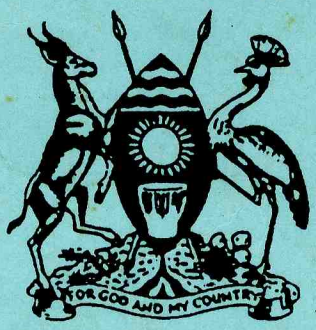

THE REPUBLIC OF UGANDA

HEALTH SUB-DISTRICTS IN UGANDA

CONCEPT PAPER

JANUARY 1999

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HEALTH SUB-DISTRICTS IN UGANDA

CONCEPT PAPER

1. Background

1.1 Introduction

This Concept Paper describes the health sub-district strategy aimed at strengthening the management of health services and improving equity of access to essential health services by the population of Uganda. The strategy is intended to facilitate equity of access to essential health services by the population of Uganda. The strategy is intended to facilitate equitable redistribution of resources, harmonize health care delivery and balance between the curative disease prevention and health promotion services.

Uganda with a population growth rate of 2.5% and a projected total population of 20.4 million people has some of the poorest health status indicators in sub-Sahara Africa. The maternal mortality rate is very high. It is estimated to range between 500 and 2,000 per 100,000 live births in Uganda, with a national average of 506 per 100,000 live births[2]. while it is less than 1per 1000 live births in developed countries. The infant mortality rate (IMR) is 97 per 1000 live births [2] The average IMR for the Sub-Sahara Africa is 107 per 1000 live births [3].
The average IMR for Europe is 7 per 1,000 live births [4]. Overall, 38% of the Uganda children under four years of age are stunted,while 5% are wasted and more than 25% are underweight for their age[2]. Stunting, wasting and underweight exceeding 2% in the population is not acceptable.

The total fertility rate of 6.9 is very high compared to the world average of 3.0[5].

The sanitation is very poor with average latrine coverage of 47.6%. There is significant regional difference with the coverage range from as low as 4.0% in the north east to as high as 88.5% in the south west (see latrine coverage by district in annex 3). The accessibility to safe water is 76.1% in urban areas while it is 43.9% in the rural areas. and the national average is 48.3%[2]. Eleven percent (11%) of the households are within 15 minutes walk from safe water sources[2].

1.2 Important factors contributing to the poor health status in Uganda

1.2.1 Inequitable provision of health care and poor accessibility to health services.

- Forty nine percent (49%) of the population live within 5 km (walking distance) from the nearest health facility that serve as static immunization centres and receive essential drug kits. Even then the accessibility varies very much

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[1] Statistical Abstract. Statistics Department. Ministry of Finance and Economic Planning. 1996.
[2]. Uganda Demographic and Health Survey, 1995.
[3] The state of the World's Children, 1996
[4] Demographic Data for Health situation Assesment and Projection. WHO. 1996.
[5] World Health Report. 1996

between districts, ranging from 8.9% to 99.3%.[6]

- Fifty four percent (54%) of qualified health personnel are located in hospitals which are largely located in urban area[7]. Only 11.3% of the population of Uganda live in the urban areas[1]. Thirty eight percent (38%) of the expectant mothers are attended to at delivery by qualified health personnel[2].
- Forty seven percent (47%) of the Ugandan children under 1 year of age are fully immunized[2].

1.2.2 Inadequate support to disease prevention and health promotion services

The major causes of ill health and death in Uganda are communicable diseases that can be prevented through appropriate public health interventions. The top 10 causes of morbidity are malaria, respiratory infections, HIV/AIDS, intestinal worms, diarrhoeal diseases, trauma, skin infections, eye infections diseases, genito-urinary infections and anaemia[8]. However the health services in Uganda, especially government services, are largely institutional based and biased towards curative care. Fifty four percent (54%) of the qualified health personnel are located in hospitals[5]. On average 63.2% of government recurrent expenditure on health goes to hospitals[7]. Despite the high expenditure government has run hospitals as if they should offer only curative services. On the other hand most of the NGO hospitals provide curative, preventive and promotive services, even with comparatively less resources.

1.2.3 Poor quality of health services.

- The services in most of the small rural health facilities in Uganda are provided by unqualified health personnel.
- The rural health facilities are often short of equipment and supplies.
- Absence of effective continuing medical education system
- The management of district health services is weak.

There is no coherent health system that links up all the various providers of health care at various levels. There is inadequate coordination between the public, NGO and private sectors. There is inadequate supervision of health services and the scarce available resources are inefficiently utilized. This reality not withstanding, the decentralization has increased management responsibilities at the district level especially in respect of planning, coordination, supervision, resource mobilization and allocation.

2. Reorganization of the district and national health system.

The district and the national health system as a whole will be reorganized and strengthened to effectively address the current poor health status of the people of Uganda. At the national level the health system is being reorganized to ensure that MOH and other national level institutions effectively play their

[6] Health Facility Inventory and Access to health Services in Uganda, 1992-Health Planning Unit, MOH
[7] Health Manpower Requirements and Training Priorities in Uganda Study, April 1993
[8] Health Planning department, Ministry of Health

role in support of the decentralized services. The mandate of the MOH in the decentralized system is defined by the Constitution and the Local Governments Act of 1997. The broad roles of the MOH are health policy formulation, preparation of national strategic health plan, coordination, setting national standards and regulations, supervision and providing technical support, monitoring and evaluation. The MOH is also responsible for the control and management of epidemics and disasters, and the delivery of tertiary health care. The MOH is being restructured to effectively and efficiently perform these functions. The districts are responsible for the provision of health services. The district health system needs to be reorganized to improve efficiency and effectiveness in health service provision. There is need for a district health system that facilitates redistribution of resources within the district to improve equity of access to essential health services and the balance between curative care, disease prevention and health promotion services.

The management of the district health services should be strengthened to improve planning, monitoring and coordination of the health services in the district as a whole. This is also necessary for the districts to be able to effectively carry out the management responsibilities including the hospitals devolved to the district level by decentralization. The District Director of Health Services (DDHS) formally the District Medical Officer (DMO) should be de-linked from the routine operations and allowed opportunity to redirect his/her efforts to core management functions of leading the planning process, data management, resource allocation, coordination and providing the main link with the stakeholders both within and outside the district.

3.0 Institutional Changes

3.1 The Community Health Department

It is fundamental that all the various aspects of health care are integrated and inter-linked with emphasis on balancing curative care, disease prevention and health promotion services. Accordingly every hospital and up-graded health centre will establish a community health department to organize, implement and supervise disease prevention and health promotion activities. The community health department in hospitals will facilitate the institutionalization of disease prevention and health promotion activities in hospitals, provision of outreach services by the hospital including supervision of services in the lower level health facilities follow up of patients, and promotion of community involvement in health services. This will correct the situation whereby government hospitals have been run as if they should offer only curative services. Both financial and human resources will be further rationalized to ensure proper balance between curative services, disease prevention and health promotion activities. As a start in the Financial year 1997/8 all government hospitals were instructed to allocate 10% of their non-wage recurrent grants to community health activities. In addition UShs. 1.7 billions was budgeted as conditional grants for primary health Care to the districts. This increased resources for disease prevention and health promotion by 2.7467 billion

Uganda Shillings. In the financial year 1998/99 further rationalization of resources will be undertaken.

3.1.1 Functions of the community health department

The major functions of the community health department are:

(i) Planning, coordination, monitoring and evaluation of disease prevention and health promotion services carried out by hospital or up-graded health centre.

(ii) Implementation of disease prevention and health promotion activities both within the hospital or up-graded health centre and in the community. The Community health department will be assigned areas for community outreach services including health education, MCH/FP services, nutrition, immunization, school health, home visiting and environmental health.

(iii) Collection, analysis and use of health information.

The data collection should include demographic statistics of the designated outreach area for the hospital like age organized in appropriate age groups and disaggregated by sex, the target groups for the major health interventions and the percentage of the target groups reached by, for example. EPI (broken down by antigen), ante-natal care, including the services offered by the traditional midwives, etc. The estimated number of women in the population expected to be pregnant should be calculated based on birth rate, fertility rates and other relevant date.

(iv) Accounting for resources for community health activities.

3.1.2 Staffing and Administrative arrangements

The community health department will be established on the same footing as any other department of the hospital. That is to say, while the hospitals have traditionally had 4 departments of Paediatrics, Surgery, Medicine and Obstetrics and Gynaecology, they will now have Community Health Department as the 5th department.

The Medical Superintendent or the In-Charge of the up-graded health centre will specifically assign one of the staff in the hospital to head the community health department who will be responsible for the routine management of the department. He or she will also be the spokesperson for the resource allocation for the community health department.

The core staff of the community health department will include:

- Medical Officer
- Public Health Nurse or Comprehensive Nurse or Double trained

Nurse/Midwife
- Social Worker/Counselor,
- Health Educator
- Environmental Health Officer

3.2 Up-graded Health Centre (Health Centre IV)

In order to have significant reduction in the MMR emergency obstetric services would be required within 5 km radius of every family, given Uganda's road network and transport system. Common emergency obstetric problems require basic theatre facilities to save the life of the baby and the mother. In Uganda only doctors are currently trained and registered to handle obstetric emergencies. The health centres up-graded to provide emergency obstetric services will need to be staffed with doctors. This will bring the services of doctors closer to the families. The doctors would also provide much needed technical support to the other health workers at the up-graded health centres to improve the quality of other services provided. A simple basic theatre for emergency operations like caesarian section will be developed at the up-graded health centres.

Fully functional health centres should have the following staff complement:

- clinical officer
- registered nurse
- enrolled midwives
- enrolled nurses
- public health nurse or comprehensive nurse
- laboratory technician
- health inspector

The additional staff for the up-graded health centres will therefore include a medical officer and anaesthetic officer. There will be one up-graded health centre in each constituency without a hospital.
The critical assumption here is the doctors and anaesthetic officers will accept posting to the rural areas and that they will be maintained there.

3.3 Health Sub-district (HSD).

The Health Sub-District is a functional health zone of the district created to facilitate the reoganization of health services to enhance the effectiveness and efficiency in planning, provision and monitoring of health services in the district. It is not a substantive new administrative unit and does not contravene the Local Government Act of 1997 which defines the administrative structures of the districts. It is named health sub-district to emphasize the fact that it remains an integral part of the district health system.

3.3.1 Basic principles of the Health Sub-district

The Health Sub-district concept is based on the following principles:

(i) Further decentralization within the districts.
(ii) Integration, better coordination and linkages between the various types and levels of health care.
(iii) Improving access to the basic health services by the population.
(iv) Improving community involvement in care planning and delivery.

3.3.2 Objectives of the Health Sub-district

The objectives of the creation of Health sub-districts are to:

(i) improve planning and management of district health services

(ii) improve equity and access to essential health services in the districts

(iii) improve the balance between curative care, disease prevention and health promotion services.

(iv) improve community involvement in planning and health care delivery in their communities and so empower them to look after their own health.

3.3.3 Strategies to achieve the Health Sub-district objectives

(i) Up-grade and strengthen management at the district level

The decentralization has increased the management responsibilities of the office of the District Directors of Health Services, particularly planning, coordination, resource allocation, health information management and the supervision of district hospital services.

Currently the DDHS, apart from providing the overall leadership to the district health services, he/she is directly responsible for:

- Procuring, distributing, and ensuring the rational use of essential drugs, vaccines, equipment, sundries, and other supplies.
- Ensuring improvement in the nutritional status of the population
- Ensuring provision of adequate safe water and promotion of environmental health in the district.
- Development and maintenance of health units
- Assessing manpower requirements and training needs

- In-service training for health personnel in the district
- Routine technical supervision of health service providers in the district
- Health information management
- Preparation of district health plans and reports
- Linking with all the stakeholders and responding to centrally initiated activities.

In the current circumstances the DDHS is overwhelmed and can hardly find time to settle in the office to adequately tackle the priority management responsibilities.

With the creation of HSD there will be further decentralization of the management of routine health service operations to the health sub-district. The DDHS will consequentially concentrate on the overall key management issues including:

- Provision of overall leadership for the district health services.
- Planning district health services
- Resource mobilization and allocation
- Coordination of health activities within the district and with the Ministry of Health (MOH).
- Surveillance and data management
- Monitoring and evaluation of district health services

The restructed MOH will give the required support to the district including development and dissemination of supportive policies, guidelines, national plan frame as a basis for district health planning and quality assurance. The MOH will also continue to provide technical support to the DDHS.

(ii) Delegate responsibility for health service operations to health sub-district level.

At present the planning and management of the entire district health service is carried out at the district headquarters. However, some districts are large in both area and population (with population between 300,000 and 1,000,000). The district headquarters are too far from many sections of the community. This leads to some areas being neglected, and also means that some essential services (e.g emergency obstetric care) are out of reach of many leading to unacceptably high MMR s. The planning and management of health care delivery in the health sub-districts will be done at the hospital or up-graded health centre located within the health sub-district. This will improve the definition of priority health needs of the community, data management, community involvement and the focusing of resources. The overall district health plan will derive from the health sub-district plans. This will enhance equitable distribution of health resources in the district as a whole. The overall district health reports will also be assembled from the health sub-district reports and will be important in the planning of district health services.

(iii) **Harness hospital and up-graded health centre resources for disease prevention and health promotion services.**

The planning and management of the health services in the HSD will be based at the hospitals or up-graded health centres and will ensure that the resources in these facilities which have hitherto been almost exclusively used for curative services are harnessed to support disease prevention and health promotion services in the HSD. The creation of the CHD discussed in section 3.1 will go a long way in facilitating this change. In the HSD strategy both funds and the hospital personnel will be rationalized to ensure appropriate balance between curative care, disease prevention and health promotion services.

(iv) **Build community capacity to take responsibility for their own health**

Fundamental to disease prevention and health promotion is the empowerment of the community itself to make decisions and implement changes concerning their own health. Under the HSD concept the planning and management of health services will take place close enough to the communities to encourage their effective participation in the decisions that affect their health and well being. Information, education and communication will be provided closer to the community as part of empowerment to make people aware of their rights and potentialities and of the importance of adopting healthy lifestyles.

3.3.4 Geography of the health sub-district

The health sub-district will be based on the constituency which comprises as a basic unit the sub-county. There are 214 constituencies and 878 sub-counties in the country[9]. The population in the constituencies ranges from 7,981 to 172,146 with an average of 95,507. Although it is the government policy to up-grade and strengthen management at the sub-county level considering the number of sub-counties and the resources available it is not feasible to create the HSD at the sub-county level in the current economic circumstances. However in the long term the HSD will be established at the sub-county level as the resources become available. It would be administratively viable to create the HSD at the county level but most of the counties are very large, with population ranging from 7,981 to 433,687 and the improved access, equity and monitoring of health services envisaged in the HSD concept would not be achieved.

The leadership of the HSD will be based at an existing hospital or an up-graded health centre. The hospital or health centre may belong to the government, NGO or private sub-sector.

[9] Electoral Commission

3.3.5 Functions and activities in the the HSD

The functions and activities in the HSD will include planning, implementation monitoring and support supervision of health services. The responsibility for these functions and activities will be delegated to an existing hospital or up-graded health centre located within the HSD.

i) Planning.

a) Preparation of detailed plan of implementation of health activities consistent with the overall district health plan.

b) Budgeting, managing and accounting for resources allocated to the HSD for health services.

ii) Provision of essential clinical care, disease prevention and health promotion.

a) The hospital or up-graded health centre will continue to provide essential clinical services. In addition it will also function as a static unit for disease prevention and health promotion activities, including immunization, health education, nutrition. etc.

b) All health units in the HSD will organise and carry out community outreach curative, preventive, promotive, and rehabilitative services in their catchment areas.

c) All health workers in the HSD will carryout home visiting. They will be expected to spend at least 50% of their time carrying out home visiting. This practice will be standardized. They will also visit schools and other institutions in the HSD for purposes of promoting health.

iii) Supervision, Monitoring and Evaluation of health services

a) The staff from the hospital or up-graded health centre will carry out support supervision in the lower level health units in the HSD, including community outreach activites done by the lower level unit staff.

b) Health workers in the HSD will provide technical support to community based health care activities.

c) All the units in the HSD will collect, analyse and use health information from their catchment area. The hospital or up-graded health centre will be expected to collect analyse and use informantion from the entire HSD for which it is responsible. The data will include demographic statistics appropriately summarized for monitoring key health interventions and planning. The age, for example should be summarized in appropriate age-groups and disaggregated by sex. The summaries should also reflect size and the proportion of the target age-groups with access to specified health services e.g immunization (how many children in the HSD are being targeted. and the percentage of this being reached broken down by antigen), ante-natal care (how many women are expected to become pregnant in the HSD given the birth and fertility rates, and the percentage being reached by ANC including the services offered by the TBSs), etc.

d) The hospital or up-graded health centre will play a key role in disease surveillance and epidemic control in the HSD for which it is responsible. This will include early detection, reporting and executing control measures in close consultation with the DDHS.

e) The hospital or up-graded health centre will be expected to monitor and evaluate the impact of health interventions in the HSD for which it is responsible with support of the DDHS.

iv) Provision of continuing medical education

The hospital or up-graded health centre will organize and implement in-service training for the health personnel in the HSD, including training of traditional midwives. The on-job training of some of the key HSD personnel will be eventually organized as a field -based training recognized by Makerere University and should eventually lead to award of postgraduate diploma or degree in Community Medicine. An appropriate curriculum will be worked out and field-based community health and other relevant specialists identified and prepared by Makerere University to support the training. This will strengthen the link between the HSD with the higher levels of care and other related institutions.

3.3.6 Administrative arrangements

i) The management of the health sub-district will be located at the hospital or an up-graded health centre within the HSD. The hospital or up-graded health centre will take leadership in the management of health service operations in the HSD, including supervision of all other health facilities.

ii) This will be a delegated responsibility for which the DDHS retains the overall responsibility and accountability.

iii) The Medical Superintendent of the hospital or the In-Charge of the up-graded health centre will be accorded the status of Deputy District Director of Health Services, and will be a member of the District Health Management Team.

iv) The hospital or up-graded health centre may belong to either government, NGO or private sub-sector.

v) The activities in the HSD will be monitored by the DDHS using performance indicators to ensure that the responsibility is carried out satisfactorily and the services for which resources are provided for are delivered.

vi) Clear terms of collaboration will be prepared specifying the mandate of the supervising unit and the responsibilities of the service providers being supervised, and the mechanisms for resolving problems and deficiencies encountered. However all the various providers will retain their identity and belonging. Internal management systems and regulations of the various providers will be respected.

vii) Specialist professionals from referral hospitals will provide additional technical support and on-job training to the staff in the health sub-districts.

viii) The HSD will embrace all aspects of health, from the community to the hospital levels. In order to ensure sustained commitment of all the key partners in health care provision in the HSD the leadership should be broad based and participatory. While the Medical Superintendent or the In-Charge of the up-graded health centre will provide the overall leadership a committee should be formed that brings together representatives of all major partners in community health activities, including the community itself, for participatory planning and monitoring.

ix) The composition of the hospital management committee and the health unit management committee for the up-graded health centre will be reviewed and streamlined to conform to the changing roles of the hospitals and the up-graded health centres in the HSD. In additional a specific community health department committee will be established at the district hospital to coordinate and monitor the community health activities of the hospital.

4. Cost implications of the establishment of Health Sub-districts

It is estimated that 214 health sub-districts will be established based on the constituencies. The HSD will be managed by the hospitals and up-graded health centres. The up-grading of health centres will be considered in constituencies where there are no hospitals. There are 98 hospitals in the country. However only 79 constituencies have hospitals (See Annex 1, Table 1). One hundred and thirty nine (139) constituencies without hospitals will require up-graded health centres to manage the HSD. Up-grading health centres will entail rehabilitation of the infrastructure including provision of basic equipment for diagnosis and provision of essential health services and management of common emergencies like those related to child birth. Additional staff and other resources will be needed both at the hospitals and the up-graded health centres.

4.1 Estimated cost

Cost Assumptions:

i) Hospitals by and large already have the infrastructure and the basic resources like personnel, equipment, etc to manage the operations of the HSD.

ii) NGO hospital infrastructure and other basic resources will be made available for the management of the operations of the HSD.

iii) The district and local community will contribute towards meeting the cost of up-grading health centres.

The estimated cost of establishing 214 health sub-districts is in Annex II

ANNEX I

Table 1: PROPOSED HEALTH SUB-DISTRICTS AND THE SUPERVISING HEALTH UNITS

Districts	PROPOSED HSD (CONSTITUENCY)	Population (projected 1997)	Hospital	HC TO BE UP-GRADED (PROVISIONAL)	Owner
1. ADJUMANI	East Moyo	113,721	Adjumani	-	Government
2. APAC	Kole County	135,114	-	Aboke	Government
	Kwania County	99,097	-	Aduku	Government
	Maruzi County	91,036	Apac	-	Government
	Oyam County North	103,185	-	Anyeke	Government
	Oyam County South	104,369	Aber	-	NGO
3. ARUA	Aringa County	121,484	Yumbe	-	Government
	Ayivu County	134,974	-	Adumi	Government
	Koboko County	75,886	-	Koboko	Government
	Madi-Okollo County	86,099	-	Okollo	Government
	Maracha County	130,982	Maracha	-	NGO
	Terego County	120,975	-	Omugo	Government
	Vurra County	79,154	Kuluva	-	NGO
	Arua Municipality	27,046	Arua	-	Government
4 BUGIRI	Bukhooli County North	90,628	Bugiri	-	Government
	Bukhooli County Central	112,154	-	Nankoma	Government
	Bukhooli County South	80,557	-	Buyinja	Government
5BUNDIBUGYO	Bwamba County	122,987	Bundibugyo	-	Government
	Ntoroko Count	32,314	-	Rwebisengo	Government
6. BUSIA	Samia Bugwe County North	103,208	-	Masafu	Government
	Samia Bugwe County South	98,236	-	Lumino	Government

7.BUSHENYI	Buhweju County	68.830	-	Nsiika	Government
	Bunyaruguru County	93,405	-	Rugazi	Government
	Igara County East	108,717	-	Bushenyi	Government
	Igara County West	90,809	Comboni	-	NGO
	Ruhinda County	166,394	-	Mitooma	Government
	Sheema County North	114,086	-	Kabwohe	Government
	Sheema County South	75,559	Kitagata	-	Government
8. GULU	Aswa County	93,360	-	Awach	Government
	Kilak County	111,878	-	Atiak	Government
	Nwoya County	47,867	Anaka	-	Government
	Omoro County	125,487	-	Lalogi	Government
	Gulu Municipality	48,309	Gulu	-	Government
9. HOIMA	Bugahya County	156,075	Hoima	-	Government
	Buhaguzi County	93,925	-	Kyangwali	Government
10. IGANGA	Bugweri County	99,891	-	Busesa	Government
	Bunya County East	71,770	-	Kigandalo	Government[x]
	Bunya County South	83,855	-	Malongo	Government[x]
	Bunya County West	101,123	Buluba	-	NGO
	Busiki County	146,662	-	Nsinze	Government
	Kigulu County North	82,454	-	Namungalwe	Government
	Kigulu County South	96,304	Iganga	-	Government
	Luuka Couty	154,402	-	Kiyunga	Government
11. JINJA	Butembe County	125,575	Kakira	-	Private
	Kagoma County	161,824	-	Buwenge	Government
	Jinja Mun. East	61,604	-	Walukuba	Government
	Jinja Mun. West	21,896	Jinja	-	Government
12. KABALE	Ndorwa County East	106,247	-	Kaharo	Government[x]
	Ndorwa County west	98,793	-	Rubaya	Government
	Rubanda County East	82,911	-	Hamurwa	Government[x]
	Rubanda County West	114,750	-	Muko	Government
	Rukiga County	116,462	-	Kamwezi	Government
	Kabale Mun.	39,135	Kabale	-	Government

13 KABAROLE	Buryangabu County	151,750	-	Yerya	NGO
	Buryahya County	163,904	-	Iruhura	NGO
	Kibale County	141,534	-	Rukunyu	Government
	Kitagwenda County	97,060	-	Nyabani	Government
	Kyaka County	75,187	-	Kyegegwa	Government
	Mwenge County North	116,787	-	Kyarusozi	Government
	Mwenge County South	98,583	-	Kyenjojo	Government
	Fort Portal Mum.	38,796	Buhinga	-	Government
14 KALANGALA	Bujumba County	10,219	-	Kalangala	Government
	Kyamuswa	7,981	-	Bukasa	Government[x]
15 KAMPALA	Kampala Central Div.	126,227	-	Kampala	Government
	Kawempe Div. North	79,477	-	Kawempe	Government
	Kawempe Div. South	98,033	Old Mulago	-	Government
	Makindye Div. East	92,377	Kibuli	-	NGO
	Makindye Div. West	116,903	Nsambya	-	NGO
	Rubaga Div. North	88,228	Mengo	-	NGO
	Rubaga Div. South	112,469	Rubaga	-	NGO
	Nakawa	152,787	Butabika	-	Government
16 KAMULI	Budiope County	160,231	-	Bugaya	Government
	Bugabula County North	82,254	Kamuli	-	NGO
	Bugabula County South	108,340	-	Namwendwa	Government
	Bulamogi County	128,800	-	Kaliro	Government
	Buzaya County	114,878	-	Nankandulo	Government
17 KAPCHORWA	Kongasis County	37,267	-	Bukwa	Government
	Kwen County	45,342	-	Kaproron	Government[x]
	Tingey	59,091	Kapchorwa	-	Government
18. KASESE	Bukonzo County West	94,745	Bwera	-	Government
	Bukonzo County East	108,432	Kagando	-	NGO
	Busongora County North	107,747	-	Bugoye	Government
	Busongora County	103,774	Kilembe	-	Private

19 KATAKWI	Amuria County	63,216	-	Amuria	Government
	Kapelobyong County	33,340	-	Kapelebyong	Government
	Usuk County	104,755	-	Katakwi	Government
20 KIBAALE	Bugangazi County	53,386	-	Kakindo	Government
	Buyaga County	152,674	Kagadi	-	Government
	Buyanja	46,539	-	Kibaale	Government
21 KIBOGA	Kiboga County East	115,893	Kiboga	-	Government
	Kiboga County West	51,307	-	Bukomero	Government
22 KISORO	Bufumbira County East	80,889	Mutolere	-	NGO
	Bufumbira County North	62,655	-	Nyabwishenya	Government
	Bufumbira County South	97,357	Kisoro	-	Government
23. KITIGUM	Agago County	127,577	Kalongo	-	NGO
	Aruu County	102,582	-	Pajule	Government
	Chua County	132,517	Kitgum	-	Government
	Lamwo County	90,024	-	Madi-Opei	Government
24 KOTIDO	Dodoth County	109,061	Kabong	-	Government
	Jei County	68,373	-	Kotido	Government
	Labwor County	56,866	Abim	_	Government
25 KUMI	Bukedea County	101,670	-	Bukedea	Government
	Kumi County	137,811	Atutur	-	Government
	Ngora County	80,219	Ngora	-	NGO
26 LIRA	Dokolo County	102,412	-	Dokolo	Government
	Erute County North	94,127	-	Ogur	Government
	Erute County South	103,423	-	Amac	Government
	Kioga County	82,528	Amai	-	Private
	Moroto County	153,695	-	Alebtong	Government
	Otuke County	52,378	-	Orum	Government
	Lira Municipality	33,227	Lira	-	Government
27 LUWERO	Katikamu County North	115,691	-	Kasana	Government
	Katikamu County South	72,284	-	Nyimbwa	Government
	Nakaseke County	119,714	Nakaseke	-	Government
	Bamunanika	137,955	-	Zirobwe	Government

28 MASAKA	Bukomansimbi County	149,734	-	Butenga	Government
	Bukoto County Mid West	87,250	-	Makondo	NGO
	Bukoto County West	75,073	-	Kyazanga	Government
	Bukoto County East	98,640	-	Kiyumba	Government
	Bukoto County South	122,754	-	Kinoni	Government[x]
	Bukoto County Central	49,970	-	Kyanamukaka	Government[x]
	Kalungu County East	91,340	Villa Maria	-	NGO
	Kalungu County West	88,541	-	Kalungu	Government
	Masaka Municipality	58,670	Masaka	-	Government
29 MASINDI	Bujenje County	56,386	-	Buijanga	Government
	Buliisa County	61,064	-	Buliisa	Government
	Buruli County	109,597	Masindi	-	Government
	Kibanda	106,752	Kiryandongo	-	Government
30 MBALE	Bubulo County West	97,108	-	Bubulo	Government
	Bubulo County East	123,510	-	Magale	Government
	Budadiri County East	90,013	-	Budadiri	Government
	Budadiri County West	92,544	-	Buwasa	Government[x]
	Bulambuli County	79,800	-	Muyembe	Government
	Bungokho County North	95,450	-	Salem-Kolonyi	NGO
	Bungokho County South	135,565	-	Busiwu	NGO
	Manjia County	97,893	Bududa	-	Government
	Mbale Municipality	66,715	Mbale	-	Government

31 MBARARA	Bukanga County	95,358	-	Nakivale	Government
	Ibanda County North	86,547	-	Ishongorera	Government
	Ibanda County South	91,805	Ibanda	-	NGO
	Isingiro County North	77,617	-	Mabona	Government
	Isingiro County South	99,760	-	Nshungezi	Government
	Kashari County	147,093	-	Bwizibwera	Government
	Kazo County	77,867	-	Kazo	Government
	Nyabushozi County	91,951	Rushere	-	NGO
	Rwampara County	144,967	Itozo	-	Government
	Mbarara Municipality	49,436	Mbarara	-	Government
32 MOROTO	Bokora County	53,280	St. Kizito	-	NGO
	Cwekwii County	57.462	-	Tokora	Government
	Matheniko County	68,758	-	Loputuk	NGO
	Pian County	36,203	-	Nabilatuk	Government
	Upe County	16,027	-	Amudat	NGO
	Moroto Municipality	14,869	Moroto	-	Government
33 MOYO	Obongi County	26,609	-	Obongi	Government
	Moyo West County	67,168	Moyo	-	Government
34 MPIGI	Busiro County East	115,929	-	Wakiso	Government
	Busiro County North	76,085	-	SOS Kkizi	NGO
	Busiro County South	113,639	Kisubi	-	NGO
	Butambala County	88,663	Gombe	-	Government
	Gomba	143,119	-	Maddu	Government
	Kyadondo County East	114,994	-	Kasangati	Government
	Kyadondo Couty North	116,004	-	Buwambo	Government
	Kyadondo County South	85,644	-	Massajja	NGO×
	Mawokota County North	101,807	-	Mpigi	Government
	Mawokota County South	86,585	Nkozi	-	NGO
	Entebbe Municipality	51,193	Entebbe	-	Government

35 MUBENDE	Busujju County	76,915	-	Mwera	Government
	Buwekula County	153,282	Mubende	-	Government
	Kasanda County North	94,771	-	Kasanda	Government
	Kasanda County South	75,597	-	Kiganda	Government
	Mityana County North	73,367	-	Kalangalo	Government
	Mityana County South	110,467	Mityana	-	Government
36 MUKONO	Bbaale County	106.666	-	Bbaale	Government
	Buikwe County North	118,567	Nyenga	-	NGO
	Buikwe County West	84,095	Kawolo	-	Government
	Buikwe County South	110,429	Nkokonjeru	-	NGO
	Buvuma County	23,099	-	Buvuma	Government
	Mukono County North	126,651	-	Mukono	NGO
	Mukono County South	100,436	-	Kojja	Government
	Nakifuma County	172,146	Nagalama	-	NGO
	Ntenjeru County North	106,387	Kayunga	-	Government
	Ntenjeru County South	82,126	-	Kangulumira	Government
37 NAKASONGOLA	Nakasongola	128,255	-	Nakasongola	Government
38 NEBBI	Janam County	87,362	-	Pakwach	Government
	Okoro County	164,440	Nyapea	-	NGO
	Padyere County	144,997	Nebbi	-	Government
39 NTUNGAMO	Kajara County	106,474	-	Rwashamaire	Government
	Ruhama County	169,503	-	Kitwe	Government
	Bushenyi County	95,421	-	Rubare	Government
40 PALLISA	Budaka County	122,526	-	Budaka	Governmant
	Butebo County	77,597	-	Butebo	Government
	Kibuku County	111,376	-	Kibuku	Government
	Pallisa County	125,202	Pallisa	-	Government
41 RAKAI	Kabula County	60,978	-	Lyantonde	Government
	Kakuto County	78,480	-	Kakuto	Government
	Kooki County	151,545	-	Rakai	Government
	Kyotera	149,396	Kalisizo	-	Government

42 RUKUNGIRI	Kinkizi County East	107,679	Kambuga	-	Government
	Kinkizi County West	100,865	-	Kihihi	Government
	Rubaho County	132,481	Kisiizi	-	NGO
	Rujumbura County	166,074	Nyakibale	-	NGO
43 SEMBABULE	Lwemiyaga County	24,997	-	Ntusi	Government
	Mawogola County	145,430	-	Sembabule	Government
44 SOROTI	Kaberamaido County	55,803	-	Kaberamaido	Government
	Kalaki County	57,713	Lwala	-	NGO
	Kasilo County	41,282	-	Kidetok	NGO
	Serere County	84,555	-	Serere	Government
	Soroti County	101,496	-	Gweri	Government
	Soroti Municipality	57,040	Soroti	-	Government
45 TORORO	Bunyole County	131,357	Busolwe	-	Government
	Kisoko/Budama County North	100,560	-	Nagongera	Government
	Kisoko/Budama County South	95,207	-	Mulanda	Government
	Tororo County	122,553	-	Mukuju	Government
	Tororo Municipality	32,979	Tororo	-	Government
TOTAL			**79**	**135**	**214**

These are dispensaries, maternity units and sub-dispensaries to up grade to HC level IV
Source: HPD inventories: 1992 and 1996 reports.

Table 2: Summary of Central Health Units For the HSD by Owner

Health Unit	Owner			Total
	Government	NGO	Private	
Hospitals	49	27	3	79
Health Centres (IV)	114	21	0	135
TOTAL	163	48	3	214

PERCENTAGE OF HOUSEHOLD WITH LATRINE AND POPULATION ACCESSIBLE TO SAFE WATER IN UGANDA BY DISTRICT, 1998

NO	DISTRICT	POPULATION	NO. HHS	NO. LATIRNES CONSTRUCTED	NO. SAFE W/ SOURCE	% LATRINE COVERAGE	% SAFE WATER
1.	Adjumani					-	-
2.	Apac					33	-
3.	Arua					40	-
4.	Bugiri					-	-
5.	Bundibugyo					39.5	27.5
6.	Bushenyi					81.4	57.6
7.	Busia					-	-
8.	Gulu					7.5	-
9.	Hoima					-	-
10.	Iganga					-	-
11.	Jinja					-	-
12.	Kabale					79	45
13.	Kabarole					60.5	26.8
14.	Kalagala					34.3	-
15.	Kamuli					-	-
16.	Kampala					-	-
17.	Kapchorwa					69.5	-
18.	Kasese					53	34
19.	Katakwi					-	-
20.	Kibaale					44	-
21.	Kiboga					31.3	-
22.	Kisoro					72	34.5
23.	Kitgum					10.9	-
24.	Kotido					1.5	-
25.	Kumi					18.3	-
26.	Lira					64.3	-
27.	Luwero					43.5	-
28.	Masaka					63	-
29.	Masindi					-	-
30.	Mbale					-	-
31.	Mbarara					72	29
32.	Moroto					0.2	-
33.	Moyo					-	-
34.	Mpigi					47.6	-
35.	Mubende					37	-
36.	Mukono					-	-
37.	Nakasongola					-	-
38.	Nebbi					3.1	-
39.	Ntungamo					45.5	33.1
40.	Pallisa					57	14
41.	Rakai					5.4	-
42.	Rukungiri					91	40
43.	Sembabule					-	-
44.	Soroti					5.9	-
45.	Tororo					56	19
	NATIONAL						

ANNEX II

Costing of health sub districts

The Costing done here reflects the magnitude of funding expected to go into the implementation of the health sub-districts. The infrastructural improvements envisaged and costed here are part and parcel of the ongoing and planned rehabilitation and equipment of health facilities already largely funded. The facilities to be improved will be reprioritized to give first priority for rehabilitation to the central facilities of the HSD. The in-service training already on-going in the country and already largely funded will be reviewed to reflect new training needs resulting from the establishment of the HSD. All hospitals and health centres are already carrying out outreach health activities. These activities are already funded through various health programmes and government budget.
The only area that will require new money is the staff salary for the medical officer and the anesthetic staff. The salaries of this additional staff will be paid by government just like it is being done for the other health staff.

1. Costing Upgraded Health Centres

Health sub districts will be based around hospitals or up graded health centres in each of the 214 constituencies. Each constituency should have at least an upgraded health centre which will have a modest operating theatre, at least 10 beds and should ultimately have one medical officer to run it and accommodation to house him or her.

Currently there are hospitals suitably located in 75 of the constituencies. No additional capital infrastructure or recurrent funding will be required in the 75 constituencies.
Of the remainder, 123 constituencies have health centre IV which will require a modest upgrading in its facilities. The other 16 constituencies have no health centre IV. All of these constituencies have dispensaries, sub- dispensaries or maternity units which will require more significant upgrading to bring them up to the required standards.

1.1 Capital Costs

At the hospital level there are no additional costs

(a) Where a Health Centre IV already exists

(i) Capital of an Operating Theatre

Table 1: Cost of constructing and equipping operating theatre.

	Unit costs (US $)	Number required	Total costs
Construciton: (105 HU)	32,480	105	3,312,960
Equipment and furniture (139 HC)	29,500	139	4,100,500
Total			**7,413,460**

Assumptions:

- 75% of the health centres require an operating theatre to be constructed; 25% have an existing room that could be made available and no construction would be required. They would however need to be equipped.
- Size of proposed theatre is 6.4m x 14.5m = 92.8m2
- Estimated cost of equipping an operating theatre is US $ 29,500 per facility
- Tables, furniture, facilities for washing and sterilization, surgical instruments, anaesthetic ether machine, portable spotlamps will be locally produced where possible.
- In all construction work and for some furniture communities will provide labour and some raw materials.

(ii) Capital Costs of In-Patient Facilities

Table 2: Cost of construction and furnishing wards

	Unit cost (US $)	Number required	Total
Construction of ward	39,950	16	639,216
Equipment and furniture	12,000	16	192,000
Total			**831,216**

Assumption:
12% of the health centres require in patient facilities to be constructed
Size of proposed facility 19.3m x 6.9 m = 133.17m^2.

- Cost of proposed housing = $300 per m^2
- US $ 12,000 per facility is assumed for additional furniture and equipment.

(ii) **Cost for staff accommodation**

Construction of accommodation for the Medical Offices is estimated to cost $21,000 per housing unit, 105 housing units for Medical Officers will be required. Total cost of constructing accommodation for medical doctors is $ 2,625,000

Assumptions:

- 75% of the health centre will require construction of accomodations for the Medical Officers.
- The size of the proposed housing unit is $70m^2$
- Cost of proposed housing unit is US $ 300 per m^2

Summary of capital costs:

1.	Construction and equipment operating theatre	$ 7,413,460
2.	Construction and furnishing in-patient wards	$ 831,216
3.	Construction of Doctors accomodation	$ 2,625,000
	Sub total	**$ 10,869,676**

1.2 **Recurrent Costs**

(a) Staff costs

At Hospital level, existing staff will fulfil this function, no additional staff will be required at hospital level

Most of the staff required for the health centre are already in place and being paid through the district budget.

The additional costs are therefore for the new cadres of staff to be introduced as result of the up-graded functions of the health centres. The key additioal staff are Medical Officers and Anaesthetic Assistants.

Additional staff cost therefore includes the salary for Medical Officers and Anaesthetic Officers.

Cadre	Number required	Annual salary per Medical Officer	Total
Medical Oficer	139	2,896	40,257
Anaesthetic Officer	139	1,515	21,053
Total			**61, 310**

How to staff the proposed facilities

There are 2 Medical Schools in the country with total output of about 150 doctors per year. Most of these doctors will be available for recruitment by the districts to work in the up-graded health centres.

The annual average output of Anaesthetic Officers from the Schools of Anaestheisa at Mulago is 10. Given that at least 139 Anaesthetic Officers would be required to staff the upgraded health centres, the output from the training schools in adequate.

The shorter (6 months) training programme for Nurse Anaesthetists currently implemented at Locor Hospital will be further developed and supported to enhance the supply of anaesthetic staff for the up-graded health centres. The critical assumption is that the staff will be willing to be posted to up-graded health centres.

(b) Other recurrent costs

(i) Outreach activities

•	Allowances -	3 x 2 x 4 x 12 x 214	=	$ 61,632
•	Fuel -	10lts x 1.14 x 4 x 12 x 214	=	$ 117,100
•	Health Education Materials:	2000 x 214	=	$ 428,000

(ii) Maintenance of new buildings = $230,000

(iii) Maintenance of new equipment (motor cycle, bicycles, theatre equipment, ward equipment) = $ 418,000

(iv) In-service Training:
1 course for 30 participants for 1 week per quarter
5000 x 4 x 214 = $ 4,280,000

Summary of recurrent

1.	Additional staff costs	=	$ 61,310
2.	Outreach activities	=	$ 606,732
3.	Maintenance of building	=	$ 230,000
4.	Maintenance of new equipment	=	$ 418,000
5.	In-service training	=	$ 4,280,000
	Sub Total	=	**$ 5,596,042**

Phasing implementation of HSD strategy

The implementation of the HSD strategy will be phased over a period of 4 years. The phasing will be done as follows

	1998/99	1999/00	2000/01	2001/02	Total
Capital costs	2,717,419	2,717,419	2,717,419	2,717,419	10,869,676
Recurrent costs	1,290,453	2,580,906	3,871,359	5,596,042	

- Capital construction will be phased over 4 years: criteria for prioritising which sub districts are established first still to be determined.
- Recurrent costs build up over the period.

Financing of the strategy

Table 3. financing capital costs by source

Capital costs	Totals cost (US $)	Gou	Country	Donor
Operating Theatre	7,413,460	-	-	7,413,460
In-patient facilities	831,216	634,565	211,520	1,269,132
Doctors Accomodation	2,625,000	787,500	262,500	1,575,000
Total	**10,869,676**	**1,422,065**	**474,020**	**10,257,592**

Table 4: Financing recurrent costs by source

Recurrent costs	**Total cost (US $)**	**Gou**	**Community**	**Donor**
Salaries (additional staff only)	61,310	54,252	-	-
Outreach activities	606,732	606,732		
Maintenance of Buildings	230,000	206,000	24,000	
Maintenance of new equipment	418,000	376,000	42,000	
In-service training	4,280,000	428,000	-	3,852,000
Total	**5,596,042**	**1,243,813**	**66,000**	**3,852,000**

The assumption is that communities make a contribution to the costs and that Government makes a small contribution to capital costs and assumes the majority of the running costs.