

**Government of Uganda
Ministry of Health**

**NATIONAL HEALTH POLICY:
Reducing poverty through promoting people's health**

May 2009 Version

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LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ARI	Acute Respiratory Infections
CDs	Communicable Diseases
CDC	Communicable Diseases Control
CHD	Community Health Department
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short Course (for Tuberculosis)
FB-PNFP	Facility Based Private Not For Profit
EMHS	Essential medicines and Health Supplies
GoU	Government of Uganda
HC	Health Centre
HDI	Human Development Index
HIV	Human Immuno-Virus
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HPE	Health Promotion and Education
HRH	Human Resource for Health
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee
ICT	information Communication Technology
IEC	Information Education and Communication
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Nets
JRM	Joint Review Mission
MDG(s)	Millenium Development Goal(s)
MoH	Ministry of Health
MoU	memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTR	Medium Term Review
NCD(s)	Non-Communicable Disease(s)
NDA	National Drug Authority
NDP	National Development Program
NEPAD	New partnership for Africa Development
NGO	Non-Governmental Organisation
NHA	National Health Assembly
NHP	National Health Policy
NMS	National Medical Stores
NTDs	Neglected Tropical Diseases
PHC	Primary Health Care
PHP	Private Health Practitioners
PNFP	Private Not for Profit
PPPH	Public Private Partnership in Health
SHI	Social Health Insurance
SWAp	Sector Wide Approach
TCMPs	Traditional and Complimentary Medicine Practitioners
TRM	Technical Review Meeting

TWG	Technical Working Group
UBTS	Uganda Blood Transfusion Service
UCMB	Uganda Catholic Medical Bureau
UGX	Uganda Shillings
UMMB	Uganda Muslim Medical Bureau
UNCRL	Uganda National Chemotherapeutics Research Laboratory
UNHRO	Uganda National Health Research Organisation
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
UNMHCP	Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau
UVRI	Uganda Virus Research Institute
VHT	Village Health Team
WHO	World Health Organisation

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1. INTRODUCTION

The development of this National Health Policy (NHP II) has been informed by the National Development Program (NDP) for the period 2009/10-2013/14, the overall development agenda for Uganda. The NDP places emphasis on investing in the promotion of people's health, a fundamental human right for all people. Constitutionally, the Government of Uganda (GoU) has an obligation to provide basic medical services to its people and promote proper nutrition. The Constitution further provides for all people in Uganda to enjoy rights and opportunities and have access to education, health services and clean and safe water. Investing in the promotion of people's health shall ensure they remain productive and contribute to national development.

Uganda's first NHP (NHP I) guided the health sector between 1999 and 2009. Over this period, a number of changes have occurred e.g. introduction of the Sector Wide Approach (SWAp), implementation of the decentralisation programme, end of the conflict in northern Uganda and the focus on recovery and development in the region, the huge increase in the number of districts, emergence of non-communicable diseases (NCDs), globalisation and the negative health consequences of changing climate. At a global level, the Paris Declaration and International Health Partnership and other Initiatives (IHP+) seek to achieve better health results and provide a framework for increased aid effectiveness. All these call for a review of Uganda's NHP to incorporate emerging issues and identify new strategies for action.

This NHP II was developed through a participatory process, involving 11 technical working groups (TWGs) whose membership was drawn from the Ministry of Health (MoH), other relevant government Ministries, health development partners, the private sector and civil society organisations (CSOs). Their task was to review the NHP I adopted in 1999, determine elements of the policy which were still relevant and needed to be carried forward in the new policy, and identify new issues that needed to be addressed. The focus of NHP II shall be on health promotion, disease prevention and early diagnosis and treatment of disease. .

2. THE SITUATION ANALYSIS

During the post-independence era (1962-1971) Uganda was one of the countries with best health indices and a vibrant health care system in Africa. Two decades of civil unrest followed and the health care system collapsed. After the war, GoU started reconstruction and rehabilitation programmes first focussing on putting in place the political and economic environment conducive to growth. Since early 1990s, GoU has given high priority to improvement of the health status of people as evident in the development and implementation of the first NHP and the Health Sector Strategic Plans (HSSP) I and II. Health indicators remain poor and disparities exist with northern Uganda, because of civil unrest, having the worst.

2.1 Demographic and health status

Uganda has a population of 30.7 million with an annual growth rate of 3.2%. With a population density of about 120 persons per km², Uganda is one of the most densely populated countries in Sub-Saharan Africa. Eighty eight percent of the population lives in rural areas. Uganda has made progress in improving the health of its citizens: life expectancy increased from 45 years in 2003 to 52 years in 2008; HIV prevalence has stabilised; polio and guinea worm have nearly been eradicated but concerns exist about the re-emergence of polio cases due to cross border migration; and prevalence of other vaccine preventable diseases has declined sharply. Between 1995 and 2005, U5MR declined from 156 in 1995 to 137 deaths per 1,000 live births; IMR decreased from 85 to 75 deaths per 1000

live births; and MMR reduced from 527 to 435 per 100,000 live births. Under-weight prevalence reduced from 23% to 16% over the same period. These health indicators are still poor.

Malaria, HIV and AIDS and tuberculosis remain the leading causes of morbidity and mortality. Seventy percent of overall child mortality is due to malaria, ARIs, diarrhoea and malnutrition. NCDs are an emerging problem and these include hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness and injuries. The increase in NCDs is due to multiple factors e.g. adoption of unhealthy lifestyles and the ageing population. Uganda has the world's 2nd highest accident rate, with over 20,000 road accidents a year and 2,334 fatalities in 2008. Neglected tropical diseases (NTDs) are still common and so are domestic violence, rape, sexual abuse, abuse of children, which are often related to excessive use of alcohol. Seventy five percent of the disease burden in Uganda can be prevented through health promotion and prevention. .

2.2. Determinants of health

Uganda, as is the case with other African countries, is experiencing a double burden of disease namely, communicable diseases and emerging NCDs. The 2006 DHS generally shows that level of education attained constitutes one of the major determinants of health e.g. prevalence of diarrhoea, ARIs and fever among under-five children decreases the higher the educational level of the mother. Ensuring that children remain in school is a major challenge as the school dropout rate is high: only 49% reach Grade 5. Despite the fact that the proportion of people living below the poverty line has significantly declined from 52% in 1992 to 31% in 2005, Uganda remains one of the poorest countries ranking 145 on the global Human Development Index. Far more people live below the poverty line in Northern Uganda (64.8%) than in other regions. A direct relationship has been demonstrated between poverty and incidence and prevalence of malaria, dysentery and diarrhoea as they are more prevalent among the poor compared to the rich. The lack of a universal national health insurance scheme makes the poor more vulnerable in terms of affordability and choice of health provider.

Latrine coverage and access to safe water remain poor: 12% do not have toilet facilities and 67% have access to improved water sources. The situation is worse in rural areas. Housing conditions are also poor with three quarters of the households having floors made of earth, sand or dung. Prevailing cultural beliefs among most people in Uganda tend to lead to self care and consultation of traditional healers which in turn delays in seeking appropriate health care. This is compounded by lack of physical accessibility of health facilities as still a significant proportion live more than 5 km radius from the nearest health facility. In addition to this, civil strife as was the case in Northern Uganda, people's way of living such as the pastoral communities and the changing lifestyles (for example eating unhealthy diets and sedentary living) impact on the health of the people in Uganda. It is evident therefore that the major determinants of health in Uganda include the low levels of literacy, poor sanitation, cultural beliefs, physical accessibility, uptake of risky behaviours and the prevailing poverty.

2.3 Organisation and management of the health sector

Both the public and private sectors are paying an important role in health service delivery in Uganda. In each of these sectors, there exist multiple players: Ministry of Health, Ministry of Defence, Ministry of Home Affairs and other Ministries and Departments in the public sector and several private subsectors as detailed below. At national level, the functions of the MoH include: resource mobilisation and budgeting, policy formulation and policy dialogue with development partners, strategic planning, regulation, advising other ministries on health and related matters, setting

standards and quality assurance; capacity development and technical support; provision of nationally co-ordinated services e.g. epidemic control; co-ordination of health research; and monitoring and evaluation of the overall sector performance. Several functions have been delegated to national autonomous institutions, including some specialised clinical support functions (Uganda Blood Transfusion Service, National Medical Stores, National Public Health Laboratories) and regulatory functions (the Medical and Dental Practitioners and other professional councils, the National Drug Authority). Research activities are conducted by several research institutions.

2.4 Health service delivery

Health services are provided by the public and private sector with each sector covering about 50% of the standard units of outputs. For the public sector, the Uganda National Minimum Health Care Package has been developed for all levels of the system, and services are supposed to be based on this package.

2.4.1 The public health delivery system

Uganda's government health system consists of the district health system (village health teams (VHTs), HCs II, III and IV and district general hospitals) and regional (RRH) and national referral hospitals (NRH), which are self-accounting and autonomous institutions, respectively. District health services are managed by the Ministry of Local Government. . The district health system is further divided into health subdistricts (HSDs). In general, district management capacity is still very limited in many districts: leadership, management and specialist skills are in short supply at all levels of health care and high levels of attrition tend to curtail capacity building initiatives. While Community Health Departments (CHDs) exist at RRH to provide support to districts, this has not been fully implemented. The increase in the number of districts over the last decade has overstretched the capacity of the MoH to manage the districts to the edge. Although 72% of the households in Uganda live within 5km from a health facility (public or PNFP), utilisation is limited due to poor infrastructure, lack of drugs and other health supplies and the shortage and low motivation of human resource in the public sector. . The functionality of the health system in Uganda is a challenge and systems strengthening especially at district level will be required to effectively deliver services.

Health promotion and education (HPE) programmes are implemented through different channels (e.g. local councils, VHTs, Civil Society Organisations (CSOs), mass media and schools) and aim at influencing behavioural change. Such programmes are affected by inadequate political support, human and financial resources and transport. For instance, only 30 out of 80 districts have trained VHTs. VHTs in particular have contributed to increasing health awareness, demand and utilisation of health services (child health days) and significantly led to decongestion at health facilities as they timely treat minor illnesses. VHTs and Health Unit Management Committees (HUMC) have helped to increase participation of beneficiaries in planning and monitoring of community health programmes.

2.4.2 The private sector

The private system comprises of the private not for profit organisations (PNFPs), private health practitioners (PHPs) and the traditional and complimentary medicine practitioners (TCMPs). The PNFPs are more organised and structured than the other sub-sectors. They have better collaboration with MoH. Even though the private sector provides a significant proportion of health services, it is not properly integrated with the public sector to fully take advantage of each other. The Public Private Partnership for Health (PPPH) has established structures of coordination at central level but

not yet at district level. A national PPPH policy has been drafted and is awaiting cabinet approval. The non-facility based PNFPs have not been properly harnessed to support health promotion at community level. Improving the partnership at district level will enhance capacity to provide health promotion and disease prevention, among other services. Large corporations such as banks and commercial farms have been involved in disease control and have been recognised and encouraged by government, but the extent is still limited.

2.4.2.1 The Private not-for-profit subsector (PNFP)

The facility-based PNFPs (FB-PNFPs) provide both curative and preventive services while the non-facility based PNFPs (NFB-PNFPs) mainly provide promotive, preventive, palliative and rehabilitative services. The FB-PNFPs account for 41% of the hospitals and 22% of the lower level facilities and are more present in rural areas, thereby complimenting government facilities. The PNFPs operate 70% of health training institutions with financial support from GoU. Seventy five percent of the FB-PNFPs exist under four umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB) and the Uganda Muslim Medical Bureau (UMMB). GoU recognises the importance of the PNFPs by subsidising the sub-sector. The PNFPs receive donations and they also charge user fees. Several NFB-CSOs operate at community level in the areas of health education and promotion, counselling, social mobilization and supporting community health workers to promote health at community level. However, the NFB-PNFPs have not been properly harnessed. .

2.4.2.2 Private Health Practitioners (PHPs)

PHPs provide mainly primary level services and have a large urban presence. Existing relevant legislation provides for licensing and regulation of health professionals who engage in private practice. The expansion of private health providers has largely been unregulated and chaotic. The pharmaceutical sub-sector is however better regulated. The number of pharmacists and pharmacy technicians is low and most people doing pharmacy work are not qualified. Difficulties in accessing capital and other incentives have limited the expansion of the private sector.

2.4.2.3 Traditional and Complimentary Medicine Practitioners (TCMPs)

Approximately 60% of Uganda's population seek care from TCMPs (e.g. herbalists, traditional bone setters, traditional birth attendants, hydrotherapists and traditional dentists) before visiting the formal sector. Many traditional healers remain unaffiliated. Non-indigenous traditional or complimentary practitioners such as the practitioners of Chinese and Ayurvedic medicine have emerged. The legal framework for TCM is outdated and weak. It has however been revised but is waiting cabinet approval. . In the communities, most TCMPs have no functional relationship with public and private health providers. .

2.5 Supervision, monitoring and evaluation

Area Teams, technical programs, District Health Teams and HSDs supervise service delivery at government and PNFP facilities at different levels, except the national and regional referral hospitals. However, challenges exist: supervision and monitoring visits are irregular and poorly documented; there is a lack of human resource especially in newly created districts to conduct supervision; lack of supervisory skills at district and HSD levels; lack of transport for supervisory and monitoring visits and inadequate budgets. Also, the envisaged joint supervision with PNFP staff has not taken off and efforts at national level to organize and support clinical supervision of RRHs by

NRHs and general hospitals by RRH clinicians have not been very successful. In general, technical supervision is weak and this has affected the quality of service delivery. The Medical Council and other councils are expected to inspect the private health practitioners' facilities. The Health Sector Progress Reports detail annual health sector performance and form the basis for discussions during the National Health Assembly. These annual reports are verified by the Joint Review Missions (JRM) during field visits. HPAC discusses quarterly performance reports and performance of agreed upon undertakings.

The operations of the HMIS are affected by inadequate human and financial resources as well as excessive volumes of data collection. Timeliness of reporting is currently estimated at 68% and data quality is questionable. The existence of parallel data collection systems for vertical programs such as HIV puts a strain on HRH. Data utilisation for planning purposes is low. The private sector does not contribute to the HMIS. The current status of the HMIS makes it very difficult for timely and reliable data to be produced.

2.6 Research

Several institutions conduct health research, e.g. universities, autonomous institutions and other public institutions with diverse affiliations. The conduct of research has so far been hampered by the lack of a policy framework, an uncoordinated priority setting of the research agenda, inadequate funding, shortage of human resource and lack of transport. Other challenges include the translation of research findings into policy and the dissemination of results. To a large extent, this was related to delays in passing the Bill that mandates the Uganda National Health Research Organisation (UNHRO) to perform this function. However, this has now been done.

2.7 Legislation and enforcement

Currently, MoH is coordinating the drafting of bills to promote and regulate health services. Bills (e.g. the Pharmacy Profession and Practice Bill; Uganda Medicines Control Authority Bill; National Health Insurance Bill and the Traditional and Complimentary Regulatory Bill) are at different stages of development. Some legislation is quite old e.g. the Public Health Act. Attempts to review it were halted in 2003 as the new Health Services Bill was considered too broad. The process of reviewing legislation and policies has generally been very slow: e.g. the Pharmacy Profession and Practice Bill and the National Policy on PPPH were initiated in 1999 and the process has not been completed. The financial and human resources allocated for these processes have been inadequate. Technology has changed and emerging diseases such as NCD require legislation. While legislation and policies may exist, enforcement is a major challenge.

2.8 Health Resources

2.8.1 Human Resources in Health (HRH)

The HRH situation is critical: in November 2008 only 51% of the approved positions at national level were filled. The situation is worse in conflict and post-conflict and in rural and hard to reach areas. Reasons for the many vacancies include insufficient training capacity for health workers with the right mix to meet need of people in Uganda, low remuneration and poor working conditions in the public and PNFP sectors, making it difficult for the sector to recruit and retain staff. There is also inequitable distribution of health workers among districts, between rural and urban areas and between public and private providers. Attrition in PNFPs is high as health workers join the public sector and has been increasing in the past few years, following government's decision to increase

salaries and incentives for civil servants. Migration of health workers to other countries is not uncommon due to more attractive salaries and opportunities. In government, productivity is low due to high rates of absenteeism and rampant dualism. . The poor attitude of health workers to clients affects utilisation of services. Health workers often do not feel accountable to client communities. Leadership and management of human resources are also weak at all levels.

In terms of training, emphasis for most curricula of health workers is on curative care. Despite the PNFP subsector producing the majority of PHC staff, there is limited coordination with government. Training of medical doctors and other health staff is governed by several institutions (MoH, MoEC, PNFP training institution, Professional Councils), with no clear leadership, line of responsibility and mandates. Often decisions taken by one sector affect the others and results in an overall reduced training capacity.

2.8.2 Medicines and Health Supplies

Adequate quantities of affordable, good quality essential medicines and health supplies should be accessible to all who need them. This is not always the case: 72% of government health units have monthly stockouts of any indicator medicine. Costs of medicines are 3-5 times more expensive in private sector compared to public sector procurement costs. For many people, medicines in the private sector are not affordable. Inadequate financial and human resources, capital investment and management issues have resulted in the public sector being unable to fulfil its mandate of providing medicines to all those who need them. This has increased dependency on the private sector.

Only 30% of the EMHS required for the basic package are provided for in the budget. Global Initiatives provide the bulk of resources needed for malaria, HIV/AIDS, tuberculosis, vaccines and reproductive health commodities e.g. in 2006/7 the contribution from the global initiatives was US\$2.39 per capita out of the US\$4.00 per capita spent. Pharmacy staff has been recruited at different levels, but serious shortfalls prevail. Despite increased capacity to train pharmacists and pharmacy technicians, output is still insufficient to meet demand from public and private sectors. Delays in procurement, poor *quantification by* and *late orders from* facilities are among the management issues that contribute to shortage and wastage of medicines in the public sector. The private sector is fragmented and comprises of dispensing hospitals and clinics, retail pharmacies and both legal and illegal drug stores. There is an emerging pharmaceutical industry in the country, with a limited production so far. About 90% of all medicines are imported; close to 95% of these are generic products. Counterfeit drugs are becoming an increasing problem.

2.8.3 Health Infrastructure Development and Management

The number of health facilities in the public sector and the PNFPs has been growing from 1,979 and 606 in 2004 to 2,301 and 659 in 2006, respectively, resulting in 72% of the population living in a 5 km radius of a health facility. Even though an Essential Medical Equipment list has been drawn, problems exist relating to procurement delays and the lack of funds. Most facilities and equipment are in a state of disrepair and lack of transport is a major handicap especially in newly created districts. Rehabilitation of buildings and maintenance of medical equipment is not regularly done. Many health facilities remain uncompleted or poorly done. Accommodation for staff especially in hard to reach areas remains a big challenge and is a major reason for low staff numbers The existing infrastructure is insufficient to ensure that the core functions of the health sector are carried out. . Specialised hospitals are developing that will treat cancer and heart diseases. Enabling infrastructure is therefore required to ensure the conduct of these core functions including health promotion and disease prevention.

283.4 Health Financing

In recent years, health expenditure as a proportion of government's discretionary expenditure has been relatively stable around 9.6%. It thus remains below the Abuja Declaration target of 15%. No user fee is paid in lower level health units and general wings of publicly owned hospitals whereas the private sector charges user fees. Health insurance is for a few and largely subsidised by employers on behalf of employees. Households constitute a major financing source of the NHE at 49.7% and this is followed by the donors at 34.9%, central government at 14.9% and then the international NGOs at 0.4%. GoU subsidizes the PNFPs and its training institutions and a few private hospitals but the level of subsidies for PNFPs has stagnated at 20%. However, the allocation to PNFP facilities is rigid, takes little account of changing needs in terms of workload and is not related to productivity. As a result, finance has been inadequate to provide the UNMHC in all facilities as envisaged: the per capita cost was estimated at USD 41.2 in 2008/09 and will be rising to USD 47.9 in 2011/12; yet the MTEF estimation was estimated at USD 12.5 in 2008/09, demonstrating a shortfall of almost USD 29. This trend has important implications for service delivery during the NHP II period as it will imply the need for further priority setting, based on the UNHCP.

Efficiency is currently not well addressed in the way resources are mobilized, allocated and used. Although most development partners now channel resources through sectoral budget support, a portion of external funds remains off budget. This affects the way government resources are allocated. During the FY 2005/06 and 2006/07 the amount within the MTEF decreased from UGX269 billion to UGX189 billion and yet outside the MTEF it increased from UGX238 billion to UGX351 billion. Although contributions from donor projects are significant, contributions to sector priorities and effective monitoring and reporting remain a major challenge.

3.0 THE DEVELOPMENT CONTEXT

3.1 The national context

NHP II has been largely informed by the National Development Plan (NDP) which is an overall development strategy for the GoU that details priority interventions in any sector. The NDP explains how economic development exemplified by, for example, reduction in prevalence of poverty can be achieved. Economic development is dependent on social and human development. Improvement of people's health is both an outcome and a cause of economic development. The NDP prioritises the implementation of the UNMHCP. Currently, the health sector is implementing HSSP II which expires in 2010. The policy and the strategic plans, which have been developed based on national development plans, have guided developments in health during this period. The NHP II has also been formulated within the context of the provisions of the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997) which decentralised governance and service delivery. Following this, the MoH has devolved responsibilities to the districts for them to manage the delivery of health care and private hospitals. The supervision of the NRH and the RRH remains under the MoH headquarters. The NHP II also takes into account the emergence of new districts: by July 1st, 2010, the number of districts will increase to 97 up from 36 at the beginning of NHP I. This and the HIV and AIDS epidemic put a big strain on all resources for the sector as well as its organisation.

As a strategy for recovery and development in Northern Uganda, GoU in 2007 also launched the Peace, Recovery and Development Plan for Northern Uganda (PRDP). The PRDP is a commitment by

the GoU to stabilise and recover Northern Uganda over a 3 year period. Stakeholders including development partners are expected to align their programmes in the region to this development framework. This Policy shall further ensure the implementation of activities in line with GoU plans for Northern Uganda.

3.2 The International Context

The NDP reflects and spells out the international initiatives to which Uganda is a signatory and these include the MDGs, the Paris Declaration, the New Partnership for Africa Development (NEPAD), the IHP initiative and the Abuja Declarations. More recently in April 2009 Uganda was among other African countries that renewed their commitment to PHC at the Ouagadougou Conference.). The country will revitalize PHC and health systems development in order to achieve the health related MDGs and other targets for example those detailed in the 2000 Abuja Declaration on AIDS, tuberculosis and malaria. In order to achieve these goals, there is a need for scaling up investments in health promotion and disease prevention and increase aid efficiency. It seems, however, that for most of the MDG indicators Uganda is way off from achieving these by 2015.

4. VISION, GOAL, MISSION AND GUIDING PRINCIPLES

4.1 Vision

A healthy and productive population that contributes to economic growth and national development

4.2 Goal

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

4.4 Mission

To facilitate the attainment of a good standard of health by all people of Uganda in order to promote a healthy and productive life.

4.5 Social values

This policy puts the patient and community in the forefront and adopts a 'patient-centred' approach and it looks at both the supply and demand side of health care. The following social values, as detailed in the Constitution of the Republic of Uganda and Uganda's Patients' Charter, will guide the implementation of this policy.

4.5.1 The right to highest attainable level of health

- The Constitution guarantees rights of access for all people in Uganda to high quality health care services.
- Patients have the right to information about diagnosis, treatment, cost of treatment and consent after obtaining information and protection of privacy.
- Patients are entitled to safety in the public and private health sector. This has implications for treatment protocols, standards of medicines, medical supplies, medical equipment and infrastructure.

- Communities are entitled to a healthy and safe environment i.e. access to safe and adequate water supply, sanitation and waste disposal and protection from all environmental dangers.

4.5.2 Solidarity

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

4.5.3 Equity

- Government shall endeavour for equal treatment for equal need and for equal access to health care according to need.

4.5.4 Respect of cultures and traditions of the people of Uganda

- All stakeholders shall respect the promotive health aspects of the cultures and traditions of the peoples of Uganda.

4.5.5 Integrity and ethics

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

4.5.6 Patients' responsibilities

- Individuals are ultimately responsible for the lifestyle decisions they adopt. Patients have the responsibility of seeking care and adhering to treatment as prescribed.

4.5.7 Accountability

- At all times and at all levels, a high level of efficiency and accountability shall be maintained in the development and management of the national health system. The health service will be accountable for its performance, including its financial management performance, not only to the political and administrative system, but, above all, to its client communities.

4.6 Guiding principles

The National policy on health shall be guided by the following principles:

- The implementation of the NHP II shall be 'evidence-based' and 'forward-looking', as has been the development of this policy.
- NHP II shall be pro-poor oriented and shall provide a policy framework that shall support sustainable development.
- Government considers PARTNERSHIPS with other institutions, ministries and the private sector as a cornerstone of all its undertakings (or something similar).
- PHC shall remain the major strategy for the delivery of health services in Uganda. PHC, based on the district health system, explicitly recognises the role of hospitals as an essential part in a national health system.

- The existing collaboration between the public and private sectors shall be further strengthened. With regard to service delivery, the private sector shall be seen as complimentary to the public sector in terms of increasing geographical access to health services and in terms of the type of services provided.
- In order to address the burden of disease in a cost-effective way, GoU and PFNP shall provide services that are included in the minimum package. However, projected financial flows will not allow providing *all* services and interventions included in the current package to *all* communities in the country. A choice will be made between various scenarios, based upon equity and efficiency considerations. , including the need for special attention to Northern Uganda and other underserved parts of the country. However, private health practitioners shall be expected to provide services not included in the minimum package.
- In line with the PHC strategy and current and projected resource envelope restrictions, greater attention and support shall be given to the health promotion and disease prevention interventions as defined in the UNMHCP and empowerment of individuals and communities for a more active role in health development. Communities shall be encouraged and supported to participate in decision making and planning for health services provision through VHTs and Health Unit Management Committees.
- Government and PFNP facilities shall offer curative, preventive and promotive services in an integrated manner.

Government shall explore alternative, equitable and sustainable options for health financing and health service organisation targeting the poor and other vulnerable groups.

- A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.
- Health shall be mainstreamed in all relevant policies and MoH, as lead advisor to Government on health issues, shall provide advice to other government ministries and departments and the private sector.
- The Ministry of Health shall strengthen the development and implementation of efficient, sound and transparent financial management, accounting and procurement methods that can ensure the effective implementation of planned activities and achievement of strategic objectives.
- In order to minimize health risks in Uganda, the GoU shall play a pro-active role in initiating cross border initiatives in health and health- related issues.

4.3 Priority Areas for the National Health Policy

The situation analysis identified a number of challenges that need to be urgently addressed through policy guidance. More than 75% of the overall burden of diseases, either CDs or NCDs, is caused by preventable diseases. Access to safe water, sanitation and living conditions are still poor, especially in rural areas and urban slums, resulting in poor health and high malnutrition levels, especially in under-fives. Unhealthy life styles have led to an increase in NCDs. As the projected resource envelope for service delivery will be insufficient to cover all interventions and services to all people in the foreseeable future, strategic decisions on investing in health shall be made. The focus of the

policy shall be universal provision and utilisation of the UNMHCP to all people in Uganda with emphasis on vulnerable populations. The selected interventions shall not only to be cost-effective, but also affordable. For many of these diseases, cost-effective and affordable primary, secondary and tertiary prevention interventions and services are available. . They shall therefore constitute the core health interventions in this health policy.

4.3.1 Health promotion and education (HPE)

HPE is often the most cost-effective approach to contain the burden of communicable and non-communicable diseases, injuries and mental health problems. HPE shall address major known health risk factors and health determinants and shall be delivered through specifically targeted, population-based programmes involving different sectors (e.g. other ministries, schools, media, political leaders, CSOs, etc).

4.3.2 Disease prevention programmes

The coverage of disease prevention programmes e.g. EPI, de-worming, vitamin A supplementation, food fortification, IPT and PMTCT has not always been adequate enough to achieve the expected reduction in disease burden. Efforts shall be made to increase coverage and achieve maximum benefits from cost-effective disease prevention programmes.

4.3.3 Early diagnosis and treatment

Early diagnosis and treatment activities shall be expanded through improving access to these health services and awareness among communities. Active screening can be envisaged when found to be cost-effective and affordable. Treatment shall be guaranteed for all who go for early diagnosis.

4.3.4 Other priority areas

- Strengthening district health systems in line with decentralisation through training, technical assistance and financial support.
- Reconceptualising and organising supervision and monitoring, including the clinical supervision, of health workers at all levels of the government health system.
- Improving the collection and utilization of data for evidence-based decision making at all levels.
- Establishing a functional integration between the public and private sectors in health care delivery, training and research. .
- Redefining the institutional framework for training of health workers, including the mandate of all actors, leadership and coordination mechanisms, with the aim of improving both the quantity and quality of health workers production.

5.0 POLICY OBJECTIVES AND STRATEGIES

5.1 Organisation and management of the national health system

In accordance with the Constitution and the Local Government Act, the health sector shall continue operating a decentralised health service delivery system where focus shall be on strengthening district health systems to deliver the UNMHCP including health promotion, disease prevention and

early diagnosis and treatment. While decentralisation shall be the focus, the increase in the number of districts and the weakness of technical supervision, warrant a reorganisation of the supervision system: CHDs at RRH shall be strengthened to effectively supervise and support district health systems. Regardless of the increase in the number of districts, the organisation of health services shall be based on technical efficiency: a district health system shall serve a population of 500,000 while the HSD shall serve 100,000 people. Adequate health resources shall be made available in order to ensure that the health system delivers the UNMHCP. The sector shall also continue to delegate certain functions to autonomous national institutions:

- Specialised hospital care will be provided in autonomous regional and national referral hospitals, as well as the National Heart and Uganda Cancer Institutes;
- Specialised support services such the provision of EMHS, blood transfusion and public health laboratories shall be coordinated through the National (and Joint) Medical Stores, National Blood Transfusion Services and the National Public Health Laboratories;
- Regulation shall be enforced through professional councils and the National Drug Authority; and Research shall be coordinated by the Uganda National Health Research Organisation and implemented by various research institutions, both public and private.

5.1.1 Policy objective

- (a) To strengthen the organisation and management of the MoH and district health systems and ensure effective harmony and linkage among the different levels of health care, the private and public sectors, and the MoH and the autonomous and self-accounting national institutions.

5.1.2 Policy strategies

In order to achieve this policy objective, Government shall:

- (a) Ensure that the MoH central level and the appropriate national autonomous institutions carry out their core functions effectively and efficiently, namely: resource mobilisation and budgeting, policy formulation and policy dialogue with development partners, strategic planning, regulation, advising other ministries on health and related matters, mentoring local governments, setting standards and quality assurance; capacity development and technical support; provision of nationally co-ordinated services, e.g. epidemic control; co-ordination of health research; and monitoring and evaluation of the overall sector performance and the implementation of sectoral policies.
- (b) Strengthen the District Health System so that it carries out its responsibilities namely: implementation of the NHP; planning and management of district health services; provision of health promotion, disease prevention, curative and rehabilitative services; control of communicable and non-communicable diseases; vector control; health education; ensuring availability of safe water and environmental sanitation; and data collection, management and utilisation.
- (c) Reconceptualise and re-organise the managerial and clinical support mechanisms and structure to districts and RRH, including redefining the role of e the Area Teams, Office of the Medical Superintendent, Community Health Departments (CHDs) at RRH and others at district and subdistrict level. .
- (d) Ensure the continued functionality of HSDs which will be responsible for management of routine health service delivery at lower levels, planning and management of health services, fostering community involvement in the planning, management and delivery of health care.

- (e) Ensure that VHTs, which constitute HC Is, are functional in all villages in Uganda and their major responsibility shall be health promotion, awareness raising and treatment of minor illnesses.
- (f) Design, pilot and implement appropriate service delivery models for specific population groups, including the pastoral population in Karamoja, the Lake Victoria island populations and the population of large urban centres, especially Kampala.
- (g) Allocate proportionally higher capital investments and recurrent resources for district health services in northern Uganda until when services are at par with other parts of Uganda.
- (h) Re-emphasise integration as central to planning and service delivery at all levels and efforts to deliver through the health system in an integrated manner. Given the high cost of the vertical programmes, maintain such programmes only for those diseases which offer a reasonable possibility of elimination or eradication in a time span of this national health policy.
- (i) Re-invent and re-prioritise SWAp and its usefulness in delivering sectoral goals and priorities instead of sector programs.

5.2 The minimum health care package

The minimum health care package in Uganda shall consist of the most cost-effective priority health care interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector. The package shall continue to consist of 4 clusters namely:

- (a) Health Promotion, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response;
- (b) Maternal and Child Health;
- (c) Prevention and Control of Communicable Diseases and
- (d) Prevention and Control of Non-Communicable Diseases.

The composition of the package shall be revisited periodically depending on changes in disease burden, availability of new interventions to address these conditions, changes in the cost-effectiveness of interventions and the total resource envelope available for service delivery. During the implementation of the NHP II greater attention shall be paid to ensure equitable access by people in conflict and post conflict situations, hard to reach and other underserved areas to the package.

5.2.1 Policy objective

- (a) To ensure the provision and increase the utilisation of a UNMHCP consisting of promotive, preventive, curative and rehabilitative services for all priority diseases and conditions, to all people in Uganda, with emphasis on vulnerable populations.

5.2.2 Policy strategies

In order to achieve this policy objective, Government shall:

- (a) Ensure that the minimum package shall not only be used at all levels for service provision, but also as an overall planning, budgeting and resource allocation tool including for example for procurement of all requisite inputs, as a basic tool for training of health workers and for setting the national research agenda.

- (b) Ensure that at all times adjustments concerning the package necessitated by limitations in the resource envelope for service delivery will be based on the best possible combination of available options for equity, efficiency and quality of services.
- (c) Prioritise interventions against diseases internationally targeted for elimination or eradication such as guinea worm and polio.
- (d) In conjunction with the private sectors and CSOs provide promotive, preventative, curative and rehabilitative services that have been proven effective and cost effective. Specifically the following shall be prioritised:
 - (i) Prevention of malaria through use of ITNs, IPT, in-door residual spraying and early diagnosis and treatment
 - (ii) Implementation of new evidence based HIV prevention strategies, increasing equitable access to ART and strengthening monitoring and evaluation of HIV and AIDS programmes.
 - (iii) Rapid expansion of quality DOTS countrywide as part of the Global Plan to STOP tuberculosis.
 - (iv) Prevention, control and surveillance of NCDs.
 - (v) Control of NTDs.
 - (vi) Promotion of responsible sexual and reproductive health behaviours, especially among adolescents.
 - (vii) Promotion of household food security and healthier eating habits to improve the nutritional status of the people especially children, pregnant and lactating mothers.
 - (viii) Implementation of the child survival strategy including IMCI programs nationwide.
 - (ix) Implementation of roadmap for reducing maternal and neonatal morbidity and mortality.
 - (x) Implementation of hygiene and sanitation programmes.
- (e) Strengthen school health services in both public and private schools and to include dietary services.
- (f) Ensure that all people in Uganda, both users and providers of health services, understand their health rights and responsibilities through implementation of comprehensive IEC programs.
- (g) Improve people's awareness about health and related issues in order to bring about desired changes in knowledge, attitudes, practices and behaviours regarding the prevention and control of major health problems in Uganda. In order to achieve this, government will promote the use of social marketing and establish a clear marketing plan that will be proactive in targeting groups with the greatest need and use varying media according to the target audience.
- (h) Gradually strengthen self-care, especially at primary care level, for selected health problems and patient categories, possibly through –carefully planned and evaluated- pilot phases. Investments in self-care skills training for patients and staff often reap very substantial longer-term benefits.
- (i) Make substantial investments in the development of telemedicine.

5.3 Monitoring and evaluation

5.3.1 Policy objective

- (a) To promote the generation of data and use of evidence for decision making, program development, resource allocation and management.

5.3.2 Policy Strategies

In order to achieve this objective, Government shall:

- (a) Strengthen the capacity of the MoH and stakeholders in monitoring and evaluation of all health development interventions.
- (b) Strengthen and ensure support for the HMIS at all levels through increased investments.
- (c) Strengthen disease surveillance at national, districts and community level.
- (d) Increase the training, recruitment and deployment of required human resource for effective data management and dissemination at all levels.
- (e) Facilitate the establishment and operation of a community based health information system.
- (f) Ensure dissemination of information to other stakeholders for purposes of improving management, sharing experiences and upholding transparency.
- (g) Generate through periodic surveys, appropriate data for effective planning, management and delivery of health services to people with disabilities.
- (h) Strengthen capacity for coordination and monitoring and evaluation of different stakeholders.
- (i) Strategy for utilisation of data.

5.4 Research

The GoU shall give high priority to research in the next decade in order to support evidence-based policy and intervention formulation, identification of gaps for improvement and identifying critical factors for special needs for vulnerable groups especially women and children. Particular attention will be given to how research can be used to guide the development and implementation of health promotion, disease prevention and early diagnosis and treatment.

5.4.1 Policy Objective

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

5.4.2 Policy Strategies.In order to achieve this objective the Government shall:

- (a) Put in place a policy and legal framework to ensure effective coordination of research activities.
- (b) Develop and implement a prioritised national health research agenda in a consultative manner and undertake effective dissemination of research findings.

- (c) Ensure adequate allocation of funds to enable the conduct of highly relevant and quality research.
- (d) Promote dialogue and information sharing between the policy makers, researchers, health care providers and communities in order to ensure that research is relevant to the needs of the people and that research findings are utilized by the relevant stake holders, and are consistent with NHP II and National Health Sector Strategic Plans.
- (e) Develop an ethical code for the conduct of health research in Uganda, promoting the safety, rights of research participants, as well as the researchers.
- (f) Strengthen the National Health Research capacity in institutions at all levels and develop quality human resource and infrastructure to respond to essential research demands of the country.
- (g) Harness donor funds to ensure funding of prioritised operational research to inform policy and strategy development.

5.5 Legislation and regulation

5.5.1 Policy objective

- (a) To timely review and develop relevant legislation governing health and to ensure their enforcement.

5.5.2 Policy strategies

In order to achieve this policy objective, Government shall:

- (a) Expedite enactment of completed bills and fast track the drafting of other relevant bills.
- (b) Identify emerging health issues, conditions and therapeutic interventions that require new legislation and policies, and develop new legislation as appropriate.
- (c) Revise the Public Health Act.
- (d) Strengthen the Policy Analysis Unit to engage in policy development in health related sectors to ensure mainstreaming of health issues.
- (e) Strengthen relevant institutions to draft and enforce health and related legislations.
- (f) Ensure that all health providers, i.e. the public, private not for profit and private for profit, deliver high quality services by supporting the design and implementation of an effective regulatory environment that will enforce existing legislation and policies.

5.6 Health resources

In order to effectively deliver the UNMHCP at all levels, government with support from development partners and the private sector shall make available all necessary health resources, including, human resources, medicines and other health supplies, health infrastructure and financial resources.

5.3.1 Human Resource Management and Development

The health sector recognises the critical role of human resource in health in terms of both quality and numbers in the delivery of the UNMHCP. There is however a shortage and maldistribution of human resource, many staff are poorly motivated, and leadership and management skills are inadequate at all levels. s. The inadequate numbers graduating from training institutions makes it difficult to meet the human resource needs for the delivery of the minimum package. Many health workers do not feel accountable to communities.

5.3.1.1 Policy Objective I

- (a) To increase availability of appropriately trained health workforce in order to meet the health needs of the people of Uganda.

5.3.1.2 Policy strategies I

In order to achieve policy objective I, Government shall:

- (a) Increase the production, recruitment and retention of health workers in partnership with the private sector.
- (b) Increase government support (need to be more specific: investment?) to public, PNFPs and private training institution.
- (c) Further develop and implement GoU/development partners pooled funding to PNFP training institutions and strategic bonding.
- (d) Strengthen coordination and partnership between public and private sectors through participatory development of strategic plans for training and management of health workers.
- (e) Review curricula and training strategies to enable health workers to cope with emerging health problems and to interact in a professional, accountable and culture-sensitive way with clients.
- (f) Redefine the institutional framework, including the mandate, leadership and coordination mechanisms of health workers training institutions.
- (g) Implement a needs-based health workforce recruitment and deployment (do we mean: a workload-based deployment? That I would understand; otherwise: what do we mean?).
- (h) Redistribute human resource to guarantee optimum national coverage (based on workload, as mentioned in an other strategy)
- (i) Develop and promote incentive schemes for e deployment and retention of health workers, especially in hard to reach areas.
- (j) Ensure training of specialised personnel for effective provision of quality care to reduce sending of patients outside Uganda.

5.3.1.3 Policy objective II

- (a) To increase productivity and performance of human resource through the development and efficient utilisation of the health workforce.

5.3.1.4 Policy strategies II

In order to achieve policy objective II, Government shall:

- (a) Strengthen management and leadership skills at all levels in government to ensure clear roles and responsibility for the health staff.
- (b) Ensure a fair and transparent career development for all government health workers based on performance and achievement.
- (c) Grant equal training and development opportunity for all health staff from government and PNFP institutions.
- (d) Develop and implement a safe working environment to minimise health risk for the human resources and patients.
- (e) Strengthen government's performance management systems through supportive supervision.
- (f) Develop effective ways of increasing health worker's accountability towards client communities.
- (g) Engage with the leaders of the healthcare professions to determine and enforce acceptable standards of professional practice and to develop robust processes to challenge poor standards of practice wherever and whenever they appear.

5.3.2 Medicines and health supplies

The shortage of medicines in health facilities constitutes a major problem in service delivery. Poor quantification, late orders, inadequate financing and lack of trained pharmacists/technicians contribute to this shortage. Over the next 10 years GoU shall ensure that safe, good quality medicines and health supplies are available and affordable to the population of Uganda.

5.3.2.1 Policy objective

- (a) To ensure that essential, efficacious, safe, good quality and affordable medicines are available and used rationally at all times.

5.3.2.1 Policy strategies

In order to achieve this objective, Government shall:

- (a) Ensure adequate financing of essential medicines and health supplies in the national budget and gradually reduce donor dependency.
- (b) Strengthen distribution and delivery systems at government health facilities.
- (c) Strengthen the existing regulation and its enforcement in the pharmaceutical sector including setting prices for the private sector.

- (d) Ensure that the National Drug Authority conducts pharmacovigilance surveys in order to ensure safety of medicines, including traditional medicines.
- (e) Promote, support and sustain interventions that ensure rational prescribing, dispensing and use of medicines and other supplies.
- (f) Promote regional and international collaboration on medicine regulation and bulk purchasing in line with East African Community and other international initiatives;
- (g) Encourage local production of medicines and ensure compliance with Standards of Good Manufacturing Practices.
- (h) Integrate relevant aspects of private sector activities into the MoH pharmacy policy framework on issues such as accreditation, standards of practice and cooperation and collaboration with training institutions.
- (i) Promote and support aspects of complimentary and traditional medicines.

5.3.3 Health Infrastructure

Health infrastructure comprises of building, plant, equipment (medical devices, other equipment for health facilities and IT equipment) and transport. Government shall provide the necessary resources to ensure provision and maintenance of adequate infrastructure over the next decade, with priority being given to consolidation of existing facilities.

5.3.3.1 Policy Objective

- (a) To provide and maintain a network of functional, efficient, safe and sustainable health infrastructure for the effective delivery of the UNMHCP, with priority being given to consolidation of existing facilities

5.3.3.2 Policy strategies

In order to achieve this objective, Government shall:

- (a) Strengthen the Infrastructure Division with appropriate personnel to plan, procure and maintain health infrastructure.
- (b) As a matter of priority, adequately finance renovations and maintenance programmes of existing health infrastructure, in particular PHC facilities, and invest in the construction of new facilities and staff accommodation, targeting war ravaged and post conflict areas such as Northern Uganda and other underserved parts of the country.
- (c) Prioritise investments in buildings, equipment and transport required to operationalise the health sector priorities of this Policy.
- (d) Standardise the medical equipment needs in terms of quantities and specifications for each level of the government and PNF health system so that all interventions and services of the UNMHC of that level can be provided.
- (e) Plan and procure medical equipment according to the agreed standards.
- (f) Provide the necessary logistical support, including transport, communication and IT equipment, to establish an appropriate and efficiently functioning referral system.

- (g) Promote and increase private sector investments in the provision of health services through infrastructure development based on complementarity.
- (h) Provide the infrastructure, including IT infrastructure, necessary for MoH staff to carry out its functions professionally.

5.3.4 Health financing

Government with support from development partners shall provide adequate resources for the health sector over the next decade. Efforts shall be made to explore alternative health financing mechanisms like health insurance but take into consideration equity concerns.

5.3.4.1 Policy Objective

- (a) To mobilize sufficient financial resources to fund the health sector programmes whilst ensuring equity, efficiency, transparency and accountability in resource allocation and utilisation.

5.3.4.2 Policy strategies

In order to achieve this policy objective Government shall:

- (a) Increase budgetary allocation to the health sector in line with the 2000 Abuja Declaration.
- (b) Ensure that public resources prioritise financing of the UNMHCP package with preferential allocation to the preventive and promotive health interventions including diagnostic services in the package.
- (c) Promote alternative health financing mechanisms other than government budgetary provisions. These shall include national social health insurance and other community health financing mechanisms.
- (d) Revise and expand contracting mechanisms with the private sector to improve efficiency in service delivery and general support services.
- (e) Implement financing mechanisms that promote private sector growth for example through generous tax breaks.
- (f) Strengthen programming of external funding for health through improved harmonisation and alignment to sector priorities and improved reporting.

5.4. Partnerships in health

Ministries, CSOs, the public and private health sectors, development partners and communities shall play an important role in the delivery of health services. It is important that GoU fosters and sustains partnerships with all the different relevant institutions that play an important role in health services delivery.

5.4.1 Public Private Partnership in Health (PPPH)

The National Policy on PPPH is now awaiting cabinet approval. Structures for coordination are in place at the central level but are absent at district level. Over the next decade Government shall establish and strengthen PPPH structures at district and lower levels necessary to implement the PPPH policy guidelines. The role of the CSOs shall further be encouraged.

5.4.1.1 Policy Objective

- (a) To effectively build and utilize the full potential of the public and private partnerships in Uganda's national health development by encouraging and supporting participation in all aspects of the National Health Policy and at all levels.

5.4.1.2 Policy strategies

In order to achieve this objective Government shall:

- (a) Assure continued participation of the private sector in the process of policy development, planning, effective implementation and quality assurance, with the aim of building consensus and sharing ownership of policies and plans.
- (b) Establish appropriate legislative frameworks and guidelines to facilitate and regulate the private sector in line with existing laws and regulations.
- (c) Establish specified structures of the partnership, at all local government levels, to facilitate consultation and coordination among partners and promote the active participation of the private sector in district health planning and services delivery.
- (d) Implement the guidelines for implementation of the National Policy on PPPH to facilitate the partnership in line with existing national laws and regulations.
- (e) Work with the private sector to reform incentive mechanisms (e.g. tax breaks) that would attract legally accepted private health practitioners to the under-served and difficult to reach areas.
- (f) Link level of subsidies to the PNFP sub-sector to performance with the objective of reaching vulnerable populations.
- (g) Support the adoption of the HMIS by the private health providers to improve completeness of national data, planning and health financing.
- (h) Assist in facilitating access to development capital by private sector in health care for developments vital to health care service expansion to the public.

5.4.2 Inter-sectoral and inter-ministerial partnership

Different sectors including government ministries and departments have a role to play in managing health. Recognising this, the MoH shall take a leading role in **advising**, mobilising and collaborating with other government ministries and departments.

5.4.2.1 Policy Objective

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

5.4.2.2 Policy strategies

In order to achieve this objective Government shall:

- (a) Define structures and methods of consultation on any cross-cutting issue which may have multi-sectoral implications.
- (b) Promote consultation and coordination with other ministries on health issues relevant for country development.

5.4.3 Health development partners

Uganda has adopted the Sector Wide Approach (SWAp) in health. A Memorandum of Understanding (MoU) exists between the MoH and the HDP. The Uganda Health SWAp is a sustained partnership whose goal is achieving improvement in people's health through a collaborative programme of work, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets.

5.4.3.1 Policy Objective

To implement NHP II and Health Sector Strategic Plans through a sector-wide approach, which addresses the health sector as a whole, and allow for effective co-ordination of efforts among all partners in Uganda's national health development, increase efficiency and transparency in resource allocation and utilization, achieve equity in the distribution of available resources for health and effective access by all Ugandans to essential health care.

5.4.3.2 Policy strategies

In order to achieve this objective Government shall:

- a) In collaboration with key stakeholders, strive for harmonization and alignment of aid delivery, following the spirit of the Paris Declaration (2005) to accelerate progress in implementation.
- (c) Reach consensus with all stakeholders on the key national development objectives and health priorities, and the main strategies for attaining them.
- (d) Promote a common framework to be used by all partners in the health sector for planning, budgeting, disbursement, programs management, support/supervision, accounting, reporting, monitoring and evaluation.
- (e) Progress with the gradual integration of on-going programs and projects into the HSSP.
- (f) Strengthen capacity at national and district levels for effective co-ordination of all development partners in health, eliminating duplication of efforts and rationalizing donor activities to make them more cost-effective.

- (g) Defining measures and standards of performance and accountability in financial management, procurement, and program implementation in line with accepted good practices.

5.4.4 Partnership with the community

Community participation and empowerment with respect to health service delivery has been very weak. Over the next decade, government shall recognise the communities and actively promote their participation in health service delivery and management.

5.4.4.1 Policy objective

- (a) To ensure that communities are empowered to take responsibility for their own health and well being and to participate actively in the management of their local health services.

5.4.4.2 Policy strategies

In order to achieve this objective, Government shall:

- (a) Expand and explore ways of sustaining the VHTs who constitute the first contact point for the majority of the people in rural areas.
- (b) Build capacity to ensure the participation of communities, through VHTs and HUMC, in the design, planning and management of health services.

6. COMMUNICATION AND DISSEMINATION OF NHP II

This policy was developed through a participatory process. It is important that different stakeholders (including communities and individuals) are aware of the policy and their role in the implementation process. In order to ensure that this policy is widely known, accepted and adhered to by all stakeholders, government shall print and disseminate the policy at all levels. The MoH and other stakeholders at all levels shall engage in communicating and disseminating the policy among all stakeholders.

7. NHP II IMPLEMENTATION ARRANGEMENTS

This policy shall cover the period 2010-2020 and will be implemented through the development of 5 year HSSPs. It is envisaged that two HSSPs will be developed over this period. These strategic plans shall be operationalised through the development of integrated annual workplans developed with input from all stakeholders. Districts will develop their annual implementation plans with input from relevant stakeholders and communities which will feed into the national integrated workplans. Districts will be responsible for implementation of their plans.

8. MONITORING AND EVALUATION

A monitoring framework will be developed to monitor attainment of the NHP objectives.