies

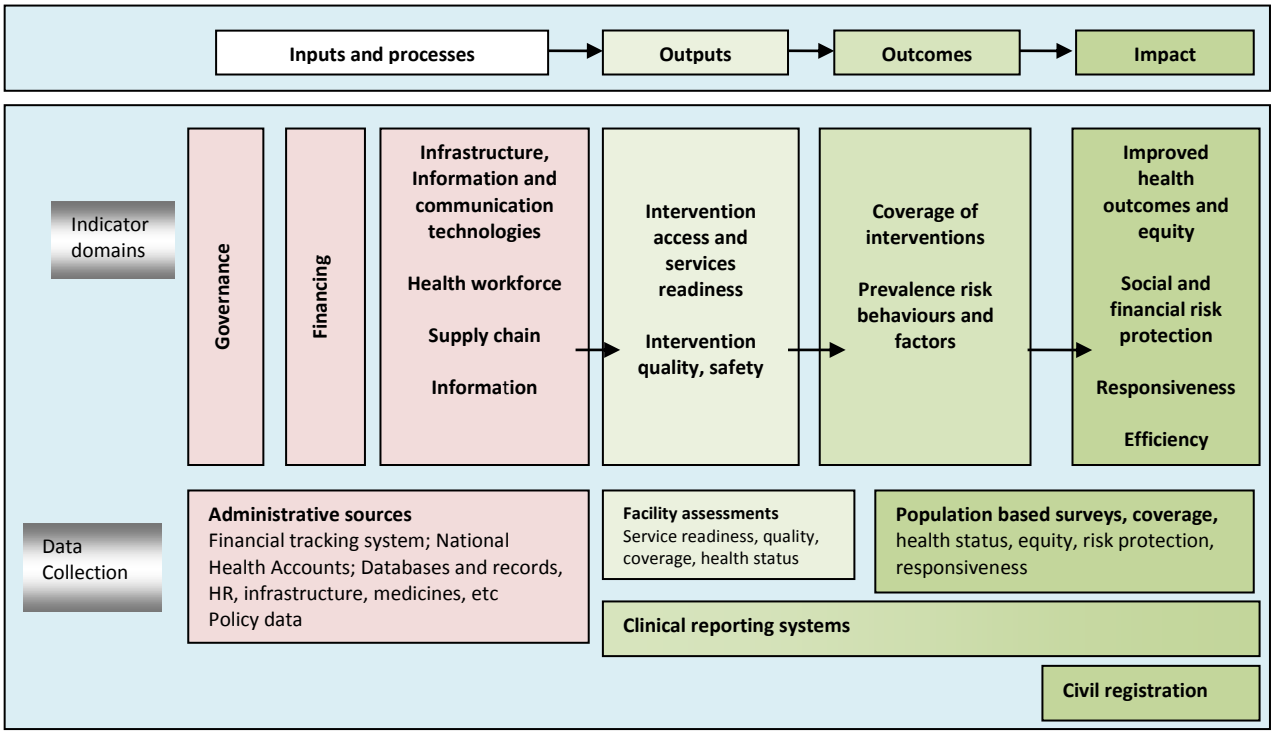
Risk	Probability of risk occurring (Low / Medium / high)	Impact of risk (Low / medium / high)	Risk Mitigation strategies	Contingencies in event of risk occurrence
Weak sector stewardship	Low	High	Strengthening Leadership and Administrative Oversight and Capacity	
Competitive environment for health workers	Medium	Low	Investment in HRH	Scale up the motivation and retention strategy
Corruption / siphoning of available funds	Medium	High	• Establishing Incentives for HRH • Strengthening Citizen Voice and participation in external oversight • Increasing Accountability of Public sector, HDPs, CSOs to Government and Citizens.	The health sector proposed to address these challenges and mitigate the effects of poor governance and to increase accountability and reduce corruption in the sector by application of the existing laws.
Inadequate buy-in to innovations proposed by all stakeholders	Low	Medium	Health sector shall work with all stakeholders to promote the IHP+ principles of country ownership through; - One planning framework - One budgeting framework - One Monitoring framework	HSDP will seek to implement proven cost effective and equity sensitive interventions
Decrease in donor support due to political exigencies	Low	High	The sector is developing a comprehensive financing strategy that should identify all	Lobby for increased GoU financing of the health sector.

Risk	Probability of risk occurring (Low / Medium / high)	Impact of risk (Low / medium / high)	Risk Mitigation strategies	Contingencies in event of risk occurrence
			potential sources of funding and act as a tool for resource mobilization	
Limited harmonization with off budget funds	Medium	Medium	Operationalization of the Compact for the HSDP	Dialogue and resolution of issues
Decreased / inadequate government funding due to competing priorities	Medium	High	The health sector shall continue to work closely with all partners to advocate for allocation of additional resources, to the health sector and promote efficient use of the allocated resources through adoption of strategic purchasing modalities e.g. performance based financing as indicated in the HFS. Resource generation modalities e.g. voluntary prepayment through the NHIS is another reform that is to be introduced in a phased manner.	Further prioritization of interventions to be implemented
Emerging / re-emerging health threats and disasters	High	High	Fully functionalize the Public Health EOC to strengthen real-time surveillance and reporting; strengthen Laboratory network and systems country wide. Promote global health security as an international security priority. Ensure adherence to the adherence to the International Health Regulations which will be spelt out in the Global Health Agenda and proposed National Global Health Strategy	Rapid response

6 MONITORING AND EVALUATION

The sector intends to strengthen the management and use of health information from all sources, to better guide decision making. The M&E framework (Figure 16) therefore provides guidance on the focus and priorities it will have, as it improves on the generation and use of required knowledge for evidence based sector decision making.

Figure 16: Monitoring and evaluation framework for health



Data generation will focus on ensuring all the different data elements needed for the HSDP indicators are being collected, from the different sources. The different sources of the data are the routine HMIS, administrative data, civil registration and statistics, surveys, census and research.

Data verification will be based on a comprehensive system to review the collected data for completeness and accuracy. The actual method used will depend on the data source. Data Quality Audits and Data Quality Surveys will be regularly carried out to provide a picture of the level of accuracy of the data collected. Appropriate correction of the data will be applied, based on its expected accuracy to provide more realistic pictures of the state of the different indicators.

Data synthesis and analysis has remained a key weak point at all levels of the health system. This will be applied at all levels of the system – from national to facility / community. Appropriate analytical approaches will be applied, with the level of automation of the data analysis increasing from national to community levels. The focus of analysis will be on comparing planned with actual results, understanding reasons for divergence and comparison of performance by peer units.

Information dissemination will focus on the packaging and sharing of the information with various constituencies depending on their needs and interests. This will range from facility chalk boards, up to the quarterly and annual performance review reports for the sector or specific donor agencies. It is primarily focused on sector stakeholders sharing information amongst them.

Knowledge management will focus on ensuring key decision makers and citizens beyond the traditional health sector stakeholders are receiving guidance and evidence of sector actions in a manner that responds to their expectations. These stakeholders include the wider Government (OPM), parliament, citizens, and all other consumers of health in line with the Access to Information Act. All M&E and research results users should be able to translate and use the data/information for decision making, policy dialogue, review and development.

The sector intends to achieve this by focusing on the following components;

- M&E organizational structure
- M&E capacity building
- Data management
- Data quality
- Performance review
- Knowledge management

The program areas and key interventions for M&E are shown in table 32.

Table 33: Program areas and key interventions for M&E

Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
Organization Structure	Strengthening the M&E structure of the MoH by establishment of an M&E Unit	M&E Unit established	0	1	1
	Establish and maintain partnerships among in-country and international stakeholders involved in the national M&E system.	M&E partnerships functional	Not well coordinated	Functional M&E partnerships	Functional M&E partnerships
Capacity building	Capacity building for M&E	In-service M&E training curriculum developed	0	In-service M&E curriculum developed	1
		Health workers trained in M&E	10	30	50
		HSDP M&E Plan disseminated	0	100%	100%
Data management	Facilitation of all levels to compile and submit timely reports.	% of districts submitting timely reports	85% (2013/14)	100%	100%
Data quality	Conduct data quality audits to ensure data accuracy and reliability at all levels.	Quarterly data quality audits conducted	2	8	16
Performance Review	Compile sector performance reports at all levels (national, regional, district & HSD)	Quarterly reports	National 4	National 4 @ year Regional 4@ year District 4 @ year HSD 4 @ year	National 4 @ year Regional 4@ year District 4 @ year HSD 4 @ year
		Annual reports	National 1	National 1	National 1

Service area	Key Interventions	Milestone	Measures of success		
			Baseline	Midterm target	End term target
			District 1	@ year Regional 1 @ year District 1 @ year HSD 1 @ year	@ year Regional 1 @ year District 1 @ year HSD 1 @ year
	Conduct performance review at all levels (national, regional, district & HSD)	Quarterly reviews conducted	40%	70%	85%
		Annual review conducted	1	3	5
Evaluation	Develop a comprehensive evaluation plan for all projects and programs.	Comprehensive evaluation plan developed	0	1	1
	Build capacity for conducting evaluations.	No. of health workers trained in evaluations	0	30	50
	Conduct reviews	Reviews conducted	0	MTR	End term
Information Sharing	Disseminate and use data from the M&E system to guide the formulation of policy and planning and improvement of programs / health service delivery.	Number / types of reports disseminated to facilitate informed decision making	AHSPRs Evaluation reports Survey reports Program reports Research findings	AHSPRs Evaluation reports Survey reports Program reports Research findings	AHSPRs Evaluation reports Survey reports Program reports Research findings

6.1 Key output areas for the HSDP

The health sector intends to attain improvements in access to services, quality of care, demand for services, efficiency and equity in delivery of services as the key outputs from investments it is making. These outputs will define the effects of any investments made, and therefore their capacity to influence the attainment of the desired health outcomes as elaborated in the previous sub section.

Each of these output areas has clear domain areas and targets the sector is intending to attain.

- Improvement in access looks at the improvements in availability, affordability and acceptability of the services provided. As such, it is monitored from the perspective of improvements attained in physical, financial and socio-cultural access to services.

- Improvement in quality of care looks at the improvements in client experiences when using services, client / patient safety afforded during provision of services and at the effectiveness of the care / services provided.
- Improvement in demand for services looks at two domain areas of the levels of health awareness of populations to ensure their health is not challenged, and their health seeking behaviours when faced with health challenges.
- Improvements in efficiency of resource use looks at how well resources are allocated to priorities (allocative efficiency), and how well these resources are used when allocated (technical efficiency).
- Finally, improvement in equity looks at fairness in distribution of health services (horizontal equity) and in the effects of accessing these health services (vertical equity).

6.2 Performance Review

The framework for reviewing health progress and performance covers the M&E process from routine performance monitoring, quarterly reviews, annual review and evaluation of all the HSDP indicator domains. The monitoring and review process will measure the extent to which the objectives and goals of the HSDP (key output indicators and their targets) have been attained. This will be complemented by a stepwise analysis to assess which policies and programmes were successful; from inputs such as finances and policies to service access and quality, utilization, coverage of interventions, and health outcomes, financial risk protection and responsiveness. The progress in terms of distribution of health system interventions will involve analyses of differences within and between population groups, among districts, etc. using a series of stratifiers and summary measures.

The HSDP monitoring and review process will be interlinked across the different planning entities. This process will be based on a national platform approach that: uses the district as the unit of design and analysis; based on continuous monitoring of different levels of indicators; gathers additional data before, during, and after the period to be assessed by multiple methods; uses several analytical techniques to deal with various data gaps and biases; and includes interim and summative evaluation analyses. This implies that information at each level will be provided from the planning entities below it. Management support, on the other hand, as well as governance/partnership information will be analyzed at the same level it is to be provided.

A comprehensive M&E Plan for the HSDP 2015/16 - 2019/20 will be developed to provide a health sector-wide framework for tracking progress and demonstrating results of the HSDP.

Evaluations shall be separately scheduled activities performed at specific intervals (for example baseline, midterm or at the end of a programme / project). All projects will be subjected to rigorous evaluation during the preparatory design phase, mid-term and end term.

Table 34: HSDP Monitoring and Review process

Process	Frequency	Focus	Level
Progress review	Quarterly	Done by Joint (public + private) Performance Assessment Teams and peers, and planning entity. A review of progress against planned activities and key targets	National Regional District HSD Health Facility
Joint Annual review	Annually	Done Jointly with key stakeholders, and planning entities as from HSD level onwards Review progress against set targets outcomes	National
Mid Term Review	3rd year of implementation	Done jointly with key stakeholders Review progress against targets for outcome and impact indicators, as well as contextual changes	National
Final Review	At end of HSDP	Comprehensive analysis of progress and performance. Includes results of specific research and prospective evaluations from the beginning of the HSDP	National

7 ANNEX

7.1 Flagship projects under the HSDP

The following projects are earmarked as the HSDP flagship projects because they are expected to generate greater impact in a number of areas in health. .

Strategic Orientation	Project
Health Service Delivery	a) Community Health Extension Worker Program b) Institutional Capacity Building Project (MoH, Rwenzori, West Nile & HMDC) - BTC c) Institutional support to the PNFP sub-sector towards Universal Health Coverage - BTC d) Uganda Reproductive Health Voucher Project (II) - World Bank e) RMNCAH Project - IDA Loan + Global Financing Facility for RMNCAH f) East Africa Public Health Laboratory Networking Project (EAPHLNP) g) National Health Laboratory Services Project h) Uganda Sanitation Fund Project i) Health Facility Quality of Care Assessment Program and QI j) Establishment of Uganda National Ambulance and Emergency Service k) Capacity Development Plan for Uganda National Malaria Control Program - DFID l) District Health Services Improvement Project - For new districts
Health Infrastructure	a) Improvement of Health Services Delivery at Mulago Hospital and the City of Kampala - ADB b) Kayunga and Yumbe Hospital rehabilitation Project - BADEA c) Karamoja Development Project for staff accomodation - Italian Cooperation d) Rehabilitation and establishment of Community Hospitals (Maracha, Kaberamaido, Kamwenge, Serere, Manafwa and Isingiro) e) Completion of the rehabilitation of the 9 hospitals under the UHSSP project - WB f) Uganda Heart Institute development g) Uganda Cancer Institute development h) Establishment of other Institutes and Centres of Excellence i) Uganda Blood Transfusion Services Capacity Project j) Construction of a modern research laboratory at NCRI k) Renovation of 13 General Hospitals (Apac, Kitgum, Abim, Bugiri, Atutur, Pallisa, Gombe, Kambuga, Lyantonde, Kitagata, Kagadi, Kyenjojo & Masindi) & 2 RRHs (Mbale & Soroti) under the IsDB Project l) Construction of 2 general hospitals - Central KCCA and Rubaga m) Construction of a Paediatric Surgery Hospital n) Construction of a Super-Specialized Hospital at Lubowa o) Improvement of Health Service through Health Infrastructure Management - JICA p) Functionalization of HC IIIs in all Subcounties q) Renovation, expansion and equipping health facilities r) Establishment of the Uganda National Ambulance Call Centre &regional offices s) Establish a fleet of 120 ambulance vehicles and equipment & supplies
Health Financing	a) National Health Insurance Scheme t) Medical Credit Fund for the Private Health sector - High cost medical equipment project - IFC
Leadership and Governance	a) Improving accountability at PHC level through Constituency (HSD) Health Assemblies b) Establishment of the National Public Health Institute

Strategic Orientation	Project
Health Information Systems and Research	a) E-Health innovations i.e. e-HMIS including Community Health Information System & telemedicine
Health products and Technologies	a) National Logistics Management Information System b) Local production of quality assured health products including herbal products c) Improving NMS Warehousing and Storage d) Staff uniforms

7.2 Summary Costs for moderate and ambitious scale up scenario

Table 35: Summary costs for Moderate scale up scenario

Investment domain	Resource requirements (US $ Millions)					
	2015/16	2016/17	2017/18	2018/19	2019/20	TOTAL
Health Products & technologies	2,096.33	3,076.07	4,195.67	5,192.29	6,311.39	*20,871.75*
Health workforce	242.32	251.63	265.43	275.69	285.17	*1,320.24*
Health infrastructure	35.87	114.29	479.77	461.15	354.02	*1,445.10*
Logistics Management	478.81	496.99	520	530.89	549.45	*2,576.14*
Health governance	0.23	0.23	0.23	0.23	0.23	*1.15*
Health information	5.81	3.31	6.28	7.89	6.74	*30.03*
Health financing	26.53	61.4	78.43	110.45	131.99	*408.80*
Service delivery systems	211.63	233.13	256.68	284.26	303.38	*1,289.08*
TOTAL	3,097.53	4,237.05	5,802.49	6,862.85	7,942.37	27,942.29

Table 36: Summary costs for Ambitious Scale up Scenario

Investment domain	Resource requirements (US $ Millions)					
	2015/16	2016/17	2017/18	2018/19	2019/20	TOTAL
Health Products & technologies	5,352.42	7,305.11	9,433.57	11,501.03	13,698.80	*47,290.93*
Health workforce	260.70	291.31	322.64	353.96	385.75	*1,614.35*
Health infrastructure	38.48	135.73	497.31	428.97	407.85	*1,508.34*
Logistics Management	478.81	496.99	520.00	530.89	549.45	*2,576.14*
Health governance	0.23	0.23	0.23	0.23	0.23	*1.15*
Health information	5.81	3.31	6.28	7.89	6.74	*30.02*
Health financing	26.53	61.40	78.43	110.45	131.99	*408.79*
Service delivery systems	211.63	233.13	256.68	284.26	303.38	*1,289.07*
TOTAL	6,374.60	8,527.19	11,115.15	13,217.69	15,484.17	54,718.80

Table 37: Per capita health expenditure for moderate scale up

Period	Projected Per Capita. (US)				
	2015/16	2016/17	2017/18	2018/19	2019/20
Moderate scale up CHE	89.56	94.02	98.81	89.69	79.66
Current CHE	53	55	56	58	60
Funding Gap	36.56	39.02	42.81	31.69	19.66

Table 38: Per capita health expenditure for ambitious scale up

Period	Projected Per Capita. (US)				
	2015/16	2016/17	2017/18	2018/19	2019/20
Ambitious scenario CHE	177	230	291	336	383
Current CHE	53	55	56	58	60
Funding Gap	124	175	235	278	324

Table 39: Cost summaries according to program areas - moderate scale up

Programme	Prevention	Treatment	Health services costs	Total	% Prevention	% Treatment
Reproductive, Maternal, Adolescent Health	121.55	137.33	4.87	263.75	46%	52%
Child Health	10.46	1,911.92	48.27	1,970.66	1%	97%
Immunization	110.50	-	4.71	115.21	96%	0%
Malaria	330.82	381.61	27.95	740.38	45%	52%
TB	29.94	3.62	15.44	49.00	61%	7%
HIV/AIDs	934.23	1,669.14	533.64	3,137.01	30%	53%
Nutrition	140.27	40.70	4.29	185.26	76%	22%
Environmental Health	462.65	-	3.23	465.88	99%	0%
NCDs	1,473.62	24,096.73	3.08	25,573.43	6%	94%
Mental, Neurological and substance abuse disorders.	0.99	135.32	0.89	137.19	1%	99%
Total Health services costs	**3,615.03**	**28,376.37**	**646.38**	**32,637.78**		
Health System	**760.01**	**5,965.73**	**135.89**	6,861.63		
Total HSDP Cost	**4,375.04**	**34,342.10**	**782.27**	**39,499.41**		

Table 4022: Cost summaries according to program areas - ambitious scale up

Programme	Prevention	Treatment	Health services costs	Total	% Prevention	% Treatment
Reproductive, Maternal, Adolescent Health	146.28	131.14	4.87	282.29	52%	46%
Child Health	8.04	1,767.39	48.27	1,823.70	0%	97%
Immunization	108.13	-	4.71	112.84	96%	0%
Malaria	407.04	414.99	27.95	849.98	48%	49%
TB	33.40	3.82	15.44	52.66	63%	7%
HIV/AIDs	944.30	1,664.87	533.64	3,142.81	30%	53%
Nutrition	140.37	37.67	4.29	182.33	77%	21%
Environmental Health	515.41	-	3.23	518.64	99%	0%
NCDs	1,596.42	38,246.93	3.08	39,846.42	4%	96%
Mental, Neurological and substance abuse disorders.	3.53	620.44	0.89	624.86	1%	99%
Total Health services costs	**3,902.91**	**42,887.25**	**646.38**	**47,436.53**		
Health System	**599.16**	**6,583.88**	**99.23**	**7,282.27**		
Total HSDP Cost	**4,502.06**	**49,471.13**	**745.61**	**54,718.80**		

7.3 References

1) The Uganda Vision 2040
2) National Development Plan 2015/16 - 2019/20, NPA 2015
3) National Development Plan 2010/11 - 2014/15, NPA 2010
4) Second National Health Policy 2010/11 - 2019/20
5) Health Sector Strategic and Investment Plan 2010/11 - 2014/15
6) Uganda Malaria Reduction Strategic Plan 2014 - 2020
7) National HIV/AIDS strategic plan 2015/16- 2019/20, UAC 2015
8) Uganda National Health Research Organization Strategic Plan 2010/11 - 2014/15
9) Draft Health Financing Strategy 2015/2016 - 2014/2015, MoH
10) Roadmap for Accelerating Reduction of Maternal and Neonatal Mortality, MoH 2007
11) Adolescent Health Strategy, 2012
12) Reproductive Maternal, Newborn and Child Health Sharpened Plan for Uganda, MoH 2013
13) Uganda Cancer Institute Strategic Plan, 2015
14) Uganda Nutrition Action Plan 2011 - 2016, MoH
15) East African Community Health Sector Strategic Plan 2015 - 2020
16) Urban Health Strategy, KCCA 2015
17) National Policy on the Public Private Partnerships for Health, MoH 2011
18) World Health Organization, Country Cooperation Strategy, 2015
19) WHO Family Planning 20/20 initiative
20) District Development Plans (DDPs), 2014/15 - 2018/19
21) Health Sector Strategic Investment Plan Mid-term Review Report, MoH 2013
22) Annual Health Sector Performance Reports 2010/11, 2011/12, 2012/13, 2013/2014
23) National population and housing census; *Provisional results.* UBOS 2014
24) National Health Accounts report 2010/11-2011/12, MoH
25) World Health Statistics report, WHO 2014
26) Uganda Bureau of Statistics, Statistical abstract 2014
27) Uganda Demographic and Health Survey, UBOS 2011
28) Draft Hospital and HC IV census report, MoH 2015
29) Human Resource for Health biannual report, MoH April 2015
30) Uganda National Budget Financial Year 2013/2014, MoFPED
31) Baseline Survey Report on NCDS, MoH 2014
32) Cost of hunger report, 2014
33) State of Uganda Population report, UBOS 2014
34) Uganda Millennium Development Goal Report, 2013
35) State of Uganda Population Report, 2014
36) Global Burden of Disease study, WHO 2010
37) Human Development Report, World Bank and WHO, 2014
38) Uganda HIV/AIDs Indicator Survey, MoH 2012
39) Annual Pharmaceutical Health Sector performance Report 2013/14
40) International Health Partner+ Country Score Card , 2014
41) Health sector Ministerial Policy Statements, Financial Years 2014/15 and 2015/16
42) WHO social determinants of Health. The Solid Facts: Second Edition 2003
43) The One Health Tool for costing National Strategies, WHO 2010
44) Global Health 2035
45) The Common African Position of the African Union 2014

MINISTRY OF HEALTH
P. O. Box 7272 Kampala Uganda
Plot 6 Lourdel Rd, Nakasero
General Telephone: +256-414-340874 / 231563/9
Permanent Secretary's Office: +256-414-340872
Fax: +256-414-231584
Email: info@health.go.ug