GOVERNMENT OF UGANDA
MINISTRY OF HEALTH

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT AND HEALTHY AGING

SHARPENED PLAN AND INVESTMENT CASE II 2022/23–2026/27

Looking beyond Maternal and Newborn survival to ensuring a healthy and productive population

Reproductive Child Health Department. Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging: Sharpened Plan and Investment Case II, 2022/23–2026/27. Ministry of Health, Kampala (Uganda): MOH; 2023.

FOREWORD

HON. DR. JANE RUTH ACENG OCERO
MINISTER OF HEALTH

Uganda has made progress towards some Sustainable Development Goals (SDGs) by increasing survival and well-being from pre-pregnancy, childbirth, postnatal, through infancy, to childhood, and adolescence.

Uganda developed and launched its first Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Sharpened Plan in November 2013 to accelerate the attainment of the Millennium Development Goals (MDGs). After two years, the country updated the RMNCAH Sharpened Plan 2015–2021, and in addition developed an Investment Case to accelerate progress through five strategic shifts building on the previous plan's foundations. The five strategic shifts are further consolidated in this current Sharpened Plan as the game changers to achieve RMNCAH targets towards Universal Health Coverage.

This Sharpened plan builds on with the bold objectives of ending preventable maternal, newborn, child, and adolescent deaths and safeguarding the health and development of all children, adolescents, and women. This will ensure a Uganda where every woman, child, and adolescent realizes the right to health and well-being and can harness their social and economic opportunities to fully participate in shaping a prosperous nation.

This plan calls for collective action and all stakeholders to align with the national and subnational mutual accountability framework to deliver their commitments.

I, therefore, call upon all the stakeholders —civil society, development partners, faith-based and cultural leaders, as well as the private sector—who have pledged priority actions to this Sharpened Plan to join hands with the government to implement this plan to end preventable maternal, newborn child and adolescent deaths in Uganda.

ACKNOWLEDGMENT

DR. HENRY G. MWEBESA
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The Ministry of health wishes to acknowledge all individuals, institutions, and organizations that contributed to developing the Reproductive, Maternal, Neonatal, and Child Health (RMNCH) Sharpened Plan. In particular, the technical leadership of the Reproductive Child Health Department for their efforts to bring together various stakeholders while developing this plan.

Special recognition is made of the efforts and commitment of the RMNCH Technical Working Group, Civil society organizations, cultural and faith-based leaders, District Health Officers, and members of professional bodies, along with the different development partners and other stakeholders.

The successful development of this RMNCH Sharpened Plan was made possible with financial and technical support from the World Bank and USAID through the USAID Maternal Child Health and Nutrition (MCNH) Activity. The Ministry of Health appreciates all those individuals, institutions, and organizations that reviewed the document as it evolved.

Finally, I would like to extend a vote of thanks to the team of technical consultants led by Dr. Andrew Balyeku, who wrote the initial document, and another team who revised the document.

EXECUTIVE SUMMARY

Uganda has progressively attained improvements in reproductive, maternal, newborn, child, and adolescent health (RMNCAH) for its population. The maternal mortality ratio (MMR) declined from 438 deaths per 100,000 live births in 2011 to 189 deaths per 100,000 live births in 2022, and the infant mortality rate (per 1,000 live births) improved from 54 to 36 over the same period.

The neonatal mortality rate had stagnated over ten years since 2006 at 27 deaths per 1,000 live births, declining to 22 deaths per 1,000 live births in 2022. In line with the sustainable development goals (SDGs), ending preventable maternal mortality (EPMM) requires Uganda to steepen the rate of MMR decline by greater than 5.5% to achieve less than 140 by 2030, infant mortality rate (IMR) must be reduced to at least 12 per 1,000 live births and under-5 mortality rate (U5MR) to 25 per 1,000 live births by 2030. The country has set targets to reduce IMR from 41 to 34, U5MR from 62.2 to 30, and MMR from 311 to 211 by 2025, in the National Development Plan 2020–2025 (NDP III).

While good progress in reducing maternal, neonatal, and child mortality in the country has been made, it is not happening fast enough to meet the 2030 goals. The neonatal and child mortality rates remain unacceptably high. The disease burden is also still high: more than 80,000 infant-preventable deaths occur yearly. Children younger than age five disproportionately contribute to almost half (44%) of facility admissions despite being only 17% of the population. Lack of critical services, e.g., for newborns and adolescents; low effective coverage across proven reproductive, maternal, newborn, child, adolescent, and healthy aging (RMNCAH) interventions; poor quality of care; poor client satisfaction; and RMNCAH service fragmentation are among the key issues identified.

For the next five-year period, 2022 to 2026, the National RMNCAH Strategy (Sharpened Plan II) will contribute towards the human capital development sub-goal of increasing the productivity of the population for a better quality of life for all and pursuing two broad objectives:

1. *Ending preventable maternal, newborn, child, and adolescent deaths*
2. *Promoting the health and development of all children, adolescents, and women*

To achieve these, the Sharpened Plan II reinvigorates the following five strategic shifts:

1. **Focusing on districts with the highest maternal and child mortality first, thus increasing efforts to address growing geographical inequities in RMNCAH outcomes in the country.** This entails establishing investments in universal coverage of Emergency Obstetric and Newborn Care (EmONC) and quality of care, strengthening community engagement and service delivery efforts, and improving equity measurements.

For the next five-year period, 2022 to 2026, the National RMNCAH Strategy (Sharpened Plan II) will contribute towards the human capital development sub-goal of increasing the productivity of the population for a better quality of life for all

2. **Increasing access for high-burden populations with a focus on addressing specific needs and service barriers,** especially for the most vulnerable and marginalized subpopulations (including adolescents) within the district health systems. This plan focuses on the targeted delivery channels, including user community-led or -based engaging and contracting—especially private sector midwives—to increase access and surveillance on inequity and impact of health determinants on RMNCAH outcomes.

3. **Scaling up delivery of evidence-based, high-impact intervention packages** prioritized for each life stage to enable continuity over a lifetime. In addition to the basic RMNCAH interventions, this plan emphasizes bringing to scale quality of care for (1) birth and first week of life, (2) antenatal care (ANC) initiation in the first trimester, and (3) IMNCI/iCCM plus as the main thrust for accelerating survival. It also recognizes (4) pre- and inter-conception care that includes FP, nutrition, and adolescent health; (5) implementing the extended nurturing care framework from preconception through adolescence (0–20 years); and (6) RMNCAH social and behaviour change communication as critical for thriving. Implementing this shift will require a substantial change of leadership; national-level leadership will drive RMNCAH policy and programmatic integration; district-level leadership will drive population health focus and continuity/linkages; and strong facility-level leadership and governance will ensure transformation toward integrated people-centred RMNCAH services.

4. **Using a multi-sectoral approach to enhance development and tackle underlying causes and determinants of poor RMNCAH** fatal and nonfatal outcomes that prevent women, children, adolescents, and men from attaining their full health and well-being potential. Implementation will require a fundamental change from facility-based output RMNCAH planning to facility catchment population health planning focusing on increased community engagement on health determinants, increased efforts on sexual and gender-based violence, and primary and secondary school health interventions.

5. **Strengthening mutual accountability for RMNCAH population health level outcomes** by all stakeholders. District RMNCAH accountability is a cornerstone of the revised, sharpened plan. Wider engagement is part of this shift toward downward accountability to local communities for service provision and horizontal accountability to peers covering managers and public and private providers. The shift also includes public access to budgets and performance information. Other key efforts will include tracking funding and resource commitments by government and partners; use of the RMNCAH accountability index to support evidence-based management decision-making, enhance transparency, and strengthen accountability for results; and community scorecard for citizens' hearings, civil society, and parliamentarians' engagement.

The Sharpened Plan will be implemented within the national long-term institutional framework, and key performance indicators will be used to monitor and guide strategic performance. The total resource requirement for the RMNCAH sharpened plan implementation is estimated at US$2.7 billion for five years, with per capita cost estimated at $26. An estimated US$2.0 billion is committed by the government and partners, leaving a funding gap of US$0.7 billion.

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01: OVERVIEW

01.1 Introduction

This Investment Case for the RMNCAH Sharpened Plan II (2022/23–2026/27) is aligned and anchored in key national and global priorities and targets. It defines the broad direction for RMNCAH in Uganda in meeting the key objectives and targets set in the third National Development Plan (NDP III) 2020–2025 and the aspirations articulated in Uganda Vision 2040. It is built on the progress, challenges, and lessons learned from previous planning and implementation experiences of the first Investment Case for the RMNCAH Sharpened Plan I (2015–2020) and the new global guidance.

The Sharpened Plan II continues with the agenda to fast-track the impact of services on key priorities toward achieving the Sustainable Development Goals (SDGs) targets within the Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) and within the five strategic shifts started in the previous period. The Sharpened Plan II focuses on human capital development. It sustains efforts in reducing maternal, neonatal, and child deaths and introduces a broader and far-sighted perspective of the global nurturing care framework (NCF) to spur multi-sectoral action toward a thrive-and-transform agenda.

01.1.1 DEMOGRAPHIC INFORMATION

Uganda's population was estimated at 42 million in 2020 and is expected to increase by 5.5 million to reach 48 million by 2025. Almost half (49%) of the population is under 15, and 70% are less than 25 years old. This predominantly young population and rising life expectancy (male: 62.8 years, female 64.5 years[1]) creates an increasing cohort of mothers, newborns, adolescents, adults, and older people demanding more RMNCAH services. Most of the reproductive health (RH) challenges the country faces are concentrated among children, adolescents, and young people (over 75% of Uganda's population). An urban annual growth rate of 5.2%, among the highest in the world, will increase as the country operationalizes the ten newly created cities in the next five years. The need to develop responsive urban RMNCAH services, especially for the urban poor, is becoming eminent. Uganda is the largest refugee-hosting country in Africa and the third globally, with the refugee population almost tripling since 2016 to over 1.5 million. [2]

01.1.2 SOCIOECONOMIC

Uganda's real gross domestic product (GDP) grew at 4.6% in FY21/22, below the 6.5% recorded in FY18/19, due to COVID-19 pandemic disruptions. Twenty percent of the population lives in poverty, and the absolute number was 8.3 million in 2019/20: one in five persons living in poverty (at the national poverty line of USD$1.77/day).

Overall, the incidence of rural poverty is more than double that of urban poverty. The literacy rate for people ten and older was 76%, lower for females (72%) than males (81%). Digital use is high, with 74% of households owning a mobile phone, 72% of household members reporting the use of social network internet via their mobile phones, and only 32% owning at least one radio. [3] This allows for expanding e-health and m-health to efficiently reach hard-to-reach individuals and address access problems.

[1] Uganda Bureau of Statistics. National Population and Housing Census 2014-main report. Kampala (Uganda); 2016. Life expectancy at birth in Uganda increased from 47 and 45 years in 2000/01 for females and males, respectively, to 63 and 64 years by 2015.

[2] Uganda Refugee Operation - Participatory Assessment 2021 - National Report December 2021

[3] Uganda Bureau of Statistics. Uganda National Household Survey Report 2019/2020. Kampala (Uganda); 2021.

01.2 Policy Alignment

01.2.1 COMMITMENTS TO GLOBAL AND REGIONAL RMNCAH AGENDA

This Sharpened Plan II is consistent with global and regional RMNCAH and nutrition-related commitments, strategies, and frameworks of the SDGs. Uganda has endorsed both Every Newborn Action Plan (ENAP) and Ending Perinatal and Maternal Mortality (EPMM) in adherence with the Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) that guides expanding from survival programming to embrace interventions that help to thrive ("ensure health and well-being") and transform health and other systems ("expand enabling environments"). It focuses on ensuring person-centred care and improving population health, especially addressing multi-sectoral drivers of poor health outcomes, community engagement in health, and community empowerment for the co-production of health in line with the revitalized vision for primary health care in the Astana Declaration.

A commitment to "leave no one behind" and emphasizing "reaching the furthest behind first" is at the core of programming to accelerate progress under this plan. This plan tackles inequities and emphasizes reaching adolescents, minorities, migrants, marginalized, and hard-to-reach subpopulations. It also sets policy groundwork for improving RH services for older people (50 years plus) as guided by the Decade of Healthy Ageing (2021–2030), endorsed by the World Health Assembly. It is also informed by the World Health Assembly 2012 Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition global targets for priority nutrition outcomes to be achieved by 2025. The East African Community (EAC) Vision 2050 underpinned the plan and linked to the EAC RMNCAH Policy Guidelines 2016–2030.

01.2.2 NATIONAL DEVELOPMENT PLAN-HUMAN CAPITAL DEVELOPMENT PROGRAM

The Uganda Vision 2040 recognizes that good health facilitates socioeconomic transformation. It calls for a paradigm shift from a facility- to a largely community-based health delivery system; prioritizes health promotion (including nutrition) and prevention over curative approaches; pushes for a more public-private partnership rather than public-centred delivery; and promotes a service more responsive to health needs of different subpopulations during the vision period. Midway toward Vision 2040 targets, NDP III defines the course for the next five years toward a sustainable socioeconomic transformation of Uganda, prioritizing the health sector under Program 12: "Human Capital Development Programme." NDP III shifts from a sector to a program-based approach to planning and budgeting, thus integrating gender and social development, education, and health sectors under one program.

01.2.3 HUMAN CAPITAL DEVELOPMENT

With a human capital index (HCI) of 38%, a child born in Uganda achieves a paltry 38% of productive potential at age 18, which, unless addressed, puts the goal of increasing productivity of the population for increased competitiveness and better quality of life for all out of reach. RMNCAH is essential to ensure the foundation for human capital development is made before pregnancy and childhood. Ensuring higher birth weight, early-life health, nutrition and development, and adolescent health are critical for human capital accumulation and long-term economic growth. The stock of human capital of the next generation is determined by the complementarity between health and education attainment, especially for women and adolescents. Investment in RMNCAH support is therefore critical for fostering a more positive human capital accumulation trajectory for the country. In Uganda, adolescent health services remain extremely limited in access and quality, yet improving the health of this large age group delivers a triple dividend of benefits for the adolescents now, for their future adult lives, and as a decisive factor for changes in the next generation. Similarly, sustained improvement of RMNCAH outcomes cannot be achieved without investing in human resources—the health workers and

managers who make service delivery possible. Addressing human resource challenges through human capacity development (HCD) and related health systems strengthening interventions is an important step toward improving long-term health outcomes.

01.2.4 HUMAN-RIGHTS-BASED APPROACH

The rights of children, adolescents, and women are central to the Sharpened Plan II to ensure universal availability, accessibility, acceptability, and quality of RMNCAH information, commodities, and services in a way that eliminates discrimination and addresses inequalities. Access rights to health care are laid out in Uganda's Patient Charter and are in the framework of respectful family-centred care, being inclusive and responsive to RMNCAH needs of different population groups through an integrated and differentiated care delivery approach. Ensuring women's sexual and reproductive health rights requires meeting standards with regard to health facilities, commodities, and services: (a) Availability of both the underlying determinants of health, as well as health infrastructure, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs; (b) Accessibility in four overlapping dimensions: physical, economic (affordable), non-discrimination, and regarding information; (c) Acceptability in terms of respect for medical ethics and of the culture of individuals, people and communities, sensitive to gender and lifecycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned; (d) Quality, including skilled medical personnel, essential medicines and equipment; and respectful care. This plan incorporates the human-rights-based approaches to reducing maternal, neonatal, and child mortality and meeting the national targets in the various strategic documents and SDG targets by 2030.

01.3 Developing the Sharpened Plan II

01.3.1 PLANNING PROCESS

The Second Investment Case of the RMNCAH Sharpened Plan II follows the expiry of the previous plan and is in line with the sector planning process requiring departments to develop Technical National Strategic Plans anchored within the Human Capital Development Program. A top-down and bottom-up mixed approach was used to ensure that strategic guidance provided at the national level is linked to the outputs articulated in the Human Capital Development Program, especially Objective 1: improve the foundations for human capital development; Objective 3: improve population health, safety, and management; and Objective 4: reduce vulnerability and gender inequality along the lifecycle.

An extensive consultation process further informed the strategic direction specific to RMNCAH. Consultations were done through more than 30 thematic group meetings and four writing workshops. Six thematic groups arranged per life stage included a wide membership of MOH and partner technical officers, CSOs, and district representatives. In addition, a nationwide conference of adolescents was held to gather adolescent health concerns and suggestions. Background analytical work involved discussions on the 12 academic and operational research reports, the midterm and end-term review reports of the First Investment Case for RMNCAH Sharpened Plan I, and document review. Though the initial task was to update the plan, especially on targets and strategies, the theory of change (TOC) was revised to reflect the country's new programming and budgeting approach, mapping backward with a focus on the new results articulated in NDP III.

A team of consultants synchronously developed the Sharpened Plan II's resource mapping, costing, and gap analysis. As recommended in the end evaluation, the costing has been aligned to the shifts and budgets for focused and annualized RMNCAH resource tracking, focusing on district-level expenditures.

01.3.2 OUTLINE OF THE DOCUMENT

Chapter 1 sets the plan's background, how it aligns with the national and global policy environment, past performance, the gaps, and how it was developed. Chapter 2 lays out the road ahead, highlighting the current burden and needs to be covered. Chapter 3 identifies the health system bottlenecks hindering effective coverage and establishes mechanisms to overcome them.

Chapter 4 provides the strategic direction for reaching the targets, identifies the theory of change, and explains the required strategic changes (or five strategic shifts carried over from the previous plan) needed to ensure impact.

Chapter 5 outlines how the plan will be implemented, describing the various actors, structures, coordination arrangements, planning and budgeting processes, and communication strategies. Chapter 6 provides the performance monitoring framework and sets the Key Performance Indicators.

Chapter 7 describes the resources required to implement the plan and provides a forward-looking picture of available resources and current funding gaps that will need to be covered for the next five years.

A nurse administering free Yellow Fever vaccine to a child. Yellow Fever vaccine is now available in health facilities & provided for free to children aged nine months as part of the routine immunization program.

02. THE ROAD AHEAD

Significant steps and actions have been taken to address appropriate service provision for RMNCAH, and some positive outcomes have been achieved. However, more effort is still required to meet the goals and targets that Uganda has set.

The end-term review of the Sharpened Plan I revealed steady but slow progress and not meeting most of the set targets. This was mainly due to delayed and limited implementation despite the availability of additional resources from the GFF framework and government. Challenges hindered implementation in operationalizing the strategic shifts at the centre and coordination and management mechanisms at the sub-national level.

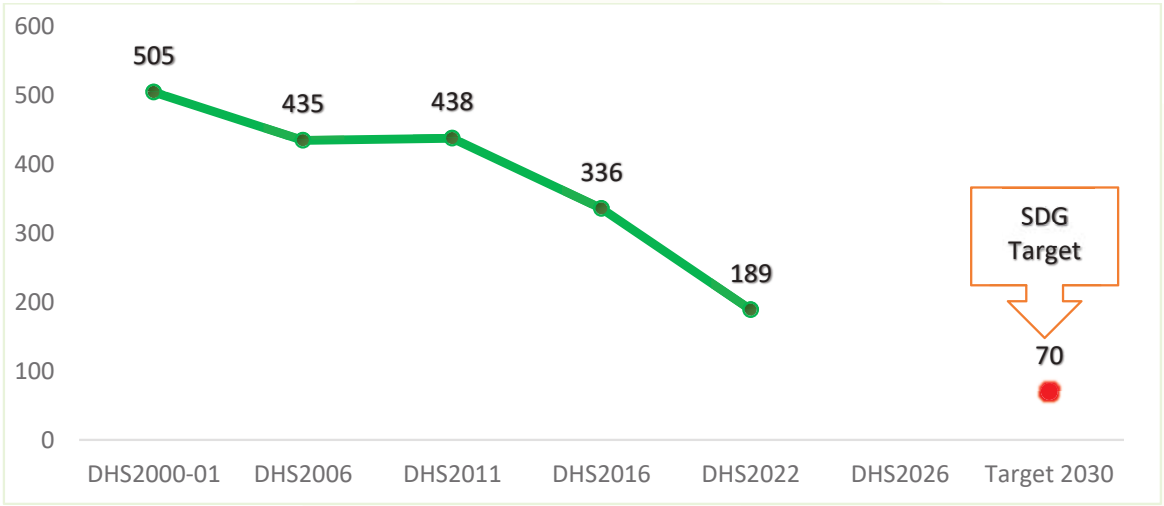
The implementation period of the Sharpened Plan I was deemed as a learning and foundational phase, whose lessons are now used to inform the Sharpened Plan II. This chapter describes the progress made towards the NDP III and SDGs targets.

02.1 ENDING PREVENTABLE MATERNAL DEATHS

SDG 3.1 is to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births, and no country should have an MMR of more than 140 per 100,000 live births by 2030. Uganda has set its targets within the NDP III to reduce MMR from 311 to 211 by 2025. In line with the SDGs targets, ending preventable maternal mortality (EPMM) requires Uganda to steepen the rate of MMR decline by more than 5.5% per year to achieve less than 140 by 2030.

Despite significant disparities between regions and socioeconomic groups, MMR has declined. MMR reduced to 189 deaths per 100,000 live births in 2022 from 336 in 2016 (a 43.8% reduction).

Figure 1. Trends in Maternal Mortality Ratio and SDG 2030 Target (Per 100,000 live births)

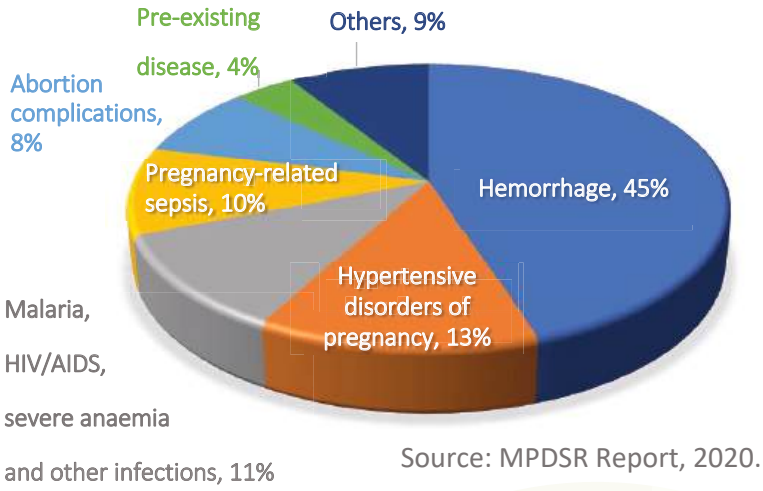


The routine Maternal and Perinatal Death Surveillance and Response (MPDSR) reports by the Ministry of Health also demonstrate a decline in the institutional maternal mortality ratio (IMMR) over the implementation period of the RMNCAH Sharpened Plan I from 108/100,000 deliveries in financial year (FY) 2016/17 to 92.08/100,000 deliveries in the FY2020/21.

Though maternal mortality has declined, significant disparities exist between regions and socioeconomic groups. Kampala, Bunyoro, Bugisu, and Acholi are the top four regions with the highest mortality.

The decline in institutional deaths is attributed to increased access to functional CEMONC sites, strengthened capacity of health facilities to provide quality MNH services, sustained availability and accessibility of essential commodities relevant to prevention and management of obstetric hemorrhage, improved health-seeking behaviors of women and their families for MNH services; sustained continuity of essential health services during the COVID-19 pandemic, investment in and intensity of focus on time around delivery; and focusing on equitable rather than aggregate achievements.

Figure 2. Causes of Institutional Maternal Mortality



Source: MPDSR Report, 2020.

The Maternal and Perinatal Death Surveillance and Response (MPDSR) 2020 report shows that almost 90% of institutional maternal deaths are due to haemorrhage (45%), pregnancy-related sepsis or abortion complications (18%), and hypertensive disorders of pregnancy (13%) (Figure 5). Postpartum haemorrhage (PPH) contributes to 80% of the haemorrhage-related maternal deaths. Pregnancy-related sepsis and abortion complications are relatively higher among adolescent and young mothers, accounting for 39% of deaths in this age group.

About 60% of maternal deaths in health facilities are attributed to late and critical referrals, delays in accessing caesarean section, and magnesium sulphate interventions at the referral sites (3rd Delay).

In Uganda, 54 unsafe abortions per 1,000 women of reproductive age occur annually, with an estimated 300,000 induced abortions that account for 14% of all pregnancies or 39 per 1,000 women aged 15–49.14 Although 77% of abortions treated in the public health system are induced, unsafe abortions account for almost 40% of admissions to emergency obstetric care units.

Overall, the quality of post-abortion care (PAC) services is "poor," with more than two-thirds of patients not receiving post-abortion FP counselling, modern contraceptives, and other reproductive health services. On average, only 1 in 4 women (27.5%) with abortion received post-abortion contraceptive methods in 2020 as part of the post-abortion care package. [4]

Future direction:

- Continue with the multi-sectoral approach, hold service providers more accountable for performance, and improve family planning delivery and literacy.

- Since more than 80% of deliveries are by midwives and the majority of births (75%), take place in health centres (HCs) and general hospitals (GHs), midwifery competencies and support need to be prioritized to ensure the quality of ANC, intrapartum care, effective referral, and immediate postnatal care (PNC) so as to reduce institutional mortality.

· Functionalise all bEmONC (HC IIIs) and cEmONC (HC IVs) facilities coupled with improving maternity care experience and client satisfaction to increase uptake is essential.

· Given a rapidly growing population and the associated need to meet higher service coverage targets toward UHC, the ability to provide services through the public sector providers alone is likely to diminish and hence necessitate enlisting the private sector providers.

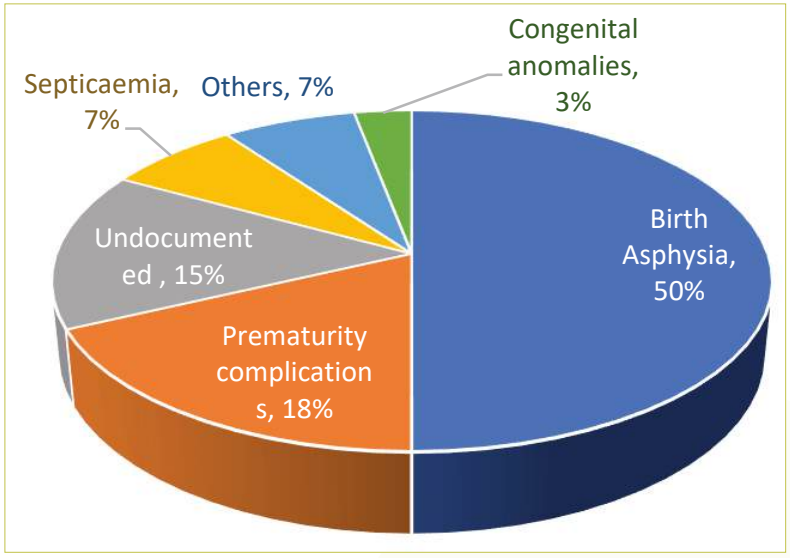
02.2 Improving Newborn and Child Health

02.2.1 END PREVENTABLE NEWBORN DEATHS

SDG 3.2 aims to end preventable deaths of newborns, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births by 2030.

The neonatal mortality rate had stagnated for the decade at 27 deaths/1,000 live births since 2006. However, the UDHS 2022 demonstrated a 26% reduction over seven years from 27 deaths per 1,000 live births in 2016 to 22 deaths per 1,000 live births in 2022. About 73% occur in the first week of life and 36% on the first day, with an equal number of stillbirths. Neonatal deaths make up one-third of child deaths in Uganda.

Figure 3: Causes of institutional newborn deaths, MPDSR 2021/22



The causes of death include preterm births, intrapartum-related events, and neonatal infections. About 75% of institutional early newborn deaths are directly due to birth asphyxia (50%), complications of prematurity (18%), and septicemia (7%) (Figure 1).

In Uganda, 12% of infants are born with low birth weight (LBW), and 14% are born premature.

The main drivers of poor quality of newborn care include HRH, infrastructure gaps, low community-based care, COVID disruptions to services, and economic hardships leading to higher rates of malnutrition and illness.

● The top four regions with the highest Institutional Perinatal Mortality Rates in Uganda are Kampala, Bunyoro, North Central, and Acholi.

Future direction:

● There is a need to address the underlying causes of newborn deaths and stillbirths.

● Improve the survival of preterm and LBW infants and management of newborn sepsis. Implement a package of priority interventions that reinforces essential newborn care competencies and investments in newborn resuscitation equipment, kangaroo mother care for LBW babies, intensive/special newborn care units at referral facilities, provision of antenatal corticosteroids for premature labor, and newborn antibiotics to decrease the 42,000 fresh stillbirth and neonatal deaths among LBW babies and 28,000 preterm babies born annually in Uganda.

● Address modifiable underlying contributors, including preconception and maternal nutrition, adolescent pregnancies, malaria prevention, and family planning, and complete all recommended ANC visits to reduce LBW babies.

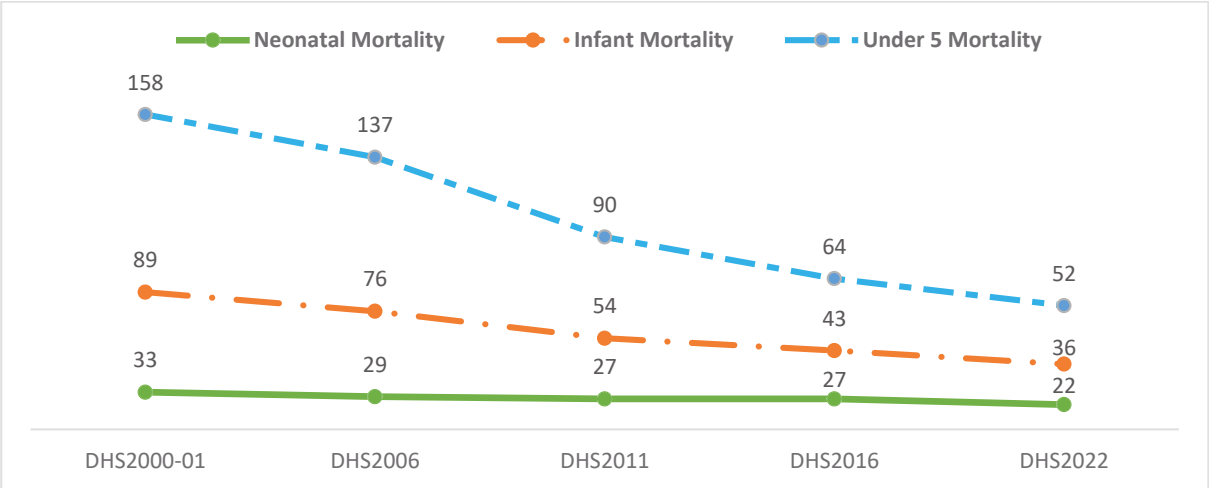
02.2.2 END PREVENTABLE CHILD DEATHS

SDG 3.2 aims to end preventable deaths of children under five years of age, with all countries aiming to reduce under-5 mortality to at least as low as 25 per 1,000 live births by 2030. Uganda has set its targets within the NDP III to reduce IMR from 41 to 34 per 1,000 live births and to reduce U5MR to 30 per 1,000 live births by 2025.

In Uganda, IMR dropped from 54 per 1,000 live births in 2011 to 36 per 1,000 live births in 2022. Annually, more than 80,000 infants still lose their lives due to preventable causes. About 37% of infant deaths occur in the first 28 days of life. U5MR dropped from 90 per 1,000 live births in 2011 to 52 per 1,000 live births in 2022 , equivalent to a 3.5% reduction per year. This means one in every 20 children will die before their fifth birthday. Although Uganda continues to progress in reducing child mortality, an estimated 60,000 children die yearly. Children under five years account for 20% and 38% of outpatients and admissions in health facilities, respectively. [6]

There have been improvements in infants' survival, but progress has been slow, with significant disparities between regions and socioeconomic groups. According to UDHS 2022, the top four regions with the highest infant and children under five mortality rates are West Nile, Ankole, Bunyoro, and Busoga. The causes of death are majorly preventable, including malaria, pneumonia, anemia, and septicemia. However, there was a decline in diarrhea, severe malnutrition, and pediatric HIV deaths from the top 4 causes – attributable to improved intervention coverage: WASH, new vaccines, timely treatment, and diagnosis, including HIV.

Figure 4. Trends in neonatal and child mortality indicators



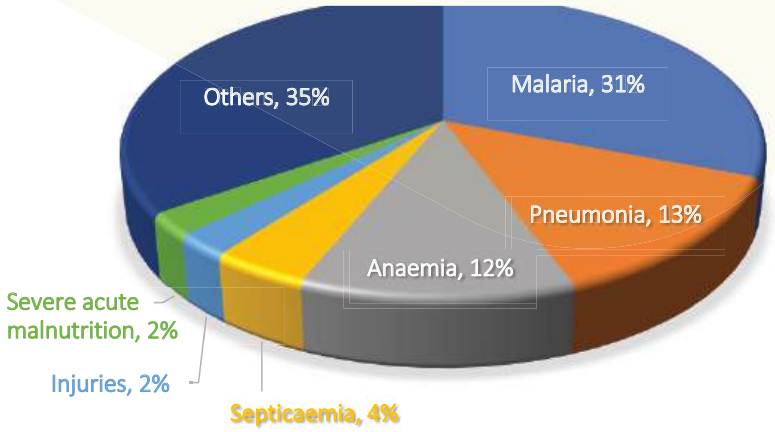
[14] Moore MA, Kibombo R, Cats-Baril D. Ugandan opinion-leaders knowledge and perceptions of unsafe abortion. Health Policy Plan. 2014;29(7):893–901.

[4] DHIS2 Data extracted on 31st July 2023

[5] Uganda Bureau of Statistics (UBOS) and ICF. 2023. Uganda Demographic and Health Survey 2022. Kampala, Uganda.

[6] Annual Health Sector Performance Report Financial Year 2021/22

Figure 5. Causes of Child (1 Month to 5 Years) Mortality in Uganda (2020)



Source: AHSPR Report, 2020.

hildren under five years represent 30% of Uganda's population. More than 167,000 children younger than five years continue to be lost every year in Uganda [4] mainly due to malaria, pneumonia, diarrhoea, and underlying malnutrition (Figure 3).[5] Diarrhoea-related deaths have declined largely due to global water, sanitation, and hygiene (WASH) improvements, rotavirus vaccine roll-out, and access to oral rehydration salts solution and zinc. Anaemia occurs in more than half (53%) of children under 5, higher than the WHO cut-off (40%). Undernutrition is the cause of about four in 10 deaths of children under 5.

Future direction: Currently, child health interventions in the country are delivered through vertical initiatives such as immunization, ICCM/IMNCI, paediatric HIV care, facility ready-to-use therapeutic foods (RUTF), and LLITN distribution.

- Accelerating and safeguarding the reduction in child mortality will require expanding high-impact preventative and curative interventions; integration of interventions for healthy, vulnerable, and sick child services across facilities; family/community and interventions by other sectors; and acting on key causes of death and poor growth and development among older children.

- Address vaccine hesitancy, especially for the new vaccines introduced into the routine immunization schedule.

- Attention needs to be given to chronic illnesses such as sickle cell and asthma and the coordination of long-term primary care delivery systems integrating facility and community/family/self-care.

- The WHO redesigned child and adolescent health standards[7] introduce a paradigm shift in programming. The standards expand the focus from age group 0–4 to 5–19 within the extended nurturing care framework, place greater emphasis on preventing emerging mortality in older children (age 5–10) and adolescents, including care for chronic physical and mental health conditions and promote people-centred delivery of comprehensive care and multi-sectoral services for families, children, and adolescents in all health programs and health-related sectors.[f]

[4] United Nations Children's Fund (UNICEF). Levels and trends in child mortality: report 2014 estimates developed by the UN Inter-Agency Group for Child Mortality Estimation. New York: UNICEF; 2014.

[5] Liu L, Oza S, Hogan D, Perin J, Rudan I, Lawn JE, et al. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. Lancet. 2015;385(9966):430–40.

[7] World Health Organization (WHO). Standards for improving the quality of care for children and young adolescents in health facilities. Geneva: WHO; 2018. License: CC BY-NC-SA 3.0 IGO.

[f] Based on the Social Development Agenda, the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) guidance for countries to address the needs of children and adolescents in an integrated manner for their optimal survival, health, growth, and development toward their full potential.

02.3 End the epidemic of HIV/AIDS and TB.

SDG 3.3 aims to end the epidemics of AIDS, tuberculosis, and other diseases by 2030.

Progress has been made with the overarching goal of ending the HIV/AIDs epidemic. Uganda has progressed in the fight against HIV and AIDS and fully achieved the 90–90–90 target across the cascade; however, children, adolescents, and men did not. Uganda drastically reduced new HIV infections from 66,000 in 2015 to 38,000 in 2020. The HIV prevalence among adults (15–49 years) is 5.4%, a 1.9% reduction from 2011 but higher among females. The TB incidence rate of 234/100,000 is above the target of 184/100,000, based on the WHO estimates of 2020. TB Case Notification Rate at 152/100,000 below the target of 172/100,000.

For ages 15–24, HIV prevalence among females is three times that of males (0.8% males, 3.3% females). Among adolescents aged 10–24, females have the largest burden, with more than 70% of new infections among females. The number of People Living with HIV (PLHIV) increased from 1.2M in 2010 to 1.4M in 2020, largely due to improved access and utilization of HIV services like testing, care, and treatment. The expanded elimination of mother-to-child transmission (eMTCT) interventions has reduced the numbers and proportion of children contracting HIV from their HIV-positive mothers. The Mother-To-Child Transmission of HIV in Uganda decreased by 77%, from 23,000 in 2010 to 5300 in 2020, with 200,000 new HIV infections averted in 2020. However, mother-to-child transmission accounts for 14% of all new infections. [7]

- Top regions with the lowest performance against HIV care indicators: Karamoja, South Central, West Nile
- The top regions with the lowest TB notification rates are Bukedi, Busoga, and North Central.

Improvements in the HIV/AIDS and TB indicators are attributed to the continued implementation of test and start policy, efficient methods of service delivery like differentiated service delivery models, and availability of ARVs in public and private health facilities.

FUTURE DIRECTION:

- Focus on retention in care and the 15- 24 age group, strengthen the delivery of integrated SRH/ HIV/ TB services, and conduct campaigns to increase TB Case detection.

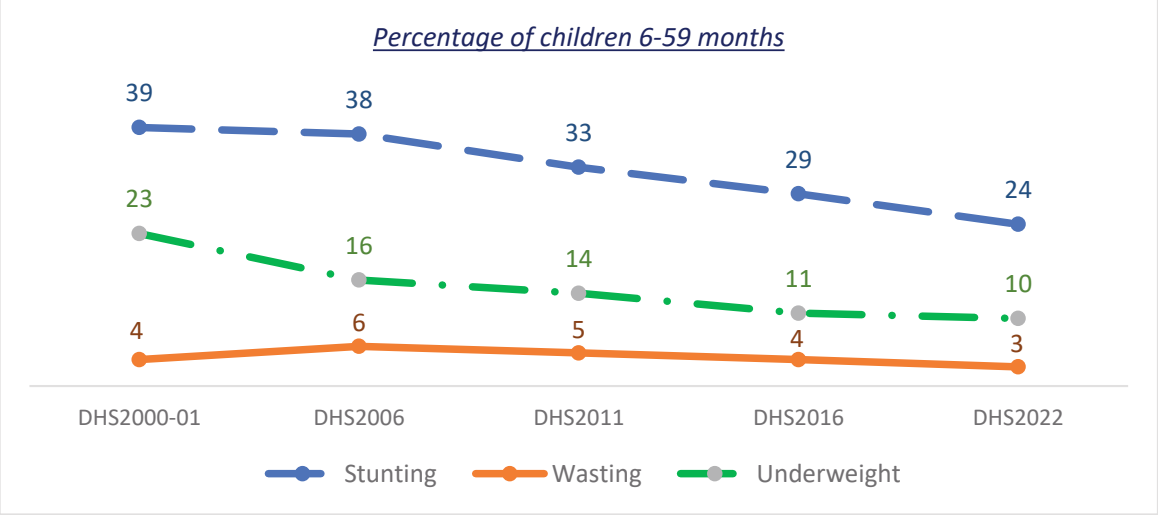
02.4 End all forms of malnutrition.

SDG 2.2 aims to end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age and addressing the nutritional needs of adolescent girls, pregnant and lactating women, and older persons.

Reducing all forms of malnutrition in Uganda is a multifaceted challenge that requires a comprehensive and coordinated approach. Over the years, there has been a progressive reduction in the levels of malnutrition. The share of stunting for children aged 6-59 months reduced from 39% in 2000-01 to 24.4% in 2022, while underweight children decreased from 23% to 9.7% over the same period. About 3.2% of children are wasted, while 3.4% are overweight. Malnutrition underlies 40% of infant and child deaths. The prevalence of underweight among women aged 15–49 is 9%.

[7] Uganda AIDS Commission. Uganda HIV and AIDS Factsheet (Based on Data ending 31st December 2020)
[8] Uganda Bureau of Statistics (UBOS) and ICF International Inc. 2023. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS

Figure 6: Trends in Nutrition Status of Children



- Karamoja remains the most affected region.

The national anaemia rate among women of reproductive age (26% in 2019/2020) has persistently remained high. An estimated 28.5% of women aged 15–49 had anaemia, which affected more than half of children (53%) under age 5 in 2016. Women's nutrition has not received sufficient program attention due to the narrow focus on nutrition during pregnancy, yet many women do not enter ANC until the second or third trimester. Key drivers of malnutrition include low nutrition assessment rates, the narrow focus on nutrition during pregnancy, and cultural and social barriers.

FUTURE DIRECTION:

- Address the underlying risks of poor nutrition, repositioning nutrition, especially for adolescents and women, in the wider multi-sectoral framework.

- Advocacy and Partnerships: Promote a multi-sectoral and collaborative approach inv government agencies, civil society organizations, international partners, and the private sect crucial for the success of nutrition interventions. Advocacy efforts can help raise awareness, secure resources, and mobilize support for addressing malnutrition.

- Through the multi-sectoral approaches of the Uganda Nutrition Action Plan (UNAPII) 2018–2025 and the Uganda Maternal, Infant, Young Child, and Adolescent Nutrition Action Plan (MIYCA) 2020–2025, more effort should be put into adolescents' and women's nutrition across the continuum of preconception to pregnancy, which is critical for ensuring positive pregnancy and long-term outcomes for mother, child, and family.

02.5 Ensure universal access to sexual and reproductive health services.

SDG 3.7 aims to ensure universal access to sexual and reproductive healthcare services (SRHS), including family planning, information, and education, and the integration of reproductive health into national strategies and programs by 2030.

Progress has been made towards increasing access to SRHS. The modern contraceptive prevalence rate (mCPR) among married women of reproductive age (15-49 years) consistently increased from 18% in 2006 to 37% in 2022. Uganda recorded a reduction in the unmet need for family planning from 38% to 22% of married women over the same period, a 16% decline since 2006. [9]

FP remains a priority intervention aiming to harness the huge, missed opportunities for FP integration at facility and community outreaches. There has been an increase in the modern contraceptive prevalence rate (mCPR) for married women over the last five years, from 35% in 2016 to 37% in 2022. [10] However, this was below the National Development Plan II and National Family Planning Costed Implementation Plan target of 50% by 2020. Although access to FP has significantly improved along with a growing demand for services, the total fertility rate[h] for Uganda largely remains stagnant, with a slight reduction from 5.4 in 2016 to 5.2 in 2022. High fertility is driven by low CPR, with almost 1 million pregnancies per year being unplanned, early sexual debut with over half (54%) of young women beginning childbearing by age 19, the persistently high teenage pregnancy rate of 25%, and near-universal marital union. Only 60% of the total FP demand is satisfied by modern contraceptive methods.

- The top four regions with the lowest modern contraceptive prevalence rates are Karamoja, West Nile, Busoga, and Acholi.

- Key drivers of low demand satisfaction include low access and uptake of modern family planning methods, inadequate knowledge and awareness about FP methods, cultural and religious barriers, and the limited availability of certain FP methods in some areas.

FUTURE DIRECTION:

- High fertility rates necessitate significant changes in FP programming and service delivery. Delaying birth beyond adolescence, preventing rapid pregnancies (spacing births by at least three years), and engaging partners offer the promise of reaching coverage.

- Reposition FP in a wider and non-medicalized framework that brings together appealing interventions for women before and after pregnancy (e.g., adolescent and maternal nutrition, ECD, prevention of nonfatal maternal disorders) will have a more significant, longer-term impact on demand and uptake.

- Adopt a broader view on generating demand for family planning to ensure gender equality and human rights that includes addressing opposition to FP, using diverse types of demand generation platforms and tools, positioning FP beyond the health sector, and identifying effective demand interventions to end unmet need.

- Adapt and scale up the coverage and implementation of high-impact practices for family planning, including postpartum family planning, especially in the context of improved utilization of facility and skilled maternal delivery services.

[9] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

[10] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

[h] Declined from 7.4 children per woman in 1989 to the current estimate of 5.4 in 2016 (UDHS).

02.6 Achieve universal health coverage.

SDG 3.8 aims to achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and safe, effective, quality, and affordable essential medicines and vaccines.

02.6.1 Skilled birth attendance and adolescent birth rate

02.6.1.1 Skilled birth attendance

There has been improved access to quality essential services, resulting in a skilled birth attendance rate standing at 91%. Over the past two decades, Uganda has significantly improved skilled birth attendance rates. According to the Uganda Demographic Health Surveys (UDHS) conducted in 2006, 2011, and 2016, the percentage of births attended by skilled healthcare professionals has steadily increased. In 2006, only 42% of births were attended by skilled personnel, indicating a considerable gap in access to quality healthcare during childbirth. However, there was a notable improvement in just five years, with the percentage rising to 58% in 2011. The UDHS in 2016 revealed a further impressive increase, reaching 74% of births attended by skilled professionals. The most recent UDHS in 2022 demonstrated a significant increase in the birth attendance rate by skilled professionals to 91%.

- The top regions with the lowest skilled birth attendance rates are Bunyoro, Bugisu, and Bukedi.
- Key drivers include low quality of care during the intrapartum period.

FUTURE DIRECTION:

Expand the quality of care by:

a) strengthening national healthcare facility networks, including for emergency obstetric and newborn care through functionalizing all HCIIIs in all sub-counties and all HCIVs in all constituencies to provide BEmONC and CEmONC services, respectively,

b) Adopting and scaling up respectful maternity care for a positive childbirth experience and satisfaction.

02.6.1.2 Adolescent birth rate

The adolescent birth rate stands at 132/1000 for girls aged 15-19 in 2016 and a rate of 2/1000 for girls aged 10-14. Adolescents accounted for 14% of institutional maternal deaths and 7% of facility deliveries in 2020, with complications of pregnancy and childbirth being a leading cause of death among 15 to 19-year-old girls.[8] The teenage childbearing rate has stagnated over the last decade at 24-25%. The median age at sexual debut for girls is 17 years, 43% are married by 18 years, and every one in four 15- to 19-year-old girls is a mother or pregnant, yet not accessing safe contraception.[9] Among the adolescents aged 15-19 with the most recent pregnancies, 69.0% of those in rural areas and 52.8% in urban areas had unintended pregnancies.[11] Adolescent girls and boys (aged 10–19), who comprise 24% of the population, have unique RMNCAH needs, burdens, and challenges and remain underserved.

- The top regions with the highest teenage pregnancy rates are Teso, North Central, and Bugisu.
- This is attributed to low levels of education, low access and uptake of modern family planning methods, inadequate knowledge and awareness about FP methods, and cultural and religious barriers.
- An estimated 20% of young people experience mental illness, such as depression, suicidal tendencies, mood disturbances, substance use and abuse, eating disorders, and gender-based violence (GBV).

[8] Ministry of Health (Uganda). The annual maternal and perinatal death surveillance and response (MPDSR) report FY2019/2020. Kampala: MOH; 2021.

[9] The Government of Uganda deferred the launch of the 2017 National Guidelines and Service Standards for Sexual and Reproductive Health and Rights, mainly due to reactions regarding contraceptives for adolescents aged 15–49.

[11] Performance Monitoring for Action (PMA) Survey 2020

While all adolescents need access to comprehensive sexuality education, their needs vary by age, gender, and context. With only 26% of health facilities having staff adequately trained in adolescent-and-youth-friendly (AYFS) services, not all adolescents can access appropriate care. Other gaps include limited reach to boys and the most-at-risk adolescent girls, verticalized and narrow range of available services, insufficient service provider competencies, and unfavorable organization[h] of adolescent health services at health facilities.

FUTURE DIRECTION:

Adolescents require access to age-appropriate and context-specific information, commodities, support, and integrated services as laid out in the National Adolescent Health Policy.

- To move forward, all adolescents will need access to comprehensive sexuality education and adequate access to modern contraceptives, whether in or out of school.
- Service delivery to adolescents (and young mothers) requires developing age- and situation-differentiated delivery models such as peer-led approaches, networks/alliances, innovative platforms for reaching the most vulnerable adolescents, and the use of motivational community-based counseling teams for modern contraception adoption, including long-acting reversible contraceptive (LARC).
- Build capacity and professional commitment of service providers to deliver rights-based information and SRHR services, particularly contraceptive services, responsive and relevant to the specific needs of adolescents and youth, including key and vulnerable populations and those in humanitarian and fragile contexts. Adolescent service provider competencies also need to be integrated into pre-service and continuous professional education.
- To increase the convergence of multi-sectoral efforts, adolescent health services will need to change from the current "treatment, prevention, and risk reduction" approach to a more "strengths- and resilience-building" approach within the extended nurturing care framework.
- Working with families through "adolescent and family-centred" care and a school health platform is needed to shape the supportive and positive parent-child relationships that increase social connections and connections with other sectors.

02.6.2 Antenatal care coverage

There has been improved access to quality essential services; coverage with any antenatal care (ANC) remained near universal. Over the last decade, there has been a 50% increase in the percentage of pregnant women who made the minimum of four antenatal visits from 48% in 2011 to 72% in 2022. [12]

- The top regions with the lowest fourth ANC coverage rates are North Central, Bunyoro, Teso, and Busoga. [13]
- Major reasons for suboptimal coverage include late initiation of ANC, low quality of care, inadequate knowledge and awareness about when to start ANC and cultural and social barriers.

FUTURE DIRECTION:

- Improve antenatal care services' quality, maternal experience, and satisfaction with antenatal care.

[h] Includes long waiting times, lack of privacy and confidentiality, long queues, multiple registration points, and inappropriate/inconvenient open hours; also, facility programs, including ANC, delivery, and PNC, are generally not attuned for teenage mothers.

[12] Uganda Bureau of Statistics (UBOS) and ICF. 2023. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS.

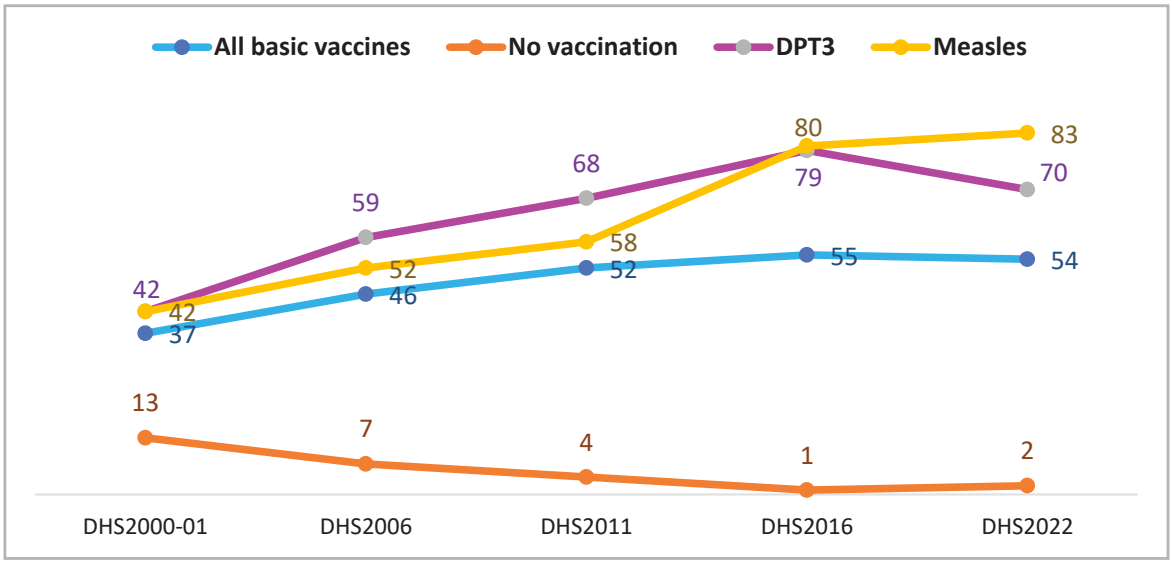
[13] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

- Improve male partner involvement in antenatal care services.

02.6.3 Immunization coverage

There has been a progressive improvement in immunization service delivery and coverage over the years: Measles coverage from 52% in 2006 to 83% in 2022 (although it is slightly below the 90% national target that is required to stop the transmission). DPT3 Hib Heb3 coverage from 59% to 70% over the same period. However, all basic vaccination coverage has stagnated over the last decade in the 52-54% range. Two percent (2%) of children 12-23 months remain unvaccinated.[14] The number of unimmunized children estimated at 350,000 for BCG and 730,000 for oral polio vaccine (OPV) in 2020 remain very high. The vaccine package has been expanded to 12 childhood vaccines.

Figure 7: Trends in basic vaccination coverage



- Top districts with the lowest immunization rates: Bushenyi and Kapelabyong
- Major reasons for suboptimal performance: reduction in the number of conducted outreaches as opposed to what was planned due to no release of GAVI funds to local governments due to delayed accountability.

Future direction: Strengthen Catchment Area Mapping and Planning; understand and address the multiple factors that have a bearing on different health parameters.

02.7 Pollution-related deaths and illness

SDG 3.9 aims to substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination by 2030.

The burden of disease (mortality and morbidity) attributable to air pollution has increased in recent years. The mortality rate for air pollution in Uganda was 155.7 for every 100,000 in 2016, a rise from 70.5 for every 100,000 deaths in 2012. This translates to 30,000 people annually.

- Kampala region is the most burdened.
- Key drivers are rapid urbanization and population growth in urban areas.

[14] Uganda Bureau of Statistics (UBOS) and ICF. 2023. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS.

FUTURE DIRECTION: Strengthen Air Quality Assessment, regularly issuing air quality alerts.

Acute diarrhea is the third leading cause of OPD attendance among children under five years old and contributes to 2.6% of all OPD attendance. Almost 61% of Ugandans lack access to safe water, improved sanitation coverage (toilet) standards at 19%, and 34% have hand washing facilities with soap and water.

- Urban areas are more affected.
- Major reasons for coverage include the high cost of construction ignorance.

Potential future direction: Improve knowledge of proper sanitation among mothers.

02.8 Early Childhood Development

SDG 4.2 aims to ensure that all girls and boys have access to quality early childhood development, care, and pre-primary education so they are ready for primary education by 2030.

In Uganda, only a tenth of children between 3 and 5 years are enrolled in formal pre-primary education. One in four births occurs outside health facilities, with sub-optimal immunization coverage.

About 30% of children under five do not have access to clean drinking water. Only about one-third (32%) of children under age 5 have their births registered with the civil authority. [15]

- Preschools are predominately privately run and located in urban areas.
- The top four regions with the lowest birth registration rates are Bugisu (11%), Busoga (16%), Ankole (19%), and Bukedi (24%).

Future direction: Reposition ECD in a wider multi-sectoral and non-medicalised framework.

02.9 Cross-Cutting Issues

02.9.1 WASH

Status: During the Sharpened Plan I period, access to sanitation facilities (improved toilet, unimproved, and shared) increased by only 4%. Although many initiatives are currently being implemented to improve WASH, almost 61% of Ugandans lack access to safe water, and 81% do not have the required improved toilets. Hygiene is still poor, with more than 58% of the population not practicing basic hygiene of hand washing with soap. Almost all (95%) health facilities have some usable sanitary facilities, with 64% having limited sanitation services (at least one improved sanitation facility, but not all requirements for basic service are met). School sanitation is also poor, with a high pupil-toilet ratio of 72:1 against the standard of 45:1 for day schools and 25:1 for boarding schools. Only 21% of schools had facilities to cater for menstrual hygiene. Hand washing coverage in schools was at 57%.

- The top four regions with the lowest percentage of households with no access to improved drinking water sources are Ankole, Kigezi, Tooro, and Bunyoro.
- The top four regions with the lowest percentage of households without toilet facilities are Karamoja, Acholi, Teso, and Buekdi.

FUTURE DIRECTION:

- Increase financing for WASH in health facilities.
- More concerted efforts in improving WASH in health facilities, paying attention to improved access to safe water and toilets for the disabled, and basic hygiene facilities.

[15] Uganda Bureau of Statistics (UBOS) and ICF. 2023. Uganda Demographic and Health Survey 2022. Kampala, Uganda: UBOS and ICF.

02.9.2 Equity

Status: Although the government has expanded health services for poor and vulnerable populations, health inequity remains widespread and impacts maternal, reproductive, neonatal, child, and adolescent health outcomes. Uganda still has vast social inequalities between rich and poor, high and low levels of education, urban and rural populations, and dominant and minority ethnicities. Some regions have higher burdens and rates of this mortality and poor child nutrition, including lower RMNCAH service utilization. One major challenge in addressing RMNCAH inequities in Uganda is the lack of systematic data collection disaggregated by socioeconomic status to better monitor health equity trends beyond the UDHS. For example, there isn't adequate data on people living with disabilities, and as such, their special needs remain largely unmet.

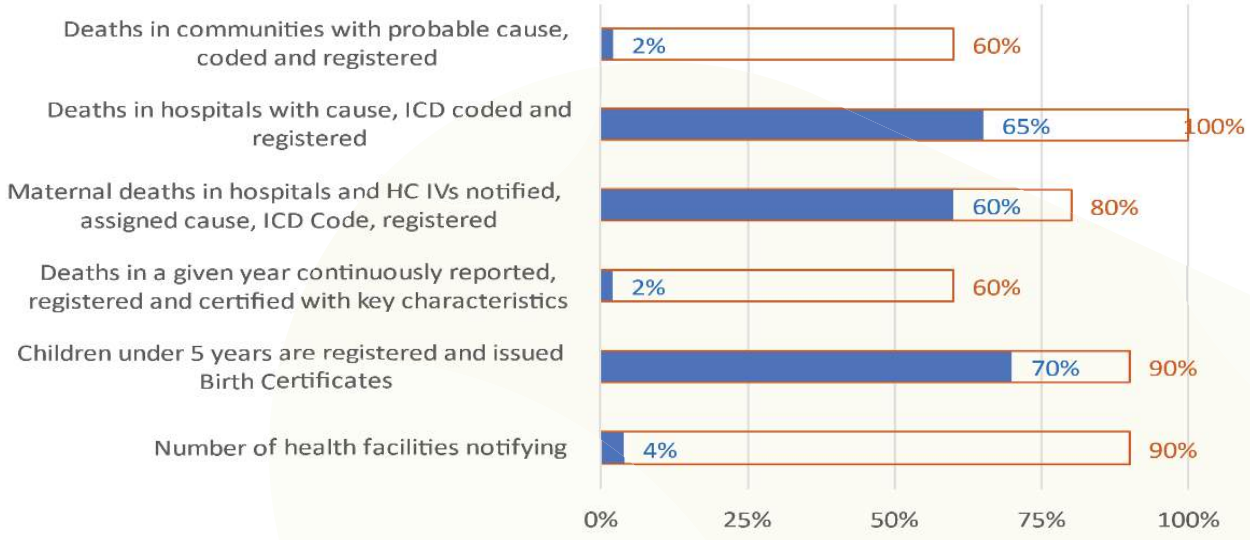
FUTURE DIRECTION:

- Identifying bottlenecks and reaching vulnerable and marginalized people requires increased effort if greater equity is to be achieved.
- Operational research is needed to provide key information on better identifying and targeting such population groups with the worst health outcomes.

02.9.3 Birth and Death Registration

Status: Systematic registration of births (30%) and deaths (1%) was virtually non-existent in 2015, so the Sharpened Plan I called for building a functioning civil registration and vital statistics (CRVS) system in the country. The new law Registration of Persons Act (ROPA) 2015 provides for immediate and compulsory registration of all births and deaths and tasked all medical facilities to record these events and file returns to the local National Identification and Registration Authority (NIRA) office, including declarant reports for events occurring outside medical facilities.

Figure 8: Coverage of Birth and Death Registration against Target Set for 2021



[16] Uganda Bureau of Statistics (UBOS), 2021. Uganda National Household Survey 2019/2020. Kampala, Uganda; UBOS

The low-cost Mobile Vital Records System (MVRS) has been scaled up at the facility level to only 63 districts. Birth and Death Registration (BDR) has been incorporated into the HMIS, and hospital providers are trained in the International Classification of Diseases (ICD) 11 coding of death. Facility-level information collection and reporting of causes of death is slowly improving, and BDR performance has been included in the results-based financing (RBF). However, information and M&E linkages between NIRA registration, UBOS, and HMIS remain undeveloped. Improvements have been registered in hospitals, and HC IV birth and death registration, but the number of facilities notifying deaths is very low (4%), and deaths continuously registered and certified with key characteristics remain at only 2% (Figure 4). NIRA currently has 117 registration centres for births, deaths, and adoptions but at the current CRVS coverage level, the BDR system cannot count every maternal and perinatal death nor provide universal birth registration.

FUTURE DIRECTION:

- Strengthening health worker capacity in notification at health facility and community (in VHT registers) levels, including providing causes of deaths, remains central to expanding BDR coverage, quality, and reporting.

02.9.4 School Health Promotion

Status: School health programs play a critical bridging role in ensuring comprehensive and cohesive health services for children into adolescence. Adolescent pregnancies remain high and are a big contributor to school drop-out in many parts of the country; sexual violence in primary schools is at 77.7%, while in secondary schools, it is at 82%, and almost 22% of adolescents are starting some form of sexual activity. Challenges to current school health and nutrition interventions are not well founded on evidence, poorly implemented, underfunded, and/or limited in reach and scope.

FUTURE DIRECTION:

Schools offer a unique opportunity to implement effective health services at scale for children and adolescents.

- Areas that require improvement include aligning school health services with health priorities; establishing effective pathways for students and adolescents to contact health providers; establishing surveillance; collecting, analyzing, sharing, and using school health data in the education and health sector at all levels; and building requisite competences in visiting or dedicated school nurses in implementing the policy.

- The country should build on existing efforts and adapt the 2020 guidelines to make every school "a health-promoting school through a standards-driven approach that includes menstrual health and hygiene promotion." Eight core global standards, implementation guidance, and core school health services need to be applied at all school levels, from ECD to tertiary institutions.

- Universal free secondary school and other efforts to reintegrate adolescent mothers remain critical for the education sector.

02.9.5 Older People services

Status: Uganda's life expectancy has gradually increased from 50 to 63 over the past ten years,[17] hence the increase of old people from 840,000 in 1991 to an estimated 1.7 million in 2020. The percentage of older adults is expected to rise to greater than 2.2 million by 2025. As people age, their physical and mental capacities decline. Their health issues become more chronic and complex, and they have unique long-term multi-morbidity health and social needs. Uganda's primary health care system is not designed to meet or address issues of older people, including the lack of health management information system (HMIS) data on the SRH of older populations and the attitudes of health providers. Challenges exist with the availability, accessibility, acceptability, and quality of health care for older people.

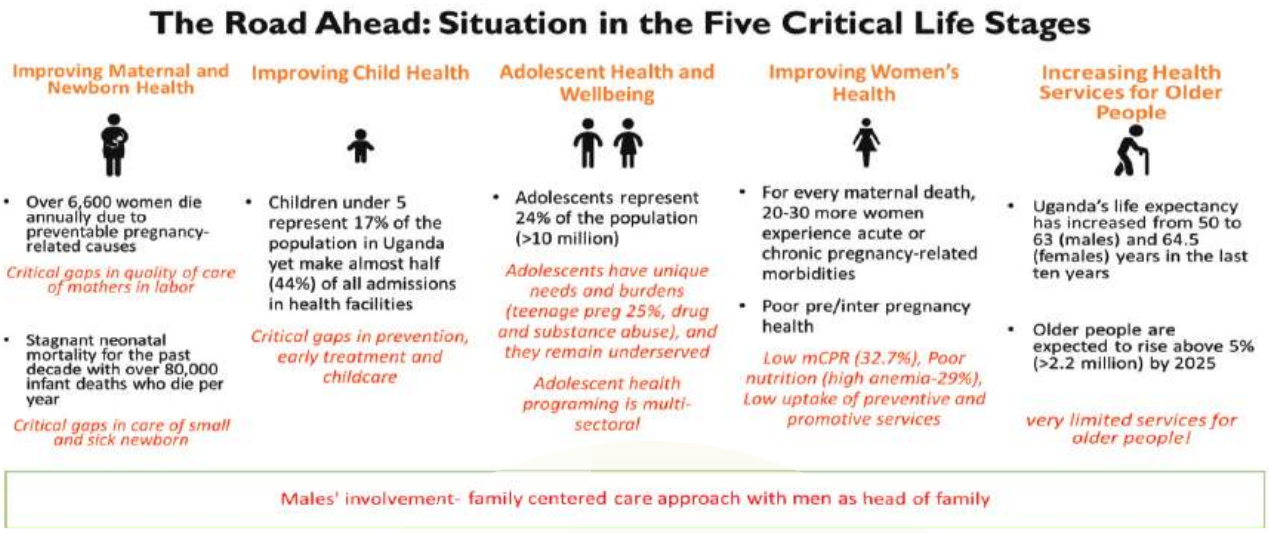
FUTURE DIRECTION:

Uganda's health care system should be strengthened to provide long-term care to older people with chronic conditions. Aligning health and long-term care systems to the older population's needs requires a transformative approach. Priority actions needed:

- Developing SRH service standards for older people and their needs based on a client-focused approach of tailored medical check-ups, diagnostic assessments, and counseling sessions.
- The establishment of community outreach or home care services for disabled older people could also solve the challenges of access.
- Conducting advocacy campaigns to raise awareness of health and multi-sectoral needs and rights of older people, ageism, and elderly abuse.

As described above, the status quo of Uganda's interventions for RMNCAH is focused and can be summed in the five stages of life (as illustrated below), with some of the interventions cutting across all five stages.

Figure 9: Situation in the five critical stages



[17] Uganda Bureau of Statistics (UBOS). National Population and Housing Census 2014—main report. Kampala (Uganda): UBOS; 2016.

Minister of State in charge of Primary Health Care, Hon. Margaret Muhanga is leading a technical team from Ministry of Health to conduct supervision of Maternal and Child Health Services in the Rwenzori Region.

03: ACHIEVING EFFECTIVE COVERAGE

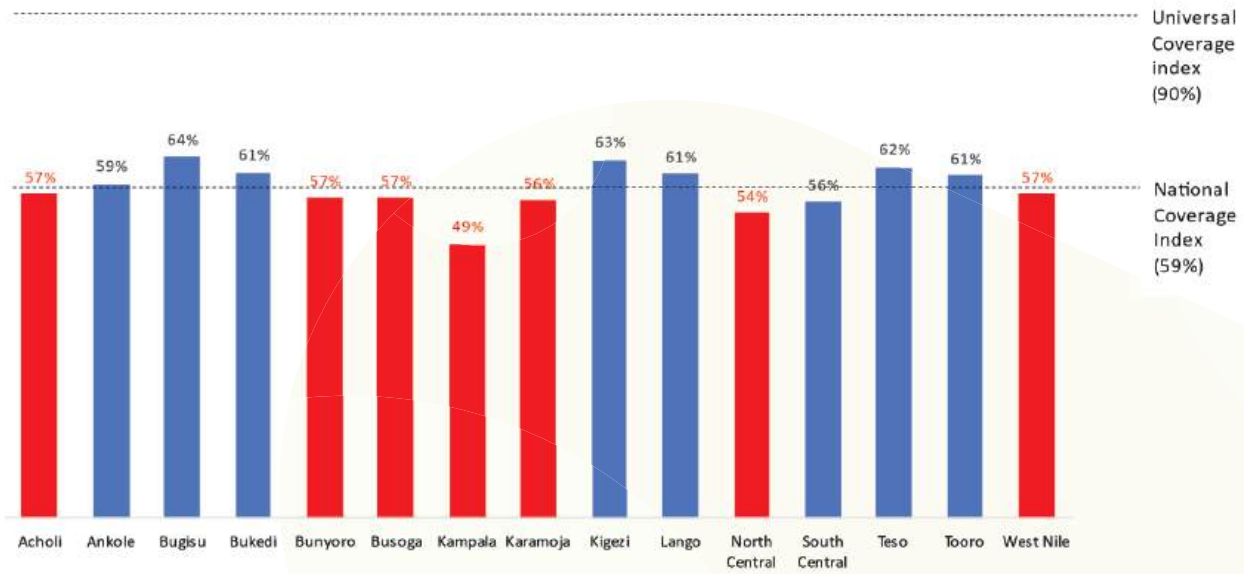
Although significant actions have been taken to ensure the provision of appropriate RMNCAH services, even with some degree of positive progress, there remain substantial challenges in meeting some of the key RMNCAH targets (as expressed in the previous chapter). This chapter presents the key bottlenecks to achieving effective coverage of RMNCAH targets.

03.1 Composite coverage of RMNCAH interventions

Despite the improvements in service delivery, current data on service utilization illustrates that 41% of people in Uganda are at risk due to ineffective and sub-optimal coverage of RMNCAH care services countrywide. The composite coverage [k] index (CCI) summarised in Figure 5 shows an overall national average of 59%, but regional disparities exist, with six of 15 regions registering wider coverage gaps than the national. A list of forty (40) priority districts with CCI less than the national average is included (Annex 1).

The indicators pulling down coverage are HPV vaccination (16%), postpartum FP (29%), ANC-1 in the first trimester (33%), perinatal death notifications (35%), full immunization (50%), and intermittent preventive treatment pregnant women (IPTp) three doses (55%). Perinatal and FP interventions are still low-performing areas.

Figure 10. Composite RMNCH Coverage Index by Region DHIS2 2020



[k] Ideally should use UDHS data, but the most current is 2016. This measures utilization data and will be updated as coverage data becomes available, but it is now used for comparative purposes.

Unless the service delivery and utilization bottlenecks are identified and addressed, efforts to strengthen health systems will be unsuccessful. This section identifies barriers impeding effective coverage and priority actions for system strengthening. The assessment of bottlenecks is presented based on the WHO health systems building blocks. [17] A health systems approach is the best way to assess the adequacy and effectiveness of service delivery that is implemented in an integrated manner, as is the case for RMNCAH.

03.2 Health System Bottlenecks affecting RMNCAH service delivery

03.2.1 RMNCAH Governance and Leadership

The main bottleneck is the governance, leadership, and management effectiveness gaps at the different levels of the health system. It is important to unpack these effectiveness gaps at each level to determine the corrective courses of action at each level of the health system.

National: Although the policy environment was considered adequate, the implementation of the additional policy instruments is still weak. This is hindered by segmented development of policy guidelines, tools, and support to districts, including piecemeal introduction, inadequate use of tools and levers [m] for implementation, ineffective technical oversight, insufficient corresponding budget allocations, and weak accountability required for system and delivery modifications.

Some progress has been made in strengthening national-level coordination, partnerships, and coalition building over the last period through the extended Maternal and Child Health (MCH) Cluster. [n] However, there remains a challenge to align RMNCAH donors, partners, and stakeholders behind a unified and systematic RMNCAH approach due to the segmentation of support and programming. The vertical approach of RMNCAH interventions still curtails integration and a continuum-of-care approach.

Sub-national: Health sector governance structures are adequate but weak at subnational levels. District and health facility leadership, including the District Health Officer and Assistant District Health Officer in charge of Maternal and Child Health, are the most important factors for changing RMNCAH service delivery and overall improvement. These mid-level health managers are swamped with district and facility leadership responsibilities and yet have limited competencies and resources. At lower levels, health service committees of local governments and facility management committees are the key mechanisms for participatory governance. However, their stewardship is ineffective and without adequate guidance to enhance ownership of the services.

03.2.2 RMNCAH Financing

Inadequate funding for RMNCAH remains a big bottleneck, as is inefficient use of existing resources. Persistent low public expenditure on RMNCAH identified in the previous plan still hinders service delivery for the health of women and children. The overall health sector has been inadequately funded over a long period. Government budget allocation for the health sector in the last five years stood at 7.8% (below Abuja Declaration of 15%), and an overall Health Expenditure per capita of US$36.9 is below WHO recommended US$86. [27] Donors continue to contribute the largest share (42%) of THE, followed by the private sector (inclusive of households) at 41%. The portion from government or public resources is the least (17%).

For RMNCAH financing, innovative donor financing through “maternal vouchers” at a small scale transitioned into a countrywide results-based funding (RBF) mechanism under the Uganda Reproductiv

[17] https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf

[m] These include regulation, legislation, standard setting, budgeting, incentives, and organizational design and change.

[n] Membership landscape includes public, CSO platform, private, bilateral, and multilateral agencies.

[27] Uganda Ministry of Health. National Health Before Pregnancy Accounts 2016–2019. Kampala (Uganda): MOH; 2020.

Maternal and Child Health Service Improvement Project (URMCHIP) financed through a loan to the government. [O] Under the Uganda Intergovernmental Fiscal Transfer (UgIFT) project, the government intends to mainstream this RBF approach into the country's public financial management systems with effect from FY 2023/24. This US$1 billion initiative will build on lessons from the URMCHIP and improve adequacy, equity, and resource management by local governments. These additional funds disbursed within the conditional PHC facility grants from the government will be for operating costs and health output/performance-based indicators covering RMNCAH, nutrition HIV, TB, and NCDs, among others. Given the limited fiscal space, this RMNCAH plan aims to identify and use new innovative financing options.

03.2.3 Health Workforce

One of the key bottlenecks for service delivery is the shortage of staff. Low staffing at the Reproductive and Child Health Department (41%) and the proliferation in a number of districts (50%) that lack substantive Assistant District Health Officer (ADHO)-MCH critically strain oversight of the decentralized governance of service delivery. The Sharpened Plan I identified staff shortage, maldistribution, absenteeism, and insufficient skills as long-standing and important health workforce bottlenecks.

Addressing this situation is critical due to the labor-intensive nature of health service delivery. Over the last period, the filling rate for approved staffing positions improved from 48% in 2008 to 74% in 2020, driven mainly by recruitment, training, and deployment of critical cadres; deployment and bonding of trained staff in hard-to-reach areas/districts with staffing below 50%; and staff accommodation. Despite this progress, workforce density remains suboptimal, with a midwife-to-pregnant woman ratio of 1:311, far below the WHO threshold of 1:200 for the region. The priority RMNCAH cadres for recruitment to fill critical staffing gaps in the next five years are anesthetic officers (200), dispensers (200), anaesthesiologists (70), neonatologists for RRH (20), critical care neonatal nurses (60), FP specialists (60), geriatric medicine specialists (35), pediatricians (300), and obstetricians and gynecologists (180). These positions are necessary to support the development of PHC essential services, optimize EmONC quality, and provide vital tertiary care

There are inequalities in the distribution of human resources. Maldistribution of HRH continues with the staffing level for rural HC IIs at only 55% compared to the national average level of 74%, and more than 70% of doctors and 60% of midwives and nurses located in hospitals mostly serving urban populations.

In addition to shortages, health worker productivity remains low, driven by working "rotational midwifery shifts," 50% of staff not available [S] due to chronic absenteeism (especially at lower-level facilities), [29] and deficits in critical skills and competence in managing emergencies, small and sick neonates, adolescents, and older people.

Village health teams (VHTs) remain an informal voluntary health workforce operating nationally. Long-standing challenges—identified in the previous plan but not addressed—persist. The government has developed the first "community health strategy," which is expected to formalize VHTs support and accountability framework, link them to the integrated human resources information system (IHRIS), and provide incentives within RBF and other funding arrangements by government and partner mechanisms or allowances. Only 58% of districts have an active VHT system, mainly in integrated community case management (ICCM). The very high number of VHT-per-supervisor ratios (average is 600:1) demands retooling and digitizing their training, support supervision, and reporting.

[O] Implemented under financing from the World Bank and the Global Financing Facility (GFF) in support of Every Woman Every Child.

[S] Unsanctioned absenteeism has been reduced to 11%, and authorized absenteeism to 38%.

[29] Zhang H, Fink G, Cohen J. The impact of health worker absenteeism on patient health care seeking behavior, testing, and treatment: a longitudinal analysis in Uganda. PLoS ONE. 2020;16(8):e0256437.

03.2.4 RMNCAH Infrastructure and Equipment

Massive medical equipment procurement and rehabilitation were previously initiated, including furniture, instruments, and critical devices such as blood refrigerators, theatre equipment, neonatal units, ultrasound machines, and electricity generators, to be distributed to 700 health centres nationwide. Of the targeted 315 HC IIs, 186 have been upgraded to HC IIIs. So far, ultrasound machines for 20 HC IVs out of 218, NICU equipment for 42 high-volume HC IVs, and assorted medical equipment for 400 HC IIIs are targeted under the Uganda Intergovernmental Fiscal Transfers (UgIFT) program. Under Global Alliance for Vaccines and Immunisation (Gavi) funding, 5,213 vaccine carriers and 1,155 cold boxes were procured, and 996 refrigerators were installed. The disconnect between equipment and available personnel is being addressed in the staffing strategy, and maintenance budgets have been increased through the UgIFT PHC grants. This significant investment in health infrastructure allows the government to establish and equip at least one HC III in each sub-county toward delivering UHC in Uganda.

The remaining infrastructure bottlenecks relate to geographical maldistribution of referral facilities, inadequate staff accommodation at health facilities, and a critical lack of equipment for inpatient neonatal care (yet more than two-thirds of newborns require specialized inpatient care). The physical structure, equipment, working space, and environment at most health facilities do not meet clients' expectations.[30]

03.2.5 RMNCAH Commodity Security and Technologies

03.2.5.1 Commodity Security

The availability of RMNCAH commodities has improved through increased government and partner funding. Long-term infrastructure developments to improve storage capacity began; cold chain storage refrigerators for oxytocin were procured with GAVI support. District-level pharmacists have been recruited to support integrated supply chains and management at lower-level health facilities. Stock delivery times have improved, but health facilities still experience stock-outs and overstocking, with 45% reporting stock-outs in the last three months of 2020.[32]. Despite there being a National Medicines Policy and the 10-year health commodities supply chain road map, the Sharpened Plan I recognized weaknesses in the national supply chain management system as an important bottleneck in service delivery. Specifically, stock-outs of essential medicines and health supplies at many facilities persist, with only 49% having more than 95% availability of essential medicines and health supplies.[31] Some of the bottlenecks included:

- shortage of pharmacy staff,
- weak coordination of different commodity funding streams, especially for FP items,
- lack of cold chain equipment for oxytocin, and
- lack of storage space at some health facilities, resulting in commodity stock-outs and overstocking
- inadequate and late deliveries from the national medical stores and
- the inability to respond to emergency orders

03.2.5.2 Digital Interventions

The NDPIII places priority on ICT, especially for reducing data and smartphone costs. Digital technologies provide quick, efficient, and effective enhancement in the coverage and quality of RMNCAH practices and services. Digitization of logistics management information systems from the national to the community level has been started through scaling up NMS+ CSSP and DHIS2 ordering apps for public and private, not-for-profit (PNFP) facilities, and through health facilities using eLMIS. Currently, all 275 HC IVs and above are ordering commodities using NMS+ CSSP, and RRHs are using HMIS.

03.2.6 Service Delivery emphasizing Evidence-Based, High-Impact Interventions

One key bottleneck is that RMNCAH service delivery at all levels remains poorly coordinated, episodic, fragmented around intervention/funder projects, uneven, and centred on providers. During the past implementation period, many quality tools were developed to improve healthcare quality and support the provision of services. The country adapted the WHO standards for quality of care over the life course, placing mothers, newborns, children, and adolescents at the centre by addressing provision and patients' experience. However, efforts have been mostly focused and designed around supply-side clinical quality indicators. Although indicated in the essential health care package, small and sick newborns, adolescents, and aging service packages are not as well institutionalized as part of routine service delivery, compared to child health, maternal health, and FP services. RMNCAH conditions are managed at all levels of care due to insufficient referral gatekeeping and the public's perception that the quality and scope of care are poorer at lower-level facilities. Weak emergency referral persists due to insufficient integration in the newly created regionalized ambulance system under the emergency medical service program, boosted during the COVID-19 response.

Client satisfaction with the public health care system is low, with only 31% expressing satisfaction with services provided at health facilities or in the community. The least satisfaction is among clients attending public HCs, and the leading quality disincentives are poor responsiveness related to promptness (long queues), respectful/courteous/dignifying care, and provision of services at all times (24-hour services).[36]

03.2.7 Health Management Information

The Health Management Information System (HMIS) is not uniform at all levels, with community centres, HCs, and general hospitals still paper-based, whose summaries are entered in the DHIS2 at the district level. Combining community and facility HMIS has been difficult.

In the end-term review of the Sharpened Plan, I identified weaknesses in data analysis, report generation, dissemination, and use. Although timeliness, completeness, and generation of reports and scorecards have improved, recent studies show that data are not used by the health facilities that collect them, so there is no impetus for data quality at the source.[37] Currently, health facilities in Uganda do not keep patient records/files beyond patient cards or facility registers, and this curtails any longitudinal follow-up or implementation of family-centred care. The increasing data burden during service provision, along with increased demand for more health indicators and more disaggregated data, has caused concern about the amount of time health workers spend on recording and reporting data at the potential cost and risk to quality service provision, taking up over one-third of consultation time.[38]

Progress made in migrating to electronic medical records has been limited to HIV and TB programs. Since its initiation in 2011, the UgandaEMR[z] has expanded to more than 1,000 hospitals and high-volume HC IVs and contains components linked to maternal and child health that could be expanded for wider RMNCAH. The assessment in 2020 showed the system is moderately secure but could be improved in line with the Uganda Data Protection and Privacy Act 2019. The inclusion of RMNCAH care in the EMR system could enable tracking from preconception through pregnancy, newborn, child, and adolescent to adulthood and allow the sharing of health information between the outpatient clinic and the hospital to inform decision-making. It thus offers the best foundation for a holistic national EMR system for the country in the long term. [39]

03.2.8 Community Engagement for RMNCAH

The Sharpened Plan I highlighted that social and behavior change communication (SBCC) interventions have hardly been implemented. Community health, an integral part of the Uganda health system, has been operationalized more through direct community health care service delivery (through VHTs and outreaches) than health promotion activities (home visits) or strategic SBCC interventions. Support for community health remains almost solely from external funding. Behavior change, community engagement, demand for services, harmful social norms, and social

accountability have long been central to RMNCAH improvement but continue to lack clear, unified initiatives and strategies. An SBCC framework is thus needed to initiate and align efforts necessary to achieve national RMNCAH priorities and align to the intersectoral coordination required for achieving results.

Community engagement is pivotal in ensuring increased programmatic focus on RMNCAH promotion and action on social determinants, self-care, equity, and rights. Community and stakeholder engagements are also critical to ensure accountability for quality of care (QoC) and results and help identify gaps, prioritize concerns, monitor performance, and provide solutions to improving QoC. Community feedback is also valuable in guiding the most strategic use of resources to improve services. The government, with support from partners, has developed a comprehensive, costed community health strategy and has created a coalition[40] to steer the active engagement of communities in health at policy and management levels.

[30] Ministry of Health (MOH). Client satisfaction survey for the health sector 2020/2021. Kampala (Uganda): MOH; 2022.

[32] Ministry of Finance, Planning and Economic Development (MOFPED). Health sector annual budget monitoring report-FY 2019/20. Kampala (Uganda): MOFPED; 2020.

[31] Ministry of Health. Annual Health Sector Performance Report (AHSPR) 2019/20. Kampala (Uganda): MOH; 2021.

[36] Ministry of Health (MOH). Client satisfaction survey for the health sector 2020/2021. Kampala (Uganda): MOH; 2022.

[37] Wandera SO, Kwagala B, Nankinga O, Ndugga P, Kabagenyi A, Adamou B, et al. Facilitators, best practices and barriers to integrating family planning data in Uganda's health management information system. BMC Health Serv Res. 2019;19:327.

[38] Siyam A, Ir P, York D, Antwi J, Amponsah F, Rambique O, et al. The burden of recording and reporting health data in primary health care facilities in five low- and lower-middle-income countries. BMC Health Serv Res. 2021;21:691.

[z] UgandaEMR is a customization of OpenMRS for Uganda and is used following guidelines issued by the Ministry of Health under the Health Management Information System (HMIS) manuals.

[39] World Health Organization (WHO). WHO Community engagement framework for quality, people-centred, and resilient health services. Geneva: WHO; 2017. Community engagement is "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes."

[40] Uganda's National Community Health Learning and Improvement Initiative (NACHLII).

In an effort to ensure that no child should suffer from a vaccine preventable disease. The Ministry of Health has made sure that all children under 1 year are vaccinated at least 5 times before their first birthday.

Routine vaccination is FREE of charge at all Government health facilities.

During the Integrated Child Health Days, Pregnant Women receive services like Antenatal Care, immunization, deworming and nutritional screening at health centres to ensure that they and their unborn babies are safe and healthy.

04: REACHING TARGETS FOR 2025

04.1 Strategic Direction of the Revised Sharpened Plan

The strategic direction of this sharpened plan is drawn from the NDP III 2020–25 that, supports the life course approach and Every Woman Every Child strategy that emphasizes the movement from "Survival" to "Thrival and Transformation".

National Development Plan 2020–25

National Vision: A transformed Ugandan society from a peasant to a modern and prosperous country by 2040.

National Development Goal: To increase average household incomes and improve the quality of life of Ugandans.

Human Capital Development Sub-Goal: To increase the population's productivity for increased competitiveness and better quality of life.

Overall Goal: To contribute to the increased productivity of the population for long-term poverty reduction, competitiveness, and better quality of life.

Specific Goal: To improve the health and quality of life of women, newborns, children, adolescents, and men, as well as older people.

Broad Objective: To accelerate the movement toward Universal Health Coverage with a focus on Primary Health Care and improve population health, nutrition, well-being, and safety,[cc] and management [dd] by 2025.

Specific Objectives:

1. To end preventable maternal, newborn, child, and adolescent deaths

- This objective maintains the commitment to addressing the unmet needs and remaining inequities in maternal, newborn, and under-5 survival.

2. To promote the health and development of all children, adolescents, and women

- This objective looks beyond survival and addresses health and development needs of all people across the various life stages.

The Sharpened Plan II will be implemented through a theory of change based on the five strategic shifts. The theory of change is founded on a robust and effective health system (looking at it from the lens of the health system's building blocks, as illustrated below). Put differently, the five strategic shifts, which are the pillars of this Sharpened Plan II, ought to rest on the foundation of a health system that is functioning effectively.

[cc] Tackling issues of sanitation, ventilation, pollution, use of clean cooking energy, and reduction of road traffic accidents.

[dd] When families are able to feed, clothe, educate, and provide health care for their children and themselves.

04.2 Theory of Change

For health system performance to sustainably accelerate improvement in people's health and well-being, critical inputs for each health system block need to contribute toward providing people-centred care services. The endline review of the Sharpened Plan I showed inadequate investment in ensuring the delivery of RMNCAH packages.

The Sharpened Plan II does not change or create new interventions from the previous one but focuses on components prioritized to bring about progress in the survive, thrive, and transform agenda for women, children, and young people and, consequently, improved human capital development. This approach also ensures confluence with other sectors in the human capital development program on harnessing the demographic dividend.

According to the theory of change, we need a robust health system to effectively implement the five strategic shifts. The health systems inputs are in the following areas:

(1) governance,

(2) human resources,

(3) financing,

(4) health infrastructure,

(5) health commodities, and

(6) health information systems.

These critical inputs are interlinked and need to be supplied in the appropriate measures in an integrated manner, ensuring that existing gaps or dysfunctions are minimized or eliminated.

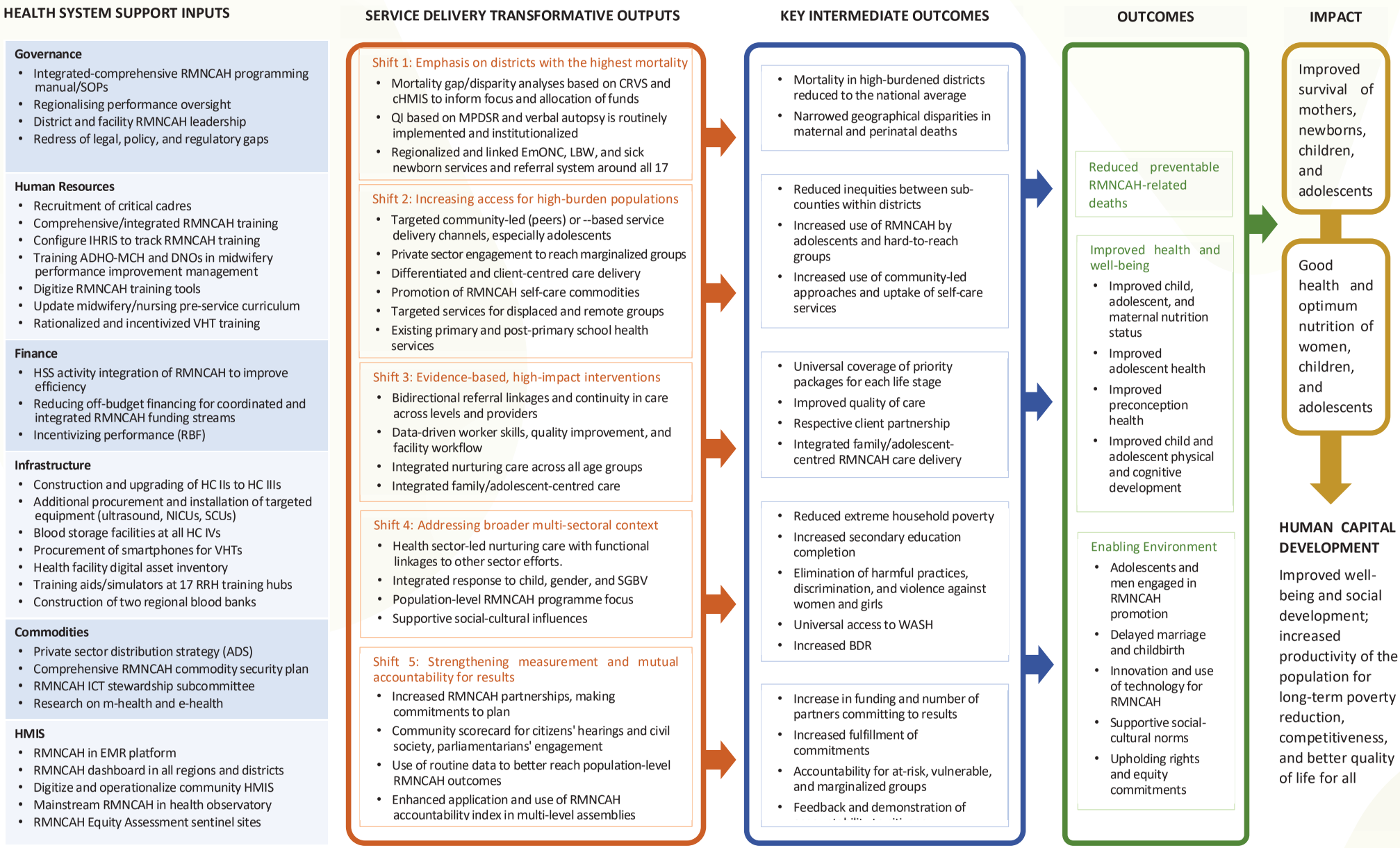
Having a functional health system enables the implementation of the five strategic shifts (which are described in detail later), which should, in turn, result in a range of intermediate outcomes, including a reduction in mortality in high-burdened districts, narrowed geographical disparities in maternal and perinatal deaths, increased use of RMNCAH by adolescents and hard-to-reach groups, increased use of community-led approaches and uptake of self-care services, improved quality of care, universal access to WASH, increase in funding and number of partners committing to results, accountability for at-risk, vulnerable, and marginalized groups, feedback and demonstration of accountability to citizens, among others,

The key intermediate outcomes would then translate into achieving the three main objectives of the Sharpened Plan II, as described above. Positive and significant progress towards achieving the intended targets would translate into the anticipated impact:

(a) improved survival of mothers, newborns, children, and adolescents, and

(**b)** good health and optimum nutrition of women, children, and adolescents. Overall, meeting targets for this Sharpened Plan II contributes to the national objective of human capital development, which is improved well-being and social development, increased population productivity for long-term poverty reduction, competitiveness, and better quality of life for all.

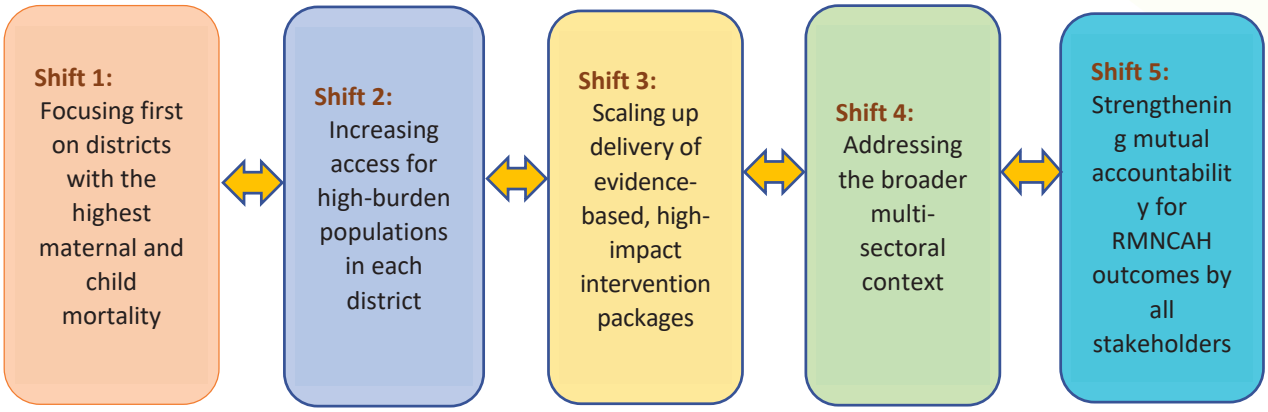
Figure 11: Theory of change



04.3 The Five Strategic Shifts

The five strategic shifts introduced in the previous RMNCAH Sharpened Plan I remain the interdependent strategies driving transformation in the Sharpened Plan II. Fulfilling these five strategies cumulatively will build more effective and equitable RMNCAH services; the shortage of progress in any one will weaken others. The five interdependent strategies are described in turn.

Strategic Shifts



04.3.1 Shift 1: Focusing first on districts with highest maternal and child mortality

This shift recommends greater attention and initial effort (sequencing) on a few geographical sites with the highest mortality. Despite the progress in mortality reduction, child and maternal deaths are increasingly clustered in a few places and population segments. The highest U5MR (more than 120 deaths per 1,000 live births) and maternal mortality (more than 400 deaths per 100,000 live births) occur in just eight districts and four regions, respectively.

Outside Kampala, the subregions with the highest under-5 mortality rate (U5MR) are Busoga, Bunyoro, Karamoja, Northern Central, Tooro, and West Nile compared to the other nine regions.43 The districts with the highest U5MR (more than 120 deaths per 1,000 live births) include Zombo, Bullisa, Kyegegwa, Kamwenge, Rubirizi, Buhweju, Lyantonde, and Rakai.

Regions with the highest maternal mortality are Karamoja, Kigezi, Northern Central, and Acholi, with more than 400 deaths per 100,000 live births.[44] Data also show that the reduction in child mortality rate is slower among the urban poor population (more than 6.8 million), hence the need to develop targeted interventions as urban population growth accelerates in Uganda. A significant proportion of severe maternal morbidity and mortality events are preventable, and efforts to do so may have higher success among these communities.

04.3.2 Shift 2: Increasing Access for High-Burden Populations in each district

This shift is embedded in the commitment to support specific people facing specific problems in specific places, which will determine whether the country is leaving large numbers of people behind by the end of this plan.

Considerable strides have been made in women's and children's health and social development. Despite this, progress has disproportionately benefited subpopulation groups, with some lagging behind.[45] Proactive, pro-equity interventions to respond to the needs of vulnerable groups and communities with poor access are needed at the district level.

Districts need the right information to identify and characterize vulnerable groups and communities and prioritize them in service planning, implementation, and institutional arrangements for targeted service delivery. Districts and health facilities will use three general methods to identify these groups:

(1) apply existing nationally defined priority groups,

(2) use composite coverage index to compare sub-counties, and

(3) conduct additional district contextual assessments.

RMNCAH encompasses the life cycle of an individual from birth to old age provided along the continuum of care to all who need services. However, members of populations and groups who are often difficult to reach face significant barriers when services are provided through routine service delivery. They need RMNCAH services delivered through community-led, targeted outreach or satellites in locations with client-centred differentiated service delivery and effective referral mechanisms. These groups also need strong preventive interventions, especially FP and behavioral interventions.

National Priority Groups

a) Adolescent and young mothers
b) Small and sick newborns
c) Children from birth through age 5
d) Adolescents
e) Vulnerable populations include the urban and rural poor, adolescents, people with disabilities, HIV or sickle cell disease, indigenous groups, islanders, refugees, migrants, minorities, marginalized, and socially excluded.

04.3.3 Shift 3 Scaling up delivery of Evidence-Based, High-Impact Interventions

This shift targets the greatest opportunities for impacting mortality, the most-at-risk period around childbirth, the first days of life, the most neglected but easily preventable child killer diseases, and increasingly the wellbeing of the mother, child, and adolescent. Survival, health, and wellbeing for women, children, and adolescents do not depend on a single intervention but on packages of interventions delivered at all health system levels. The goal remains to ensure the availability of all essential RMNCAH packages already part of the health system to high quality and high coverage rather than choosing between packages. Evidence-based packages of RMNCAH interventions have been defined and published,[46] but implementation remains suboptimal, as seen from the composite coverage index (see Figure 5). The endline review of the Sharpened Plan I showed the very limited implementation of these packages, primarily due to insufficient dissemination of the plan and tools to guide systematic implementation at each level. Recognizing that resource and capacity still constrain integration of the full RMNCAH package, an incremental approach to expanding access to interventions within each package will be continued in this period.

04.3.4 Shift 4: Addressing the Broader Multi-sectoral Context

This shift calls for evidence-informed policy and action to bring about optimal health of women and children beyond medical care, including behavioral and environmental risk factors. Despite efforts for decades to bridge areas of mutual concern under multi-sectoral actions, the endline review of the Sharpened Plan I showed that multi-sectoral partnership in RMNCAH is still weak, fragmented on vertical issues, and not systematically implemented across all levels. Up to 50% of the gains in reducing child mortality result from health-enhancing investments in other sectors—education, women's participation, the environment, governance, and poverty reduction.49 Current coverage of the non-health sector UHC tracer indicators is low; much effort is still needed, as shown in Table 2.

[44] Uganda Bureau of Statistics (UBOF). Health status and associated factors: thematic series based on the national population and housing census 2014. Kampala (Uganda): UBOF; 2017. Available from: https://searchworks.stanford.edu/view/13588685.

[45] UNICEF. Narrowing the gaps: the power of investing in the poorest children. New York: UNICEF; 2017.

[46] World Health Organization (WHO). Packages of interventions for family planning, safe abortion care, and maternal, newborn, and child health. Geneva: WHO; 2010. Available from: https://apps.who.int/iris/handle/10665/70428.

Table 1. Non-Health Sector UHC Tracer Indicators

Indicators	2020	Ideal
Households appropriately treating water (%)	52	>90
Improved toilet coverage (%)	19	>90
Hand washing with soap and water (%)	34	>90
Use of clean energy (access to electricity) (%)	29	>90
Undernourishment (population) (%)	40	<5
Housing floors made of cement screed (%)	52	<90
Alcohol abuse	5.8	<1
Average years of schooling	6.1	11
Gender gap index	0.52	0.8
GBV prevalence	56	<10

04.3.5 Shift 5: Strengthening Mutual Accountability for RMNCAH Outcomes by All Stakeholders

This shift calls for answerability regarding decisions and actions for improving the implementation of RMNCAH commitments, focusing on three thematic areas: accountability for results and resources, performance-based financing, and innovation. Population-level improvements are a shared responsibility of healthcare providers, governmental public health agencies, and many other community institutions. The emphasis on population health demands that improvements consider all factors that influence and are affected by RMNCAH. Accountability remains an important factor for success and acts as a motivator to concentrate on commitments and allocated roles or responsibilities. Mutual accountability means that stakeholders agree to be held responsible for obligations and commitments they make to each other in achieving the intermediate results. Over the last strategic period, the country moved toward establishing joint RMNCAH accountability mechanisms at the national level and progressively initiated regional reviews that are being strengthened.

District RMNCAH accountability remains a cornerstone, but the system is weakly developed at this level. This emphasis on community engagement is part of the shift toward accountability based on improving catchment area population health, institutionalizing inclusiveness, complaint mechanisms, feedback loops, openness, transparency, and access to budgets and performance information. Mechanisms to link facility RMNCAH outputs, service delivery, and community HMIS on population health coupled with a community scorecard will be introduced to ensure services retain community support and respond to local perceptions of needs and priorities.

District and facility managers will collectively become fully accountable for results and implement quality measures to gradually hold each provider accountable for high-quality care delivery. The people-centred care approach in this plan extends a provider's accountability beyond current answerability to local government employers (district and sub-county) or professional associations. The new dimension involves accountability to local communities for service provision and horizontal accountability to peers.

To track progress and ensure accountability for RMNCAH outcomes, improvements in the availability and quality of data and reporting from community HMIS, MPDSR, HFQAP, RMNCAH scorecards, and BDR will be critical. For effective social accountability, transparent and inclusive mechanisms involving RMNCAH assemblies at regional and national levels and facility-level catchment area review meetings/barazas are needed to improve responsiveness to community needs and demands. Covering both public and private sectors will be critical. Tracking of resource commitments by government and partners will be through the "System of Health Accounts 2011," which provides detailed expenditure data on RMNCAH. Priorities to strengthen accountability are linked to political engagement, attracting more or improving the use of financing, responsiveness to user needs, and rallying multi-stakeholder approaches toward achieving universal access to services.

[49] Kuruvilla S, Schweitzer J, Bishai D, Chowdhury S, Caramani D, Frost L, et al. Success factors for reducing maternal and child mortality. Bull World Health Organ. 2014;92(7):533–44.

Ministry of Health Permanent Secretary Dr. Diana Atwine doing a Lab and diagnostics ward round at Kayunga RR Hospital under the theme, 'test before you treat'. Here we interface with patients, physicians, laboratory and radiology teams on how patients are clerked, investigations are done, and how these inform treatment.

05: IMPLEMENTATION STRATEGY FOR THE PLAN

This Sharpened Plan II focuses on the strategic shifts that will deliver universal coverage of high-quality, people-centred care and integrated RMNCAH services. This change will require concerted and unceasing commitment from the government (central and local), partners, the private sector, and all stakeholders. The MOH will collaborate with all partners at the national and sub-national levels. Implementation will adhere to the set sector institutional governance, management, and decentralized implementation mechanisms.

05.1 Key Implementation priorities to improve health systems

As noted earlier in the description of the theory of change, the six health systems' building blocks form the foundation that allows the implementation of the five strategic shifts, which is the basis for implementing the Sharpened Plan II. The priorities under each health system building block are briefly discussed in turn.

05.1.1 RMNCAH Governance and Leadership

To improve the status quo, in the period for the Sharpened Plan II, there is need to:

1. Harmonise, align, and consolidate the various RMNCAH policies and programming, and develop a comprehensive RMNCAH manual/SOPs. This should be done in partnership with individuals, families, communities, and frontline service providers.

2. Regionalize technical oversight and performance improvement across the public and private sectors around the regional referral hospitals.

3. Develop training, job aids, and tools for improving district and facility RMNCAH leadership in management, change management, building partnerships with local communities, and achieving people-centred and integrated care.

4. Develop tools for the various subnational health governance[26] committees for implementing the alterations in service delivery design to people-centred RMNCAH care and population RMNCAH management, including services and accountability.

5. Reanalyze the legal, policy, and regulatory frameworks to identify gaps and barriers to RMNCAH's extended nurturing care framework and develop a redress strategy.

6. Develop guidelines, implementing tools, and mechanisms with professional bodies and associations for effective private sector engagement, especially midwives/nurses in RMNCAH delivery, particularly for adolescents and hard-to-reach subpopulations.

05.1.2 RMNCAH Financing

Over the Sharpened Plan II period, priorities will be towards:

1. Improving efficiencies through integrating RMNCAH program implementation, management, training, and supervision activities and increasing domestic resource mobilization for RMNCAH.

2. Continuing to track national and district level expenditure and reduce off-budget financing of RMNCAH services currently at 79% (UGX 129 billion).[28]

3. Aligning RMNCAH/N partner funding toward service delivery at community, HC III, and HC IV levels

4. Establishing additional innovative resource mobilization efforts targeting RMNCAH.

05.1.3 Health Workforce

To further influence the national 10-year Human Resources for Health (HRH) Development Strategic Plan, additional efforts are needed to speed up health worker retention, productivity, competence, and responsiveness toward RMNCAH priorities to achieve set targets. The priorities to improve health worker productivity, competence, and responsiveness to RMNCAH needs are:

1. Configure and build capacity for continuously tracking RMNCAH training information to determine district- and facility-level progress and deficits based on an electronic IHRIS.

2. Train mid-level managers (especially ADHO-MCH and nursing officers) in implementing RMNCAH nursing and midwifery performance improvement management.[v]

3. Digitize RMNCAH training materials and tools, including for adolescent peer providers, school health, and self-care.

4. Train 17 regional teams of trainers/supervisors/mentors with integrated biannual, short on-site courses; provide peer support for frontline workers organized within districts; and develop information and communications technology (ICT)-enabled distance-learning schemes.

5. Update midwifery and nursing pre-service national training curriculum and cover new RMNCAH competence requirements and rural health issues to improve competence and interest in rural practice.

6. Develop and roll out training module on the expanded RMNCAH package (including the use of digitized technologies) for VHTs, and incentivize VHTs to meet RMNCAH performance standards within the expanded community package (ICCM-plus, commodity distribution, pregnancy mapping, etc.).

05.1.4 RMNCAH Infrastructure and Equipment

Priorities within the Sharpened Plan II period are:

1. Procurement of targeted equipment:

(a) low-cost portable obstetric ultrasound machines with a training package for midwives, (b) NICUs for general hospitals,

(c) SCUs for 100 high-volume HC IVs, general hospitals,

(d) Kangaroo Mother Care (KMC) beds for all HC IIIs and HC IVs.

2. Establishment of blood storage facilities at all HC IVs to ensure timely availability of blood supply and other products such as fresh frozen plasma and platelets.

3. Procurement of smartphones for VHTs to contact health facilities for referrals using mobile phone-based alerts and audit services and report using rapid SMS.

4. Establishment of facility digital asset inventory system to track equipment availability, functionality, and servicing requirements.

5. Provision of training aids/simulators at 16 regional hospitals to serve as pre- and in-service competence training hubs.

6. Renovation of grossly dilapidated health facilities in selected districts.

7. Equipping and strengthening the regional equipment maintenance workshops to maintain all the existing and newly procured medical equipment within the districts.

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[26] Outlined in Ministry of Health guidelines for governance and management structures. Kampala (Uganda): MOH; 2013

[28] MOH, UNICEF. Tracking off-budget financial resources in the health sector FY2019/2020. Kampala (Uganda): MOH and UNICEF; 2020. The Uganda Equity Atlas and Aid Management Platform (AMP) were used.

[v] Changing from personnel administration to a more comprehensive HRH development approach, addressing staff supply, performance management, and personnel relations.

05.1.5 RMNCAH Commodity Security and Technologies

Over the Sharpened Plan II period, the priority will be on improving quantification and forecasting critical lifesaving RMNCAH commodities at the facility and community levels; refining commodity flow, tracking, and accountability; and promoting RMNCAH self-care commodities and technologies through

1. Streamline and strengthen the alternative, private sector distribution strategy (ADS) for FP and selected RH commodities, including self-care commodities, to increase access points.

2. Develop a comprehensive RMNCAH self-care commodity security and safety strategy.

3. Establish and support an effective government-led regulatory and stewardship subcommittee to steer and monitor the digital health development partnership among government health services, private IT platforms, and public and private sectors to harness the enormous ICT potential.

4. Research the use of new technology under m-health and e-health in supporting service delivery improvements and community engagement.

05.1.6 Service Delivery Emphasizing Evidence-Based, High-Impact Interventions

Within the Sharpened Plan II period, the priority should be strengthening the quality of care at all levels within the PHC health promotion approach for the majority and quality, respectful, people-centred care. Improving technical quality is needed, but so is redesigning service organizations toward promoting acceptability, experience, responsiveness, and trust to drive service demand and utilization. This will be achieved by the following steps.

1. Develop guidelines, pilot, and scale up a system for remodeling facility and community RMNCAH service delivery organization towards integrated people-centered services across the continuum of care and differentiated care.

2. Support the development of a centrally coordinated system of regionalized RMNCAH care services integrated with coordinating RMNCAH care, HRH training, regional service delivery ambulance network, multilevel quality improvement, and simplified effective referral pathways. There is a need to establish 17 RRH skills hubs per the national regional support policy guidelines.

3. Use differentiated service delivery (DSD) in response to the increasing diversity of needs of demographic groups, building on decentralization, task sharing, integration, peer support, and patient and community empowerment. Develop guidelines, training, and mentoring, and adjust existing RMNCAH data systems to meet the variety of delivery approaches.

05.1.7 Health Management Information

Over the Sharpened Plan II period, priorities should be on using indicators that measure the quality of integrated activities based on characterized population groups and building capacity to implement integrated RMNCAH M&E data use in guiding programs. Steps will include:

1. Develop and tailor reporting tools and configuration of RMNCAH reporting.

2. Roll out the RMNCAH dashboard embedded in DHIS2 to the remaining ten regions.

3. Digitalize and operationalize the Community Health Information Systems with a simplified mobile application dashboard.

4. Together with the Division of Health Information and NITA-U, develop a platform for national and district health managers to access interlinked data from RMNCAH-sensitive sectoral information systems.

5. Deploy the RMNCAH Equity Assessment building on existing sentinel sites and efforts.[aa]

05.1.8 Community Engagement for RMNCAH

The newly developed and launched National Community Health Strategy and the COVID-19 community engagement strategy present a critical foundation and opportunities for steering community participation and engagement in the implementation to scale of the priority interventions in addressing the community health gaps and needs with regard to availability, accessibility, and utilization of MNH services.

To improve community engagement, the Sharpened Plan II prioritizes a revised Health Facility Catchment Area Planning and Action (CAPA) to empower communities to take an active role in improving their health and a long-term strategy for sustainable improvements in nurturing care. The WHO estimates that 70%–90% of all health care takes place in the home[41] and the people-centred model proposed by this plan indicates a large role for families and communities in the co-production of health.[42] Positioning CAPA at HCIII harmonizes with the parish and sub-county development model in the NDPIII.[bb] by engaging local structures, networks, and social supports toward effective and inclusive local service delivery, strengthening local accountability, and increasing household nurturing care practices and action on health determinants. The strategies and interventions to strengthen community participation and engagement will also be aligned with the strategic objectives and priorities under the National Community Health Strategy.

Priority actions include:

3. Developing, digitizing, and disseminating the RMNCAH CAPA manual as part of the broader strategy to digitalize the community health data, facilitate timely data use, and drive greater program performance monitoring.

4. Training health and community health workers in implementing the CAPA model and coordinating the CAPA efforts.

5. Harmonizing and disseminating a comprehensive RMNCAH SBCC strategy that incorporates information and communications technology (ICT) and practices on health determinants.

6. Launching and rolling out extensive awareness campaigns to promote and scale up the adoption and use of RMNCAH self-care commodities and technologies.

7. Identifying, reaching, and engaging underserved, disadvantaged, and marginalized populations (see Shift 2).

8. Operationalizing and intensifying the delivery of an integrated community health service package that incorporates health promotion and education and creating demand for MNCH services, considering the multiple contexts and different target groups to achieve the desired outcomes.

[aa] Adaptations for deployment will be made from the WHO's "Health Equity Assessment Toolkit (HEAT)," UNICEF's "Equitable Impact Sensitive Tool (EQUIST)," and USAID's "Maternal and Child Survival Equity Toolkit."

[41] USAID. Acting on the call: ending preventable child and maternal deaths: a focus on health systems. Washington (DC): USAID; 2016.

[42] World Health Organization (WHO). WHO global strategy on people-centred and integrated health services: interim report. Geneva: WHO; 2015.

[bb] Sub-county as the unit of development planning (with the parish chief as the focal person in coordinating supervision of health service delivery) and parish level where people are organized and supported to increase health production.

05.2 Key Implementation priorities for the strategic shifts

The five strategic shifts form the main pillars of implementing the Sharpened Plan II. For each strategic shift, critical priorities are identified for attention during the Sharpened Plan II period, as described below.

Shift 1: Focusing first on districts with highest maternal and child mortality

Reducing mortality in these regions will require improving access to and quality of emergency obstetric and neonatal care (EmONC) and addressing health system deficiencies (e.g., staffing, infrastructure, equipment, referral failures, guidelines, non-use of clinical protocols). In addition to system inputs, priorities to reduce severe morbidity and mortality in these regions include: [ff]

1. Establishing functioning BEmONC in 1,200 HC IIIs and CEmONC in 200 HC IVs within a coordinated referral system of regionalized RMNCAH service to improve access to critical lifesaving interventions in the continuum of care.

2. Scale up and institutionalize the quality of care initiatives that elevate and standardize RMNCAH&N care delivery at all health facilities and effectively use MPDSR and community verbal autopsy approaches in all facility catchment areas (i.e., 2,184 sub-counties).

3. Measuring disparities continuously through strengthening the BDR through NIRA and DHIS2,[gg] community HMIS, and use of composite indices to identify overburdened districts/regions and track progress in reducing disparities.

4. Setting up three RMNCAH HCIII sentinel sites per region to provide more detailed surveillance data on inequity and the impact of health determinants on RMNCAH outcomes.

SHIFT 2: Increasing access for high-burden populations in each district

To recognize progress in closing intra-district equity gaps, districts need to monitor the outcomes of their efforts using routine and valid qualitative measurements to adjust interventions based on evidence.

Priority actions include:

1. Changing to targeted delivery channels through task-shifting to community-led (peers) or community-based (VHT, outreach, and satellites) service delivery to assure universal access to and benefit from quality services that are coproduced according to specific needs of the marginalized and disadvantaged. These groups will be identified in the annual facility CAPA within each of the 2,184 sub-counties.

2. Engaging and contracting private health care midwives (CSOs, PNFPs, and PHPs), especially through district-level RBF, to expand access.

3. Strengthening the comprehensive community delivery (VHTs) system, engaging communities to address existing access barriers, and implementing data-driven community-led actions in all 70,626 villages.

Shift 3: Scaling up delivery of evidence-based, high-impact intervention packages

a) Priorities for Survival

These interventions reduce maternal and newborn deaths by saving more lives rapidly by focusing on immediate causes of maternal deaths and newborn deaths.

Priority interventions are:

1. Care at birth and in the first week of life: care for small and sick newborns, and EmONC will give a high return on investment by saving maternal and newborn lives and preventing stillbirths and disability.

- Functionalise basic and comprehensive EmONC to manage obstetric haemorrhage hypertensive disorders of pregnancy within two hours,[hh] and post-abortion. Annually, 311,880 mothers require critical care for maternal complications, and 25% do not have access to skilled services. This will help about 40% of pregnant women who experience delivery complications and about 15% who develop sudden onset and unpredictable potentially life-threatening obstetric complications.[47]

- Establish NICUs and SCUs: More than 200,000 newborns require inpatient care; 135,315 do not have access to skilled neonatal care services, including specialized care in NICUs.

- Provide essential and inpatient maternal and infant care, including kangaroo care, facility-based care for small and sick newborns, emergency triage, assessment, and treatment, and tertiary admission care (ETAT+) for severely ill infants and children. The addition of special and intensive care services for small and sick newborns will reduce newborn mortality by almost half.

Shift 3 Top Five Priorities

Survival

- Care at birth and first week of life (EmONC and care for sick and small newborns)
- IMNCI and ICCM

Thrive/Transform

- Preconception and interconception care (family planning; maternal, infant, youth children and adolescent nutrition [MIYCAN]; and adolescent health)
- Extended nurturing care from preconception through adolescence
- Comprehensive RMNCAH social and behavioral change

2. ANC initiation in the first trimester and reaching at least eight visits may have a lower impact on maternal and newborn mortality but is prioritized because it remains the only entry point into formal health care services for most mothers. The package of quality ANC interventions increases outcomes and effectiveness of care during childbirth and PNC.

3. IMNCI and Integrated Community Case Management (ICCM Plus):[ii] in addition to case management, nutrition and safety, bonding, and breastfeeding to promote parent-child relationships and learning opportunities will be added to increase cognitive and socioemotional development. Ready-to-use therapeutic food (RUTF) will be provided at the hospital and HCIV level for severe acute malnutrition.

b) Priorities for Thrive/Transform

Fostering the next generation's development begins before conception and must continue through pregnancy, ensuring the health and wellbeing of adolescents and young women before childbearing.[48]

Priority interventions are:

1. Preconception and inter-conception care

- **Family planning:** need to de-medicalize FP and integrate it into other sector efforts, upstage persistently high teenage pregnancy rate, and counter misconceptions and norms for preference of large families. Review and align current laws and policies related to contraception among 15- to 19-year-olds; scale up selected high-impact interventions, including postpartum FP and post-abortion FP, self-care, and other innovations to attain better achievement of the new FP 2030 commitments.
- **Maternal, infant, young child, and adolescent nutrition (MIYCAN):** scale up the intermittent iron and folic acid supplementation to improve iron status in menstruating rural adolescent girls and women living in high-prevalence districts.[jj]
- **Adolescent health:** emphasis on school health, age-differentiated RMNCAH services, and building an enabling environment.

2. Extended nurturing care framework (NCF) from preconception through adolescence (0 20 years).[kk] Investment in individual- and family-centered care will be a critical first step toward realizing the full potential of Uganda's cross-sectoral NCF. Scale up multi-sectoral interventions to build multiple aspects of nurturing care to ensure sustained effects on human capital. Strengthen the quality of childcare services within the health system as an effective platform for building learning and parenting interventions in early childhood and continuity in responsive caregiving for young children. Leverage schools to improve health and nutrition, reduce infectious diseases, and address children's socio-emotional development and mental health.

3. Comprehensive RMNCAH social and behavior change communication framework:

4. The interventions are spelled out in the service delivery section (see Chapter 5).

5. Address the adolescent sexual and RH and fertility in general.

6. Improve the quality of care with a special focus on basic and emergency MNCH care.

7. A special focus on malaria and malnutrition as they are critical determinants of most outcomes.

8. In view of the COVID-19 pandemic, build on the innovative mechanisms that ensure continuity of services.

[ff] Annual targets are set in the work plan and monitoring framework.

gg Only 20%–35% of deaths are currently reported through the HMIS.

[hh] MPDSR Report 2020 shows that among women aged 20 and above, haemorrhage was the leading cause of death at 48% (≥25 years) and 31% (20–25 years). For mothers under 20 years, hypertensive disorders of pregnancy were the leading cause at 21%, followed by pregnancy-related sepsis at 20% and hemorrhage at 19%.

[47] World Health Organization (WHO). The world health report 2000: health systems: improving performance. Geneva: WHO; 2000.

[ii] Crucial in reducing catastrophic household expenditure on health since malaria, respiratory infections, and diarrhea are most common among children and account for 20% (over UGX 50 billion) of OOP for health.

[48] Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB, et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet Commissions. 2016;387(10036):2423–78.

[jj] Anemia in women of reproductive age (15–49) was reported at 38.9% in 2019 (>20% threshold for interventions).

[kk] Organized into five developmental periods: preconception/prenatal, newborn, 0–3 years, older children, and adolescence to receive the five inter-related and indivisible components of nurturing care (good health, adequate nutrition, safety and security, responsive caregiving, and learning opportunities).

Table 2. Delivery Platforms for Priority Intervention Packages

Direct Provision	Key System Supports
Community and HC II	
1. Short-term FP 2. Child: (ICCM, immunization) 3. Newborn: (KMC, assess and refer sick newborns, nurturing support) 4. Maternal: focused antenatal care 5. School health package 6. Adolescent package 7. Health education 8. ECD and parenting support 9. Menstrual health management 10. KMC and care of the sick newborn 11. Identification and referral of SGBV 12. Older persons package	• Community-based RMNCAH surveillance • Referral mapping and support • Adolescent peer VHW • VHT incentives • CAPA
HC III	
All above, plus 13. FP: LARC 14. Maternal/newborn: (SBA, PAC, bEmONC, IMNCI, essential newborn care package, daily static immunization) 15. Voluntary medical male circumcision 16. Integrated outreaches 17. Growth monitoring and promotion 18. RUTF 19. ADH friendly package 20. Fistula screening and referral 21. Screening: (for RH cancers and preventive treatment, sickle cell trait)	• Support supervision • Area-wide (sub-county and parish level) microplanning–this should be CAPA • MPDSR • Portable ultrasound machines
HC IV and GH	
All above, plus 22. Maternal/newborn (cEmONC) 23. Permanent contraception 24. Continuation of chronic care for NCDs 25. Post-abortion care 26. Nutrition wards	• Maternal perinatal death surveillance and response • Regional referral network • CAPA • Blood storage • High dependence units • SCUs

SHIFT 4: Addressing the broader multi-sectoral context

The extended Nurturing Care Framework (NCF) will provide the road map for children, adolescent women, and family multi-sectoral elements of the thrive and transform agenda. It defines the synchronized linkages with other sectors related to the needs and demands of people at different life stages. Adopting the extended NCF promotes equity and reduces threats of poor health, food insecurity, illiteracy, neglect and cruelty, inadequate resources, and limited social freedom for women, children, and young people. This NCF embeds adolescent health and wellbeing, nutrition, FP, male involvement, and other components the previous plan inadequately addressed in the multi-sectoral shift, avoiding over-medicalization and harms related to the overuse of clinical interventions.

The health sector, with its many contacts from before pregnancy through early childhood and the after-school period, is central to the NCF introduction and establishment, especially within the human capital development program under NDP III. Placing the NCF framework at the district level will entail a new approach to sector convergence within the district NDP III programming guidelines. At the community level, guidance will be provided to health facility CAPA to merge health delivery with social, WASH, education, and community development services.

Priority actions are:

1. Manage and coordinate the multi-sectoral approach in implementation at all levels;

2. Strengthen the clinical response to child, gender, and sexual-based violence through cascaded training of health care providers (facility and community levels) on managing sexual and gender-based violence survivors/victims, based on adapted WHO tools piloted in the country from 2014 to 2018.

3. Scale up and strengthen the health-sector-led nurturing care with functional linkages to other sector efforts.

4. Adopt and scale up the implementation of CAPA and community engagement approach to empower communities to take an active role in improving population-level RMNCAH outcomes.

5. Integrate quality education with health and nutrition by implementing an extended Nurturing Care Framework and strengthening the implementation of school health interventions.

SHIFT 5: Strengthening mutual accountability for RMNCAH outcomes by all stakeholders

Priority actions are:

1. Strengthen the capacity of districts to plan, manage, and implement perhaps through a regionalized approach;

2. Support 17 annual regional RMNCAH performance reviews and one national meeting incorporating results from community scorecards and patient satisfaction surveys.

3. Strengthen management at all levels, including partnership coordination to ensure system efficiency;

4. Develop facility management committee guidelines and tools for inclusiveness, community feedback-reporting-action follow-up, and an IT-based RMNCAH community scorecard for use in social accountability (mutual accountability between provider and user).

5. Develop and use the RMNCAH accountability index in national and subnational level joint review assemblies.

6. Improve community health systems;

7. Use a community scorecard for citizens' hearings, civil society, and parliamentarians' engagement.

8. Increase RMNCAH partnerships with a commitment to the plan and the extended NCF.[mm]

9. Strengthen the accountability mechanisms, use of data and evidence, and

10. Disseminate and generate wider buy-in of the RMNCAH Sharpened Plan II among partners and implementers at all levels.

The mutual accountability mechanism is anchored on human rights and accountability processes. All partners commit to specific, measurable, achievable, realistic, and time-bound actions that set out their contributions to the achievement of the targets and results of this plan and, consequently, to the SDGs.

[mm] This plan expands accountability work to include monitoring critical underlying determinants of RMNCAH outside the health sector, e.g., education, gender, justice, law, and order (JLOS). Indicators for this will be developed based on routine data from respective sector information systems.

05.3 RMNCAH Partnerships

The partnership aims to maintain policy dialogue, promote joint planning, and drive effective implementation and monitoring of the revised sharpened plan. Partners include health development partners (HDPs), private, not-for-profit organizations (PNFPs), private health practitioners (PHPs), and civil society organizations (CSOs), collectively referred to as RMNCAH implementing partners.

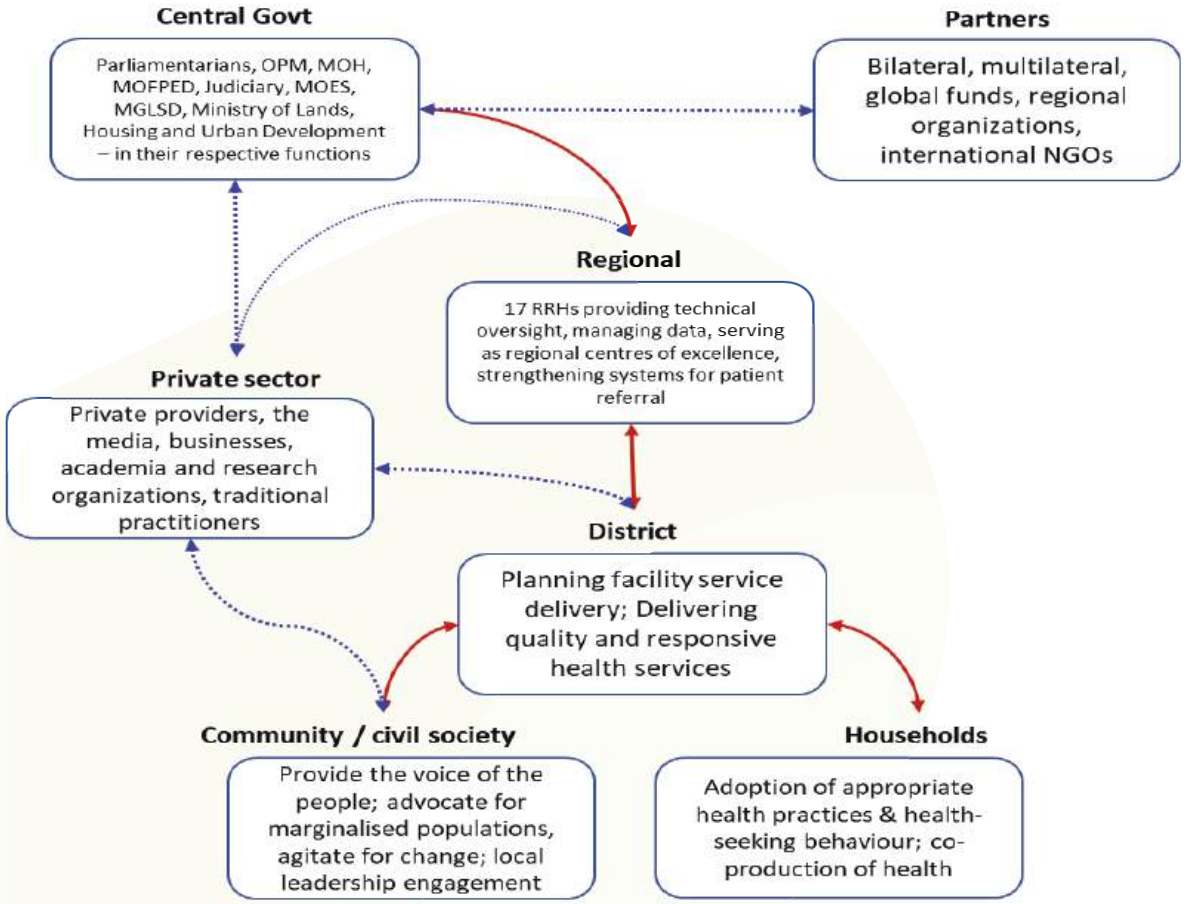
05.3.1 Aligning Partners

This partnership will work toward resource mobilization and allocation and aim at ensuring transparency and accountability between the government, partners, and citizens in implementing the plan. Efforts will be made to align the various existing technical subcommittees, RMNCAH CSO coalition, private sector coalition, RMNCAH Research Network, RMNCAH Assembly, and other related partnership platforms to ensure consistency of purpose and contributions to success. Many groups have been operating with little relationship to each other or the Sharpened Plan, yet their operations put the shifts into action.

The RMNCAH Monitoring and Communication Group will be created to improve coherence, monitoring, reporting, awareness, and advocacy. It will bring efficiency to all RMNCAH communication activities and play a vital role in engaging with more partners, other sectors, and communities on the themes important to RMNCAH, using a unified visual image, innovative digital tools, and strategic media partnership building.

Among the activities will be keeping stakeholders fully informed about their roles and responsibilities and progress in the implementation.

Figure 12: Relationship between key RMNCAH partners



05.3.2 Key Stakeholder Roles in Maximizing Impact

Strategic responsibilities and their outputs are assigned so that stakeholders understand their core roles within the plan, make their commitments, and set targets for accountability for commitments in the following areas:

INDIVIDUALS, HOUSEHOLDS, AND COMMUNITIES

- Individuals and households: Adoption of appropriate health practices and health-seeking behavior; co-production of health and self-care; active participation in the management of local health services
- Community: Community and home-based self-help interventions, ownership of and commitment to community-level actions, peer-to-peer communication

COMMUNITY

- Opinion leaders (including cultural, social, and religious): Community voices for RMNCAH, influencing social and cultural gender and male engagement norms, nurturing, and parenting
- Faith-based service organizations: Service delivery to remote and underserved populations
- Civil society organizations (including community-based organizations, local and national nongovernmental organizations [NGOs], networks): Have ears to the ground, provide a voice of the people, provide education on rights,[pp] advocate for marginalized populations, agitate for change litigation, raise discussion on sensitive RMNCAH issues, promote social accountability,[qq] functional RMNCAH&N CSO platform.

CENTRAL GOVERNMENT

- Parliamentarians: Making RMNCAH supportive laws and allocating budgets
- Office of the Prime Minister (OPM): Leadership for coordination and implementation of UHC across ministries, departments, and other public institutions
- Ministry of Lands, Housing and Urban Development: Stewardship for multi-sectoral action on urban health
- Ministry of Education and Sports: Sectoral interface on RMNCAH within Human Capital Development Program, age-appropriate sexuality education in school, school health
- Ministry of Gender, Labour and Social Development: Prevention of teenage pregnancy, early child development, nurturing care and parenting; SGBV prevention; mobilizing male involvement; empowering young people and youth leaders
- Judiciary law and order: Identifying legal and regulatory gaps and instituting reforms; implementation and enforcement of laws
- Ministry of Health: Policy guidance, funding, coordination, oversight for quality assurance, ensure availability of human resources for health, M&E function, protect and fulfill human rights for all, regulate professionalism, functioning of all service delivery platforms.
- Ministry of Finance, Planning, and Economic Development: Resource mobilization and allocation to the sectors, including the health sector.

LOCAL GOVERNMENT

- District Health Management Team (DHMT): Population health planning, coordination, public-private service mix, local leadership engagement, universal community health services, and increasing domestic WASH coverage.
- HSD Management Team: Community action planning, quality reviews, functional referral mechanisms.
- Health Unit Management Committee (HUMC): Planning facility service delivery, linking facility with service users, and ensuring local cultural responsiveness.

- Health facilities: Delivering quality and responsive health services to the population.
- Local Government Councils: Local resource mobilization and allocation to sectors, including health, supervision, and monitoring of service delivery in the district.

PRIVATE SECTOR

- Private providers: Provision of quality person-centred care, working within district health systems, provision of health promotion services and information.
- Commercial/business: Cooperate with RMNCAH social responsibility, implement RMNCAH SOPs for employees and their families, assist with production and social marketing of RMNCAH promoting commodities and information, social entrepreneurship.
- Academia and research organizations: Build the evidence base to shape effective and equity-oriented policies and programs, promote knowledge exchange, influence discourse about development, and conduct targeted in-country research.
- The media: Promote health literacy and self-care; mobilize for male engagement; target unhealthy social norms, including SGBV.
- Traditional health practitioners: Complementary RMNCAH services.

DEVELOPMENT PARTNERS

- Multilateral and bilateral organizations and funders (UN, bilateral development partners): Mobilise financing, technical support for country-identified priorities, bridge-building between sectors, capacity strengthening, technical assistance, scaling up innovations and best practice, international human rights laws, accelerating services for marginalized populations, define evidence-based norms, regulations, standards, and guidelines.
- Regional organizations: Standard setting, regional consensus, lobbying for unsupported RMNCAH services, collaboration around priority issues such as cross-border cooperation and regulations, knowledge and technology transfer
- Global funds, programs, and partnerships: Financing RMNCAH gaps, health system strengthening, capital financing, mobilizing resources to fill funding gaps at the country level, including through innovative financing mechanisms
- International NGOs: Innovation, accountability, service delivery, and advocacy for social inclusion create transparency and mutual accountability among partners for results, resources, and rights.

05.4 Implementation Arrangements roles of actors

05.4.1 Ministry of Health (National Level)

The MOH, through the Reproductive and Child Health Department, maintains oversight on the actions of implementers within their mandate to ensure the attainment of strategic plan objectives. Comprehensive RMNCAH annual operational plans reflecting all interventions and costs will be developed and anchored in the RMNCAH Sharpened Plan II. The current understaffing at the national level will require short-term technical assistance (TA) support. Prioritized areas for TA include M&E, newborn care, service integration, nurturing care, private sector engagement, advocacy/SBCC, and other demand-driven TA to cover emerging gaps and priorities in the strategy implementation in collaboration with HDPs.

The Sharpened Plan II will use the structures aligned with the health sector organizational framework and health partnership.nn The specific structures for health sector governance and management under the long-term institutional arrangements include the Senior Top Management Committee (STMC), Top Management Committee (TMC), Health Policy Advisory Committee (HPAC), and Senior Management Committee (SMC). The overall coordinating organs will be the quarterly expanded MCH Cluster (Country Platform) and the monthly MCH TWG. The MCH Cluster will be responsible for resource mobilization, coordination, monitoring of implementation, and

holding actors accountable for delivering results. Subcommittees of MCH TWG may be constituted or recomposed to focus on priority elements. These subcommittees will link with the other MOH TWGs[51] to ensure that the requirements of the Sharpened Plan are integrated into the agenda and decisions made around health system inputs and provide a monthly progress briefing to MCH TWG.

05.4.2 Regional Health Systems (Regional Level)

The health sector is establishing regional health systems through which the national level can provide its oversight mandate for health service delivery. This is to be achieved through functionalizing and strengthening the capacity of 17 RRHs in providing technical oversight, managing data, serving as regional centres of excellence in providing comprehensive health care packages, strengthening systems for patient referral, establishing and operationalizing accredited teams that provide high-quality continuing medical education and professional development. It also includes transferring skills from RRHs to lower-level facilities. Within the RRHs, the departments of obstetrics and gynecology, pediatrics/neonatal, and community health will form the RMNCAH regional mentoring team and be capacitated to steer and implement the regional RMNCAH technical support to district health facilities. This will include technical supportive supervision/mentorship/coaching visits to the districts/telemedicine, including performance reviews, developing research agenda, quality improvement, pooling regional trainers, creating supervision and on-site mentoring teams, generating localized CME topics, and strengthening regional RMNCAH-related HMIS, among others.

05.4.3 District Health System (District/Local Government Level)

The Constitution and the Local Governments Act 1997 (with Amendment Act 2001) provide the legal mandate for local governments in decentralized service delivery that includes management of GHs and all HCs, implementation/enforcement of the various Health Acts, community mobilization and education, supervision and monitoring within the local government. Under the Sharpened Plan II, establishing functional ADHO-MCH staff in every district will be critical for quality, effective, and efficient RMNCAH management, and service delivery at the local government department level, the health sub-district (HSD) level, lower-level HFs, and the community.

These focal points will ensure the national RMNCAH Sharpened Plan II adaptation in district health activities, ensuring that the priorities are incorporated in the integrated district annual work plan and mobilizing the health management structures to drive local implementation and rally local multi-sectoral action. Much of the implementation reforms in this plan will depend on strengthening the functionality of ADHO-MCH in every district, starting with the poor-performing ones.

All health facilities will work toward improving the facility's performance and developing annual catchment area plans that include RMNCAH activities based on population health characteristics. The VHT implementation will be incorporated within the facility performance system. Community engagement will be critical in the service reorganization demanded by this plan to ensure the delivery of people-centred care, the inclusion of hard-to-reach people through differentiated care approaches, and the implementation of the nurturing care framework. Services to older children and adolescents need to be developed in each facility. This will include providing school health services, developing adolescent networks, and including young people in facility management.

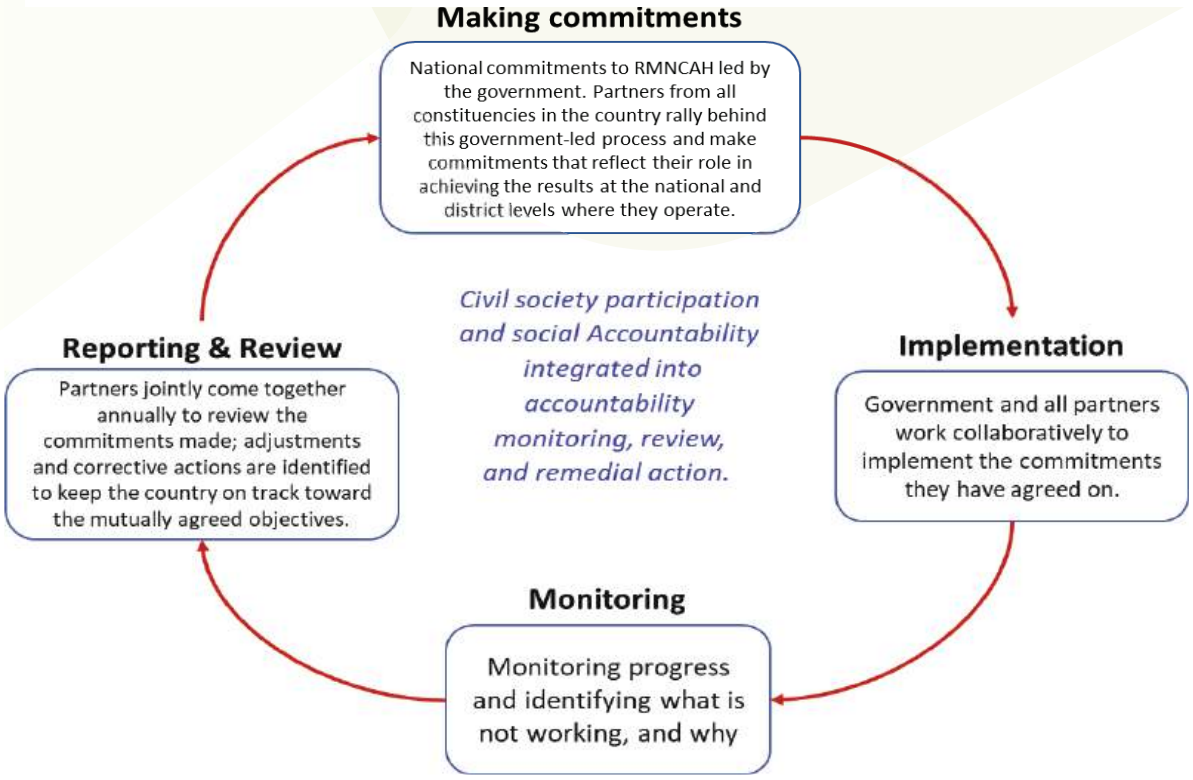
[pp] Educate people about their rights and entitlements in the health system, care options, right to competent care, respect, information, privacy, consent, and confidentiality; and provide options for redress when care falls below the quality standard.

[qq] Through citizen report cards, community monitoring, social audits, participatory budgeting, and patient charters.

nn Outlined in the MOH Guidelines for Governance and Management Structures, 2013.

[51] The TWGs are outlined in MOH. Guidelines for governance and management structures. Kampala (Uganda): MOH: 2013.

Figure 13. Accountability Framework Applied at National and Subnational Levels



05.5 Key Promising Innovations

In the next five years and beyond, keeping the community's voice on top and advocating will be critical in implementing the Sharpened Plan II. Equally important is the need for the country to accelerate the "game-changing innovations" to increase survival and thriving and transformative innovations. Specifically, innovations that reduce complexity streamline service delivery, minimize human resource workload, offset infrastructural demands, and promote home care will be critical.

Several digital innovations have been piloted in RMNCAH and found promising for ICT-based health promotion, prevention, and treatment.[oo] Over the next period, priority will be on strengthening SMS-based applications like FamilyConnect, which targets community health with information on what families can do to keep themselves in good health; self-care apps such as the Digital Fertility-Awareness one that allows women and couples to take control of their lives.

Innovations for reaching marginalized populations have been developed within the HIV arena, and efforts will be made to leverage these to promote RMNCAH care coverage for key populations RMNCAH shares with such programs.

[oo] The ICT sector, within the NDP III framework, is working toward doubling Internet penetration from 25% to 50%, expanding connectivity to districts, reducing cost of ICT devices and services (unit cost of 1Mbps/month for Internet service on the retail market from USD$237 to USD$70, unit cost of low-entry smartphones from UGX 100,000 to UGX 60,000, and cost of a computer from UGX 1,600,000 to UGX 800,000), and providing 80% of government services online.

Innovations for scale-up include treatment of presumed sepsis and pneumonia among infants aged two months and less using the newly simplified oral antibiotics, Self-injection with DMPA-SC (Sayana Press) and other contraceptive devices to reduce access-related barriers for women, increasing contraceptive continuation rates, and enhancing women's autonomy; heat-stable carbetocin and tranexamic acid (TXA) for addressing postpartum hemorrhage at lower-level facilities; and formulated ready-to-use MgSO4 packs for preeclampsia.

Digital Applications Prioritised for Scale-Up

- Birth notification to NIRA through the Mobile Vital Records Systems (MVRS)
- Institutional maternal and perinatal death notification with MPDSR context through DHIS2
- Stock notification and commodity management through mTrac
- Provider-to-provider telemedicine, e.g., consultation, referral communication
- Targeted client communication (TCC) across five population groups, e.g., *FamilyConnect* providing information via SMS to pregnant women and mothers linked to VHT services, ADH, service point awareness, service use feedback, self-care support
- Provision of training to health workers and VHTs via mobile devices (mLearning) and IHRIS tracking
- Health worker decision support (CDSS) for ICCM/IMNCI, use of lifesaving commodities and procedures, FP services
- VHT digital health tool

Other sector-wide efforts will be toward the inclusion of VHT workers in the health workforce system (IHRIS) digital registry as well as using performance-based funding to incentivize them within the wider Uganda Intergovernmental Fiscal Transfer (UgIFT) Program for Results (PforR).

The HBV vaccine is safe for infants and has been used globally for many years.

It is recommended by the World Health Organisation and Ministry of Health as a key intervention for preventing hepatitis B Vertical transmission from mother to child which is the main cause of the virus in infants

06: PERFORMANCE MONITORING & EVALUATION

Performance monitoring will be regularly and systematically used to track the implementation progress based on the RMNCAH theory of change. The Reproductive and Child Health Division will need to establish a Monitoring and Evaluation team to undertake monitoring and evaluation systems of RMNCAH Strategic Plans. The M&E team will produce quarterly and annual program implementation reports to feed into the program reviews and advise on essential steps to take with respect to the overall improvement of implementation actions.

Performance monitoring and evaluation aims to provide information about implementing the Sharpened Plan and all RMNCAH Operational Plans and promote evidence-based decision-making. It also monitors the utilization of fund allocation and disbursement and provides performance assessments.

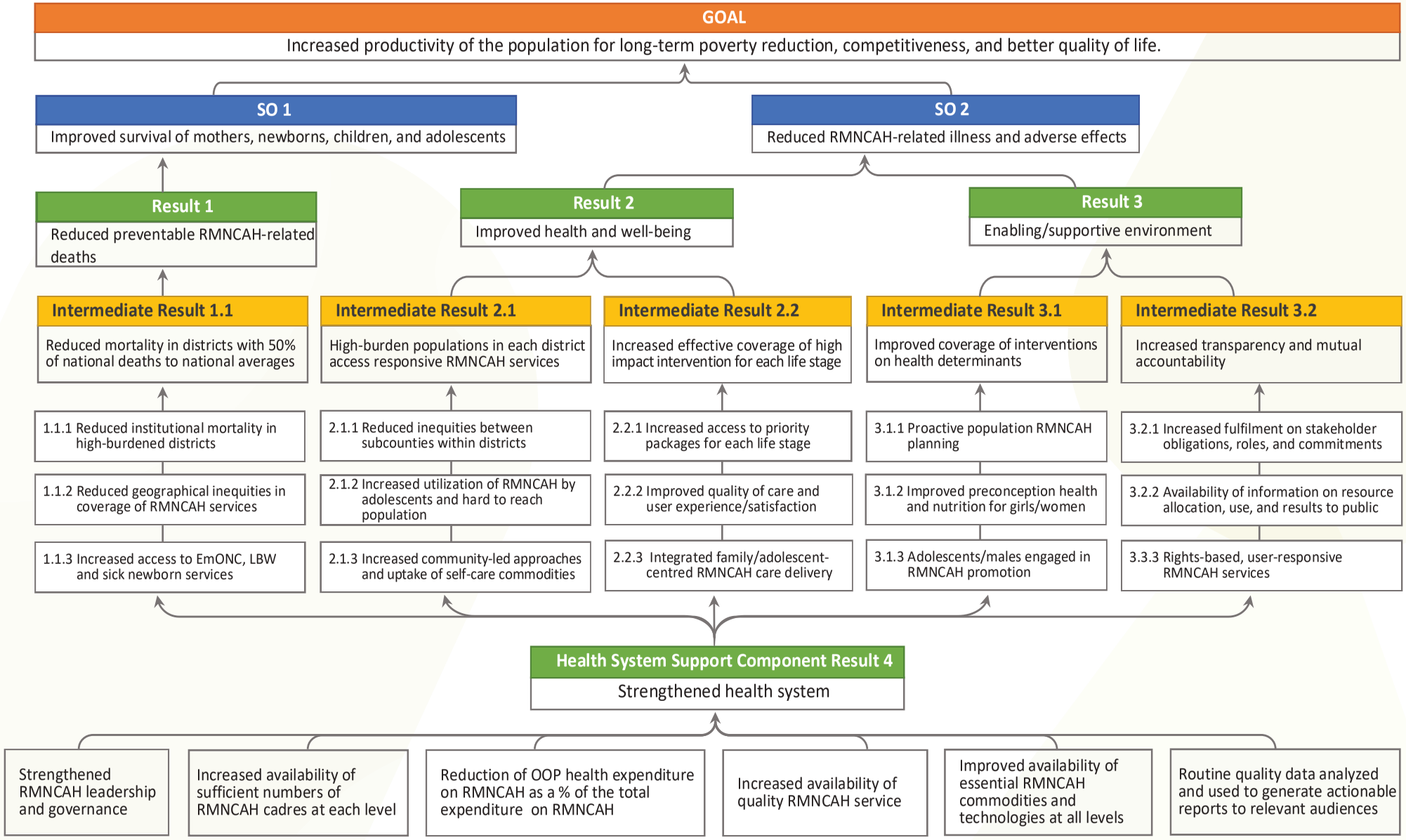
It will strengthen the monitoring capacities within the RMNCAH division, regions, and districts to efficiently use routine data systems for decision-making. It will also assist in improving routine health management information systems so that critical monitoring and evaluation information is routinely available, complete, and of good quality. This section sets the monitoring and evaluation framework, with well-defined and commonly agreed-upon indicators to track progress in specific areas.

06.1 The Results Framework

The results based on the complete set of indicators at different health system levels—service delivery, service improvement, and systems strengthening/reforms—over the next five years of implementation will generate a chain of evidence of program performance aligned to the theory of change. It lays out three main results through which five intermediate results (IRs) (based on the five strategic shifts) collectively contribute.

The sub-results under each IR are based on transformative service delivery actions implemented at the different levels. The critical inputs needed to overcome the health system bottlenecks are also key results in this plan.

Figure 14. The Results Framework



06.2 The Performance Indicator Framework

06.2.1 Key Performance Indicators

These strategic key performance indicators (KPIs) will play a vital role in managing the transformation toward Population Health Management. The KPIs cover multiple levels of performance information:

1. Strategic KPIs measure combined progress toward achieving the high-level targets set for the two Strategic Objectives

2. Implementation KPIs track specific progress on each of the five strategic shifts needed to achieve the three top-level result areas and the critical inputs in the health system support for RMNCAH.

They include operational inputs for the health system support.

Ten strategic KPIs will measure progress toward the RMNCAH objectives and targets set for the next five years in line with the NDP III Human Capital Development Program Implementation Plan. These KPIs aggregate several implementation indicators, generally from routine HMIS or quarterly reports, and act as collective proxies for annual performance reporting.

While some KPIs rely on survey-based data, mostly routine health information system data will be used together with document reviews (supervision reports and other studies) and data mining, especially for the community (community HMIS and CAPA) and population-level data.

Ten KPIs have been selected to inform and determine whether strategic governance is succeeding, and more elaborate performance measures are used to focus on areas of poor performance that need deeper review to improve operations.

Table 3. Strategic Key Performance Indicators and Targets

Indicator	Baseline	Target					Data Source	By Whom
		'22/23	'23/24	'24/25	'25/26	'26/27		
KPI 1: Tracks performance against mortality targets (SO 1)								
• Institutional neonatal mortality rate per 1,000 live births	18	15	14	14	13	12	Annual MPDSR Reports	DHI
• Institutional maternal mortality rate per 100,000 deliveries	84.7	80	75	70	65	60	Annual MPDSR Reports	DHI
KPI 2: Tracks performance against health and development of all children, adolescents, and women (SO 2)								
• Full immunization coverage by one year	54%						HMIS	DHI
• Prevalence of under-5 stunting	29%	27%	25%	23%	21%	19%	HMIS	DHI
• Adolescent birth rate (age 15–19 years)	132					125	HMIS	DHI
• Modern Contraceptive Prevalence Rate, Married women	37%				46.6%		PMA Survey	MOH
• Couple years of protection (millions)	3.2	4.5	5.7	7	8.2	9.5	HMIS	DHI
KPI 3: Tracks efforts on prioritizing the district with the highest maternal and child mortality first								
• The gap in perinatal mortality between the highest and the lowest quintiles among districts	TBD					50% baseline		
• The gap in the RMNCAH composite coverage index between districts with the highest and lowest newborn and maternal mortality rates	32	27	22	17	12	5	HMIS	DHI
KPI 4: Tracks coverage of services for high-burden populations								

Indicator	Baseline	Target					Data Source	By Whom
		'22/23	'23/24	'24/25	'25/26	'26/27		
• Human papillomavirus vaccination coverage for 10-year-old girls	40%	50%	65%	60%	65%	70%	HMIS	DHI
• Uptake of FP self-care RMNCAH services (Sayana) among young women	TBD					Double baseline	UDHS	MOH
• Facilities offering adolescent and youth-responsive SRH services	26%	32%	39%	47%	57%	70%	UDHS	MOH
• RMNCAH service coverage for displaced populations	TBD					Double baseline	UDHS	MOH
KPI 5: Tracks coverage of evidence-based, high-impact intervention packages along age groups against set targets at levels of coverage and quality required to cause impact								
• Proportion of maternal deaths due to PPH, hypertension, and maternal sepsis/post-abortion	90%	78%	68%	59%	52%	45%	Annual MPDSR Reports	
• Proportion of newborn deaths due to complications in premature birth, birth asphyxia, and septicemia	75%	66%	58%	51%	45%	40%	Annual MPDSR Reports	DHI
• The proportion of expected live births that have postnatal contact at six days	36%	41%	47%	54%	61%	70%	HMIS	DHI
• The proportion of facilities by level scoring >75% in the HFQAP tool in the RMNCAH module	TBD					50% increase		
• The proportion of women who deliver at health facilities that received postpartum family planning within 6 weeks	6%	15%	25%	30%	40%	50%	HMIS	DHI
• The proportion of women who received post-abortion care and also received FP (PPFP)	27.5%	35%	45%	60%	70%	80%	HMIS	DHI
KPI 6: Tracks performance of multi-sectoral efforts								
• Prevalence of stunting among children under 5 years	29%	27%	25%	23%	21%	19%	HMIS	DHI
• Attendance in Early Childhood Education	37%	43%	49%	57%	65%	75%	Countdown 2030	UNICEF
• Basic sanitation coverage (improved latrine coverage)	19%	50%	55%	61%	68%	75%	HMIS	MOH
• Quality-adjusted years of schooling	4.5	4.6	5.0	5.3	6	7	Educ MIS	MOES
• Proportion of births by adolescents (%)	25%	22%	20%	18%	16%	15%	HMIS	MOH
• Children under 5 years registered and issued Birth Certificates	40%	70%	75%	80%	85%	90%	CRVS	NIRA
• GBV prevalence	56%	50%	45%	40%	35%	30%	GBV IS	MOGLSD
KPI 7: Tracks performance of mutual accountability for RMNCAH outcomes								
• % commitments met annually								
• Percentage of deaths in a given year continuously reported, registered, and certified with key characteristics	2%	10%	40%	50%	60%	70%	CRVS	NIRA
• The proportion of users very satisfied with provider family–communication and shared decision-making	31%	36%	41%	47%	54%	62%	Client satisfaction survey	MOH

Indicator	Baseline	Target					Data Source	By Whom
		'22/23	'23/24	'24/25	'25/26	'26/27		
KPI 8: Tracks health systems inputs to maximize the impact of RMNCAH service delivery								
• % health facilities with 95% availability of 41 basket of EMHS, including lab, vaccines, and blood transfusion supplies	46%		60%		75%	80%	SARA	MOH
• % approved staffing levels filled by qualified health workers	73%	80%	82%	84%	85%	86%	HRIS	MOH
• % RRHs with functional ICUs/HDUs	20%	100%	100%	100%	100%	100%	Administrative reports	MOH
• Number of functional National and Regional Call Centres with EmONC referral streamlined.	0	2	5	10	14	17	Administrative reports	MOH
• The proportion of facilities with functional EmONC-based level of care	19%		33%		57%	75%	SARA	MOH
• % health facilities with newborn care corners (NBCCs)	4%		12%		35%	60%	SARA	MOH
• The proportion of health facilities (HCIIIs and above) offering LARCs (both IUDs and Implants) as part of the contraceptive method mix	57%	60%	65%	75%	85%	100%	HMIS	DHI
KPI 9: Tracks financial performance								
• Out-of-pocket health expenditure as a % of the total health expenditure.	37%	28%	22%	17%	13%	10%	NHA	MOH
• Proportion of RMNCAH off-budget support	58%	50%	44%	38%	33%	29%	Annual off-budget tracking report	MOH
• Proportion of Vote 116 for RH commodities utilized to procure FP commodities.	0%	10%	25%	40%	50%	50%	Annual budget tracking report	MOH
KPI 10: Tracks delivery of the transformative interventions								
• The proportion of facilities implementing Health Facility Catchment Area Planning and Action	0%	10%	30%	40%	60%	70%	Administrative reports	MOH
• The proportion of primary and secondary schools having or being linked to health facilities	14%	20%	28%	40%	57%	81%	Administrative reports	MOH
• Anaemia rates among women of reproductive age	26%	21%	17%	14%	11%	9%	UDHS Studies	MOH

06.2.2 Thematic Reporting Indicators

Thematic reporting is part of the comprehensive monitoring system at facility, district, regional, program, national, and international levels. It is intended to improve the knowledge focus in RMNCAH integration, staff learning, and skills development, and providers strengthening external knowledge partnerships and promoting good feedback. Thematic reporting indicators will focus on progress against the intermediate targets in the results framework and annualized operational milestones in the annual implementation plans using quantitative and qualitative methods. They will complement and clarify the interpretation of the strategic KPIs and inform correction.

Although useful for performance monitoring, the strategic Results Framework for the Sharpened Plan does not include data collection at the operational level. Thus, these data will be found in individual Operational Plan Progress reports that feed into performance reporting. The Department of Health Information and the Division monitoring unit will provide much of the data, with the latter taking the lead in completing quarterly annual data quality assessments (See Table 6).

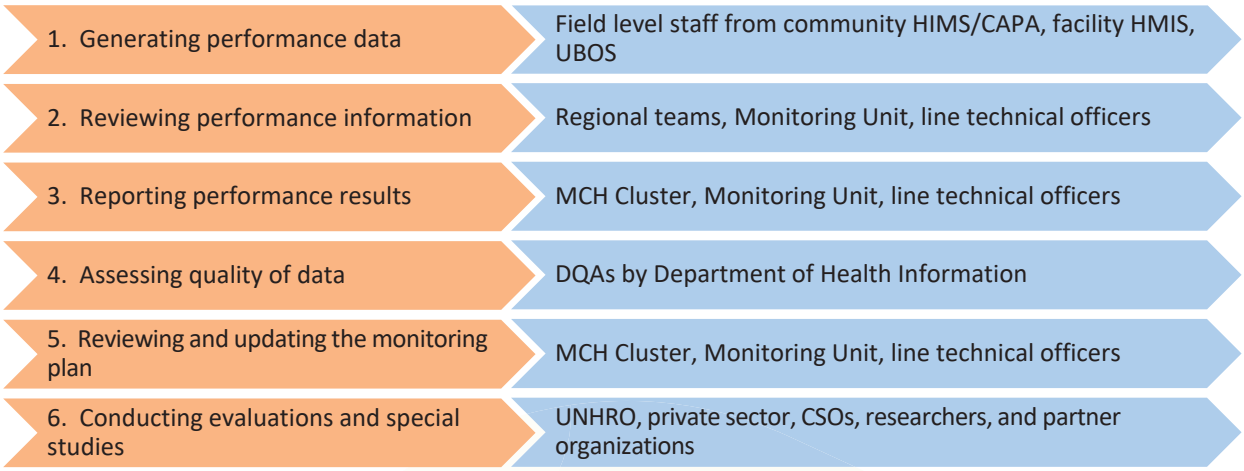
06.3 Managing for Results

The Ministry of Health and partners of RMNCAH have specific roles and responsibilities in the overall performance monitoring system.

Managing for results will also work toward establishing effective communication and better information/data-sharing mechanisms among the MOH, agencies in the National Human Capital Development Program, partners, and other key stakeholders for proper monitoring and implementation of the plan.

Figure 8 outlines the responsibilities for each of the major steps in the monitoring process, which are further discussed in detail in this section.

Figure 15. Steps and Responsibilities for Managing Results



06.3.1 Decision-Support Tools and Approaches

Data should be presented in usable formats to allow policymakers to make well-informed decisions within a limited timeframe. Various decision-support tools and approaches such as data dashboards, summary bulletins, RMNCAH status report cards, and color-coded data presentation techniques, will be used depending on the audience.

- Health summary bulletins to disseminate data in the Joint Assemblies to provide an overall picture of RMNCAH status in the country.
- Health status report cards report on HSDP core indicators or program areas to compare progress to a target or past report card trends.
- Policy briefs are used for conveying specific evidence-based policy recommendations arising from the M&E system, including operational research findings.
- RMNCAH data dashboards visually present critical data (including strategic KPIs and thematic reporting) in summary form for different health system levels so that decisions can be made quickly. This will enable users to identify problems and target specific follow-up activities to improve services and provide feedback.

06.3.2 Quarterly and Annual Joint RMNCAH Performance Reviews

The Line Technical Officers and Development Partners will monitor performance data during the financial year based on annual program implementation reports prepared by the Monitoring Unit. Depending on the results of these reviews, the Line Technical Officers may need to adjust their programming and implementation activities.

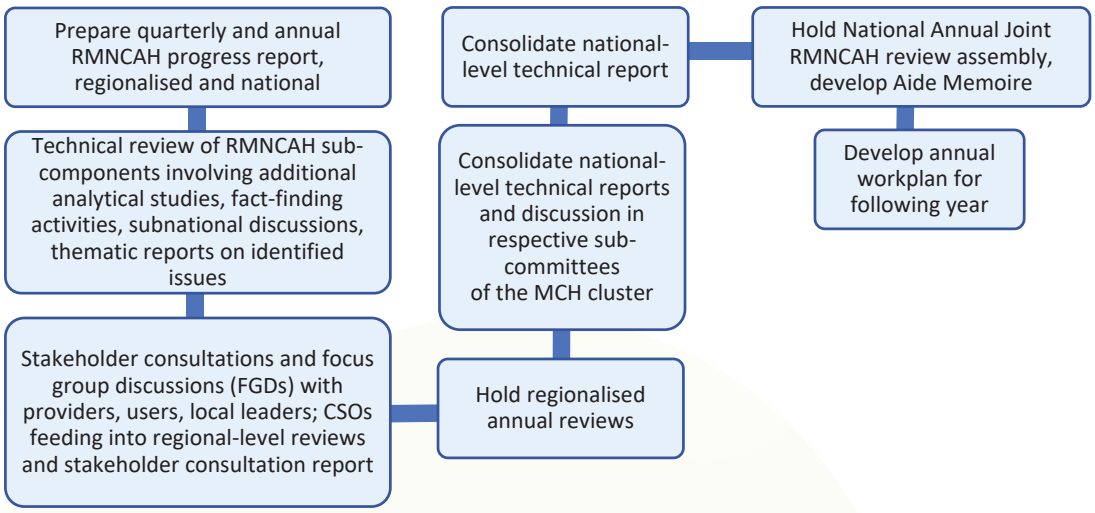
The RMNCAH Monitoring Unit will conduct quarterly and annual program reviews and develop national and district/regional review reports.

The annual Joint RMNCAH Performance Review of the RMNCAH-SP will be a management instrument designed for both government and RMNCAH partners to monitor implementation progress and to verify that management, policy responsibilities, and commitments are met. It will focus on implementing shifts, service delivery reforms, and resource tracking to suggest a course of action for achieving the RMNCAH-SP goals and objectives and provide risk management strategies and financing recommendations. It will have the following specific objectives:

1. To review the implementation of the RMNCAH-SP, take stock of quantitative and qualitative progress and achievement of goals, targets, reforms, and fund utilization, and recommend revisions to these for the remaining program period.

2. To review the financing arrangements and assess how well MOH and partner support meet the priorities and requirements of the RMNCAH-SP.

Figure 16. Annual RMNCAH Performance Review Process



06.3.3 Evaluations and Special Studies

Evaluations and special studies/surveys to collect data at the population level will complement routine performance monitoring efforts with more rigorous, in-depth analysis on topics of special interest determined along the implementation cycle. The major surveys to inform this plan are shown in Table 4.

Figure 16. Annual RMNCAH Performance Review Process

Surveys and Special Nationwide Studies	Responsibility	Timing
Service Availability Readiness Assessment	MOH Quality Assurance Dept	Every 2 years (May-June)
Efficiency Analysis	MOH Planning Dept	Annual (April-June)
National Health Accounts	MOH Planning Dept	Annual (July-December)
National Client Satisfaction Survey	MOH Quality Assurance Dept	Every 2 years (January)

Uganda Demographic Health Survey	UBOS	Every 5 years
Panel Survey	UBOS	Annual (July-December)
National Household Survey	UBOS	Every 3 years
National Service Delivery Survey	UBOS	Every 5 years
Countdown to 2030	MUSPH	Annually
Track20/FP2020	MUSPH	Quarterly
Performance Monitoring for Action (PMA) Survey	MUSPH	Annually

06.3.4 Reviewing and Updating the Monitoring Plan

This monitoring plan serves as a "living" document to guide RMNCAH-SP performance monitoring and management efforts. As such, it will be updated as necessary to reflect changes in strategy and/or activities in consideration of the following issues:

- Are the performance indicators measuring the intended results?
- Are the performance indicators providing the information needed?
- Are the performance indicators requiring improvement?

06.3.5 Reporting

Reporting will be monthly, quarterly, and annual, providing a link between data collection, analysis, and use. It will further provide a basis for assessing progress against targets and strategic plans.

Table 5. Type, Schedule, and Responsibility for Reports

Type of Report	Scope	Responsibility
Activity-Based Reports	These will include workshop/training reports, field reports, consultancy reports, etc.	Activity Managers
Quarterly Report	The report will include programmatic and financial information. Each active division will prepare quarterly reports highlighting key achievements, challenges, lessons learned, and planned activities for the next quarter. A consolidated report for the entire department will be desirable in the long term.	Designated M&E Person
Annual Report	This will serve as the key communication tool for the department at the end of each year. The annual report will provide highlights of key achievements for the year against set targets.	Designated M&E Person/ Commissioner
Annual Work plan	At the end of each year, each division will develop an operational plan that outlines key activities and deliverables, expected outputs, timelines, and budget. These will be consolidated into an organizational work plan.	Designated M&E Person/Program Officers
Evaluation Reports	These will include baseline, mid-term, and end-line evaluation reports.	External Consultant
Financial Reports Monitoring	Resource mapping and finance monitoring for accountability and reporting purposes and measuring financial efficiency (maximization of outputs with minimal inputs).	Finance

Table 6. Activities to Strengthen Performance Monitoring

Item	Location	Quantity	Frequency
Rolling Out the Sharpened Plan			
1. Central level orientation on the Sharpened Plan (targets and indicators)	MOH CH	1	one-off
2. District-level (DHT) orientation on the Sharpened Plan (targets and indicators)	District	136	one-off

Item	Location	Quantity	Frequency
3. Health facility level orientation on the Sharpened Plan (targets and indicators)	Targeted health facility	3000	one-off
4. Consultancy support to the MOH Department of Reproductive and Child Health for plan rollout activities	MOH CH/ District	4	one-off
Routine Data Collection			
5. Qualitative data collection—community level	Community	20	quarterly
6. Quantitative data collection—HF level	Health facility	20	quarterly
7. Targeted data quality assessment/audits	Health facility	20	quarterly
8. Performance review meetings	District	20	quarterly
9. Annual population-based survey	District	5	yearly
Data Use Activities			
10. Trainings/mentorships in data quality improvements, analysis, and use	District/HF-based		quarterly
11. Establishing the RMNCAH data repository	MOH		
12. Annual M&E system performance reviews	MOH CH	5	yearly
13. Training on the use of scorecard	District		yearly
Dissemination			
14. Quarterly bulletin	MOH CH	20	quarterly
15. Abstracts and manuscripts writing and approval	MOH CH	20	Semi-annually

06.4 Programmatic Risks

06.4.1 Risks

● Failure to build systems by focusing on targets: This plan requires fundamental changes, especially in integrated, comprehensive programming and reorganization of service delivery with a new emphasis on people-centred care to optimize processes, improve value for money, and attain targets. Furthermore, incremental improvements need to be sequenced toward set annual targets rather than the end.

Sporadic lessons guiding the delivery of new international guidelines contribute to the fragmentation of training, donor-driven funding, and shifting priorities to subcomponents of RMNCAH. Many of these new guidelines do not work toward integrating and strengthening the system, thus impeding the delivery of integrated service packages.

● CSOs as direct implementors: Many NGOs have become direct implementing partners, even duplicating interventions, thus weakening their role as representatives of their constituencies and making them unable to promote the advocacy and social accountability needed to drive this plan.

● Suboptimal engagement of district and facility-level strategy development limits recipient roles, resulting in poorly understood, owned, contextualized, or aligned with and relevant to stakeholder priorities at the community and local government level.

In most cases, strategies and shorter-term projects have a vested interest (achieving numbers) and are disseminated without the support and resources to effect the changes needed to implement them or achieve post-funding sustainability.

● Inadequate M&E or poor data quality characterized by slow progress in CRVS hinders identifying and targeting the highest-burden population groups and areas. Non-standardized and ad-hoc N&E products provide 'soft' indicators on progress output numbers instead of impact and outcome indicator analysis. Inadequate data to measure quality of care and equity—critical components of

the plan—make it difficult to measure the performance of RMNCAH interventions.

The lack of facility patient records makes it very difficult to fit them within the continuum of care advocated for in the plan. Population-based community health data is not integrated within the facility HMIS data and, hence, is not used to adequately plan and address population health and identify unreached populations within the catchment areas. Many critical RMCAH indicators/data elements remain unreported. The most catastrophic is that HMIS data is not used at the source, which deleteriously impacts quality.

- Regulatory weakness by private sector councils leaves private sector outlets inadequately regulated on quality, over-concentrated in urban areas, technically unsupported, not fully integrated into the district health system, and not attuned to government priorities. The major emphasis for RMNCAH should be on engaging and promoting the private sector midwifery and missing critical cadres.
- Failure to harness cultural and religious values/norms, poor interpersonal communication, and providers' cultural insensitivity (including open hostility) to certain populations, especially adolescents, minority groups, and older people, actively limit effective utilization.
- Heavy dependence on external funding limits the sustainability of health interventions.

06.4.2 Risk Mitigation Measures

- Ensure effective coordination, system management, and channeling of resources to priorities of the RMNCAH plan, including focusing on effective management of health workers at all levels and providing mid-level managers with support, clear guidelines, adequate salaries, and other incentives to use health records and establish realistic expectations.
- Strengthen joint government donor collaboration and coordination mechanisms at all levels, such as joint annual program reviews and the development of joint donor working groups.
- Establish a healthy balance between delegation of responsibilities and accountabilities with clear communication to facilitate timely decisions that prevent service disruptions, provide flexibility to encourage innovation, and reduce wastage.
- Establish a system that measures accountability and performance at all levels, especially for inclusive health governance through strengthening cultural competence.
- Provide public access to information about health budgets, policies, disbursements, standard pricing, patient rights, and health worker responsibilities to promote accountability and sound data analysis, including information on marginalized populations.

07: RESOURCE REQUIREMENTS, FINANCING PROJECTION, AND GAPS

The RMNCAH Sharpened Plan resource requirements were estimated using OneHealth Tool (OHT), while the resource commitments were carried out using Resource Mapping and Expenditure Tracking (RMET). The Resource Mapping and Expenditure Tracking tool helps map retrospective and prospective resource projections from the government, key implementing partners, and donors. It provides an overview of resources spent on RMNCH programs and the estimated upcoming resource commitments reported by the stakeholders. The limitation was that interventions do not disaggregate reported financial commitments from partners, and the resource mapping did not include out-of-pocket (OOP) expenditures from household estimates.

07.1 RMNCAH Sharpened Plan Estimated Cost

The resource requirement was estimated using OneHealth Tool (OHT) based on:

(1) the accessed information on RMNCAH profiles documented as part of the Sharpened Plan,

(2) official figures for base year population demographics,

(3) national protocols and expert opinions used for clinical practices, and

(4) expansion targets set to meet the standards as based on population figures and other set criteria.

The unit costs for human resources, commodities, and investment requirements were extracted from recent HSDP II costing exercises, and the data collection team verified each unit cost. The system priorities and targets were set by the team, and unit costs were verified by the team to be used in this resource requirement. The unit costs for human resources, commodities, and investment requirements were also informed by GOU Procurement and Disposal Guideline rates for 2020–21.

The total resource requirement for RMNCAH Sharpened Plan implementation is estimated at US$2.7 billion for five years. Of this, a significant share (93.4%)—about US$2.5 billion—goes to sustaining evidence-based, high-impact interventions in the form of service delivery. The second highest share goes to system strengthening with only 6.4%, about US$174 million. The least is investment in strategic shifts (Table 7). The per capita cost of RMNCAH services is estimated to be $26.

Table 7. Total Estimated Cost of RMNCAH Sharpened Plan (000 US$)

	2020–21	2021–22	2022–23	2023–24	2024–25	Total	Share
Strategic shifts	847	1,196	1,149	1,102	1,102	53,952	0.2%
Systems strengthening	119,646	11,281	11,652	14,400	16,784	173,763	6.4%
Service delivery	419,381	456,745	503,737	559,213	594,5128	2,533,588	93.4%
Total	**539,874**	**469,222**	**516,538**	**574,714**	**612,398**	**2,712,746**	

The strategic shifts are a major area of focus, and implementation cost is estimated at US$5.4 million (Table 8). The highest share—82%—is related to the fifth strategic shift: strengthening mutual accountability.

This allocation is likely to have resulted from the under-costing of strategic shifts 1 and 3, as their detailed strategic interventions are going to be developed as part of the plan implementation. If reaching the underserved geographic areas and population groups requires different service delivery approaches with additional investments, this is not reflected in this costing estimation.

Table 8. Estimated Costs by Strategic Shifts (US$)

Strategic shifts	2020-21	2021-22	2022-23	2023-24	2024-25	Total	Share
1. Focusing first on sub-regions with the highest maternal and child mortality	273,968	79,634	82,023	82,023	82,023	599,671	11%
2. Increasing access for high-burden populations	91,584	83,617	8,015	8,015	8,015	199,245	4%
3. Emphasizing evidence-based, high-impact interventions	53,509	41,134	-	-	-	94,644	2%
4. Addressing the broader multi-sectoral context	39,595	10,937	11,265	11,265	11,265	84,329	2%
5. Strengthening mutual accountability for RMNCAH outcomes	388,105	980,346	1,047,911	1,000,444	1,000,444	4,417,250	82%
Total	**846,761**	**1,195,669**	**1,149,214**	**1,101,747**	**1,101,747**	**5,395,137**	**100%**

The RMNCAH Sharpened Plan is pushing for universal coverage of six types of services to be delivered at different levels of care (Table 9).

In estimating service delivery costs by levels of care (not including system strengthening costs, see Table 10 below), three cost elements were considered: human resources, commodities, and program strengthening support. Human resource cost was estimated based on the person-days that each service takes from the total time of each cadre—through OHT—and the estimate to apportion the cost based on annual salaries.

The commodities are based on the targets set and the required types and units of drugs and medicine required per intervention to reach the targeted population in need. Program strengthening costs are estimated assuming there will be a monthly coordination meeting at all levels, preparing and implementing TV and radio communication twice a year, two national-level coordination meetings annually, and an annual review and planning for each service area.

All programs' total service delivery costs are estimated at US$2.53 billion, of which 38% is estimated to finance the requirement of MNRH services, 21% for child health services, and 20% for nutrition services.

As shown in Table 9, 55% of the estimated resource requirement is for procuring and distributing health service commodities (medical supplies, vaccines, etc.), while 41% is for financing human resource salaries of providers at different levels of care. Specific program system strengthening costs account for only 4% of the total service delivery cost.

Table 9. Cost by Types of Services and Major Cost Components (000 US$)

	Service delivery		Program strengthening	Total	Share
	HRH	Commodities			
MNRH Services	574,471	365,659	33,009	973,139	38%
Child Health Services	197,423	98,093	25,282	520,798	21%
Immunization Services	10,899	330,577	27,227	368,705	15%
Nutrition Services	235,422	272,112	9,573	517,108	20%
Adolescence Health Services	10,432	14,802	8,862	34,096	1%
School Health Services	10,215	103,658	5,869	119,742	5%
Total	**1,038,863**	**1,384,902**	**109,824**	**2,533,588**	
Share	41%	55%	4%		

The dimension of the costing exercise was to estimate the share of different levels of service provider platforms, as outlined in Table 10, from the total cost of the service delivery.

The basic assumption is to use the service utilization share of each of the services at different levels of care. The highest share of the total service delivery cost is HC III at about one-third (US$829 million).

GHs follow this with a share of 19%. PHC service providers (community, HC II, HC III, and HC IV) account for 47% of total service delivery costs. The share of higher-level care (national and super-specialized national referral hospitals) is about 21%.

Table 10. Cost by Types of Services and Major Cost Components (000 US$)

	Service delivery		Program strengthening	Total	Share
	HRH	Commodities			
Community and Health Centre II	94,700	126,244	10,011	230,955	9%
Health Centre III	339,884	453,098	35,931	828,913	33%
Health Centre IV	49,874	66,487	5,272	121,634	5%
General Hospital	197,381	263,127	20,866	481,374	19%
Regional Referral Hospital	144,633	192,809	15,290	352,731	14%
National Referral Hospital	141,594	188,758	14,969	345,320	14%
Super-Specialized Hospital	70,797	94,379	7,4844	172,660	7%
Total	**1,038,863**	**1,384,902**	**109,824**	**2,533,588**	**100%**
Share	41%	55%	4%		

The other area of focus for this costing process was system strengthening. The unit costs of most of the system-strengthening interventions are based on the GOU Procurement and Disposal Guideline rates for 2021. The targets were taken from the Sharpened Plan.[rr] The total cost for interventions aimed at removing system bottlenecks is estimated at US$173.8 million. Of this, the major share goes to infrastructure and RMNCAH equipment at 63% (US$109.5 million).

[rr] The exchange rate used for this estimation is US$1=UGX 3,650.

The major cost driver in this intervention is the planned construction of 138 HC IIIs in sub-counties. The costs for health infrastructure development—health facility construction and maintenance, medical equipment purchases and maintenance, and transport—are planned to be completed in the first three years of implementation.

The second highest share of the estimated cost goes to human resources (upgrading skills and filling RMHNCAH human resource gaps), accounting for 25% (US$43.3 million). For detailed costs of each intervention and their share of the total cost, see Table 11.

Table 11. Estimated Costs of System-Strengthening Core Priorities (US$)

	2020-21	2021-22	2022-23	2023-24	2024-25	Total	Share
RMNCAH Leadership	1,911,013	2,488,653	2,293,166	2,216,121	2,118,244	11,027,197	6%
Infrastructure and Equipment	109,473,210	-	-	-	-	109,473,210	63%
Health Workforce	6,601,327	6,720,823	7,450,097	10,195,379	12,350,654	43,318,280	25%
RMNCAH Financing	39,692	39,692	40,883	40,883	40,883	202,032	0%
RMNCAH Commodity Security	870,376	1,026,253	1,259,962	1,462,884	1,665,806	6,285,280	4%
RMNCAH Service Delivery	351,383	339,344	197,631	197,631	197,631	1,283,621	1%
Community Engagement	171,123	208,842	176,257	176,257	176,257	908,736	1%
Health Management Information	227,524	457,524	234,350	110,750	234,350	1,264,496	1%
Total	**119,645,647**	**11,281,130**	**11,652,346**	**14,399,904**	**16,783,824**	**173,762,852**	**100%**

07.2 Resource Mapping and Projections

The resource mapping exercise carried out in developing this Sharpened Plan sets forth the commitment of all development partners for the plan period. Total resources available are estimated to be US$2.1 billion.

The highest contributors, according to the mapping report, are the government of Uganda, USAID, World Bank, and Global Fund with shares of 29%, 19%, 15%, and 15%, respectively, for a combined contribution of about 80% of total commitments (see Table 12).

When the commitment is disaggregated by government and development partners, 71% is from external resources. The government share is estimated to be about $613.1 million (29%) for the whole Sharpened Plan period (see Table 13).

A significant share of government expenditure is its estimated contribution to the payment of the wage bill (with the assumption that 60% of the total wage bill will be allocated to RMNCAH services), which accounts for 86%.

Table 12. Commitment by Different Partners (Million US$)

Name of organization	Commitment						
	2021	2022	2023	2024	2025	Total	Share
Government MOH	128	121	121	121	121	613	29%
Donors	267	285	331	303	298	1,484	71%
ENABEL	2.22	4.43	3.66	3.69	3.69	17.69	1%
The Global Fund	41.26	38.31	95.39	76.60	71.43	322.99	15%
Save the Children	4.41	4.35	4.25	4.18	4.19	21.38	1%
UNAIDS	1.29	1.27	1.25	1.26	1.26	6.33	0%
World Bank	62.24	61.43	60.46	60.84	60.93	305.90	15%
UgIFT	9.0	9.0	9.0			27.0	1%
GAVI	13.55	34.49	33.95	34.16	34.21	150.38	7%
UNFPA	7.86	7.62	6.95	6.76	6.76	35.95	2%
WHO	3.39	3.00	2.93	2.77	2.78	14.87	1%
SIDA	0.99	0.63	0.62	0.63	0.63	3.51	0%
UNICEF	12.73	12.29	10.65	10.68	10.69	57.04	3%
Duetsche Stilfung Wettbeokerng	0.50	0.54	0.47	0.43	0.43	2.36	0.1%
Koica	1.81	3.11	3.06	3.10	2.91	14.00	1%
USAID	86.44	81.21	79.94	80.44	80.56	408.58	19%
Royal Netherland Embassy	8.32	8.38	7.65	6.81	6.82	37.97	2%
Other Donors	11.15	14.59	10.47	10.65	10.67	57.54	3%
Total	**395.38**	**406.02**	**451.82**	**424.19**	**419.18**	**2,096.59**	**100%**

The resource mapping exercise indicated that RMNCAH's current expenditure and estimated commitment for the coming five years are almost similar for most programs, with a slight increase in adolescent health, child health, and immunization.

Table 13. RMNCAH Expenditure 2020 and Commitment (2021–2025) by Focus Area (000 US$)

Major Focus Areas	Expenditure	Commitment						
	2020	2021	2022	2023	2024	2025	Ave/yr.	Total
Adolescent Health	13,333	13,799	13,724	37,715	36,683	34,623	27,309	136,544
Child Health	13,624	15,584	13,798	28,951	28,325	26,821	22,696	113,478
Immunization	18,078	17,950	37,048	37,046	37,046	37,046	33,227	166,137
Maternal/ Newborn and RH	130,253	135,960	125,181	141,966	126,166	124,909	130,836	654,182
Family Planning	440	437	902	902	902	902	809	4,044
Other MNR Health	129,813	135,523	124,279	141,064	125,265	124,007	130,028	650,138
Nutrition	6,017	4,532	4,246	4,260	4,260	4,260	4,312	21,559
School Health	202	177	177	177	177	177	177	886

Major Focus Areas	Expenditure		Commitment					
	2020	2021	2022	2023	2024	2025	Ave/yr.	Total
Others	51,482	27,607	27,715	28,101	28,119	28,119	27,932	139,661
Total	**363,241**	**351,569**	**347,069**	**420,183**	**386,943**	**380,864**	**377,326**	**1,886,628**

07.3 Funding Gap Management

The analysis of estimated costs and commitments shows a financing gap of US$616 million during the plan period. This implies that about 23% of the estimated costs will not be financed if the additional resources are not mobilized (see Table 14). The financing gap increases from about 13% in 2021 to 33% in 2025. Overall, the financing gap is not that significant.

Table 14. Costs Financing and Gaps (Million US$)

	2021	2022	2023	2024	2025	Total
Required Resources	455	493	540	595	630	2,713
Available Resources	395.3	406	451.8	424.2	419.2	2,097
Gap in US$	**59.6**	**87**	**88**	**171**	**211**	**616**
Gap in %	13%	18%	16%	29%	33%	23%

The financing gap will negatively affect the implementation of the Sharpened Plan II. Managing and matching the costs in relation to available funding during the annual planning and budgeting process will be used as a strategy to match the set targets with available resources. In this regard, three major strategies will be used to manage the resource gap.

- The first strategy is that the implementing units will review annual targets and revise them as part of the annual planning and budgeting process.
- The second strategy is for the sector to enhance value for money by focusing on efficacy gains in the supply chain and human resources. In this regard, the required quantities of commodities for the interventions associated with:

(1) treatment of pelvic inflammatory disease (PID),

(2) malaria treatment for children aged 0–4,

(3) zinc supplementation,

(4) pneumococcal vaccine, and

(5) management of moderate acute malnutrition in children will be annually reviewed and adjusted. To enhance efficiency in the procurement and distribution of commodities, enforcement of the use of the essential medicines list will be followed up.

- The third strategy is to build the capacity of evidence generation and advocacy for increased funding for the RMNCAH Sharpened Plan from domestic and external resources. The RMNCAH delivery units will work with the overall health sector to engage and influence increased government resource allocation for health in general and receive their fair share from this increased investment. They will also work toward mobilizing additional funds from external resources by engaging and showcasing the investment case of this plan to partners that have the potential to increase funding.

ANNEXES

Annex 1: A Call to Action—We All Have a Role to Play

The commitments by stakeholders to help deliver the new Sharpened Plan 2022/23–2026/27 over the next five years are outlined here.

Civil Society Organizations (CSOs)

These commitments also align with the Uganda CSO Global Financing Facility engagement strategy.

CSOs' complementary role and renewed commitments are tailored toward working closely with government to:

(1) identify high-burden districts using agreed on criteria and also support community engagement in the process and how to address existing RMNCAH issues;

(2) establish accountability for results and conduct independent review and monitoring mechanisms for the implementation of government-led RMNCAH policies, programs and projects;

(3) advocate and support uptake of the social accountability tools including the RMNCAH scorecard at national and subnational levels;

(4) support scale-up and implement prioritized RMNCAH services;

(5) leverage resources and expertise in integrating health with other sectors, including strengthening public-private partnerships, and work more effectively toward a shared goal of ending preventable deaths;

(6) mobilise citizens to call on government to increase investment/budget allocations for high-impact maternal, newborn, and child interventions for improved RMNCAH outcomes;

(7) implement budget oversight actions including tracking budget allocations and expenditure against the Government commitments for RMNCAH; and (8) track clearly defined district indicators to strengthen and guide the country in planning as well as in allocating resources and ownership of the problem.

Cultural Institutions: Cultural institutions commit to:

(1) address cultural/gender norms, taboos, and practices that are detrimental to RMNCAH;

(2) contribute to the mobilization of citizens to create awareness, access, use of, and adherence to RMNCAH high-impact service intervention packages; and (3) address sexual and gender-based violence and support all efforts to uplift the status of women and girls in society.

Religious Leaders: Religious leaders commit to:

(1) contribute to the mobilization of citizens to create awareness, access, use of, and adherence to RMNCAH high-impact service intervention packages, including highly burdened and under-served populations to ensure women and children everywhere survive and thrive. Reach, follow-up, and influence at least 200,000 families in Uganda or an estimated 10 million people living in those communities with the highest burden of maternal and child deaths.

(2) promote behavior that protects the health of the most vulnerable and marginalized members (including adolescents) of society, and

(3) engage in robust community education against discrimination/stigmatization, poverty, practices that harm or suppress women and girls, including female genital mutilation, early marriages and coerced childbearing, poor education and other social inequities; prejudices, and other attitudes that restrict members of the community from accessing the full range of RMNCAH services, commodities, and information they need in line with religious beliefs and values.

Annex 2: Work plan

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
A. HEALTH SYSTEM INPUTS							
1.1 RMNCAH Governance and Leadership							
1.1.1 Harmonise, align, and consolidate RMNCAH policies and programming; develop a comprehensive RMNCAH manual/SOPs in partnership with individuals, families, communities, and frontline service providers.	Consolidated RMNCAH manual/SOPs	The proportion of facilities where RMNCAH policy manual/SOPs are available and in use				Support supervision reports Evaluation survey reports	All components of RMNCAH agree to consolidate
1.1.2 Regionalize technical oversight and performance improvement across public and private sectors around regional referral hospitals	17 regional referral hospitals	# regions with fully institutionalized and fully functional oversight and performance teams				Quarterly regional supervision reports	adequate availability of regional leadership support, technical staff, and logistics to functionalize
1.1.3 Develop training, job aids, and tools for improving district and facility RMNCAH leadership in management, partnership with local communities, and achieving people-centred and integrated care	Mid-level health managers and facility governance committees	# districts/health facilities where relevant bodies are consistently engaged and contributing to RMNCAH operations and services in line with refined tools				Periodic administrative reports	Linkage between facilities and community, interaction among various facility management bodies in the district
1.1.4 Develop tools for subnational health governance committees for implementing alterations in service delivery design to people-centred RMNCAH care, population RMNCAH management, inclusive of services and accountability	17 regionals	# regionals where the guidelines and tools are available and in use at all levels				Periodic administrative reports	Governance bodies are fully constituted and fully functional
1.1.5 Reanalysis of legal, policy, and regulatory framework to identify gaps and barriers to RMNCAH's extended nurturing care framework and develop a redress strategy	Refined legal, policy, and regulatory framework	% health facilities implementing RMNCAH extended nurturing care based on refined legal, policy, and regulatory framework				Quarterly supervision reports	Support systems are in place to enable review of legal, policy, and regulatory framework
1.1.6 Together with professional bodies and associations, develop guidelines, implementing tools, and mechanisms for effective engagement of the private sector, especially midwifery/nurses in RMNCAH delivery for adolescents and hard-to-reach subpopulations	17 regionals operationalizing this engagement to at least 25%	% midwives/nurses in the private sector engaged in RMNCAH service delivery, especially for adolescents and				Quarterly supervision reports (private	All-inclusive growth plan (public, PNF, PFP) for periodic analysis and growth projection- opportunities and promotion to enable private

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
		hard-to-reach subpopulations per region.				sector health facilities)	and PFP complementing public commitment to PPP
1.1.7 Annual meetings of professional councils, associations, and regional teams to review in-service training/CMEs based on RMNCAH performance data and supervision/mentoring reports	18 meetings per year (17 regional, 1 national)	# regions holding meetings per year				Filed meeting minutes	Professional bodies operational in all regions
1.2 RMNCAH Financing							
1.2.1 Improve efficiencies through integration of RMNCAH program implementation, management, training, and supervision activities and increasing domestic resource mobilization for RMNCAH	17 regionals integrated work plans	# regions with integrated plans				Integrated workplans	Willingness of other departments and interventions to integrate
1.2.2 Develop multidepartment activities with HIV, malaria, and TB to implement health system strengthening within the Global Fund and especially community health systems	Integrated workplans all levels of planning	% districts/health facilities implementing integrated workplan				Periodic activity reports	Willingness of other departments and interventions to integrate
1.2.3 Continue tracking national and district level expenditure, reduce off-budget financing of RMNCAH services currently at 79% (UGX 129 billion)	100% of regions and districts	# regions/districts where tracking is routinized (quarterly, semester, and annual)				Resource tracking/finance reports	Open access to finance data
1.2.4 Align RMNCAH/N partner funding toward service delivery at community, HC III, and IV levels, and establish measurement and tracking mechanisms in light of high (65%) household total expenditure on health used in seeking services through hospitals	Identify and profile RMNCAH funding partners	% partner funding aligned toward service delivery at community, HC III, and IV levels; established measurement and tracking				Budget framework papers	Flexibility in budgeting and management of partner funding
1.3 Health Workforce							
1.3.1 Absorb the pool of trained health workers (formal recruitment) into the health system	17 regions	# Health workers (midwives) recruited per region/district annually				HRH reports	Recruitment of HW is aligned to targets in the Uganda human resource for health strategic plan
1.3.2 Develop a comprehensive training needs assessment and training plan hinged on the comprehensive RMNCAH manual/SOPs	17 regions	# regions/districts where training needs assessment is done and used as the basis for annual training plans				Periodic workplans and reports	Staffing is full and allows for training

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
						Evaluation reports	
1.3.3 Configure and build capacity for continuously tracking RMNCAH training information to determine district- and facility-level progress and deficits based on the electronic Integrated Human Resource Information System (IHRIS).	Comprehensive leadership training, job aids, and tools targeting all mid-level health managers and facility governance committees	# ADHOs-MCH and nursing officers trained in the implementation of RMNCAH nursing and midwifery performance improvement management				Periodic administrative reports	
1.3.4 Train mid-level managers (especially ADHO-MCH and nursing officers) in implementing RMNCAH nursing and midwifery performance improvement management.	All RMNCAH training materials and tools are uploaded on the digital platform.	The proportion of digitized RMNCAH training materials and tools, including adolescent peer providers, school health, and self-care				Digitalised RMNCAH training materials and tools	Support systems are in place to enable the digitalization of RMNCAH training materials and tools
1.3.5 Digitalise the RMNCAH training materials and tools, including for adolescent peer providers, school health, and self-care	17 regions	# regions with trained and functional teams of trainers/supervisors/mentors				Administrative reports	Staffing is full and allows for training.
1.3.6 Train 17 regional teams of trainers/supervisors/mentors with integrated biannual short on-site courses and peer support for frontline workers organized within districts; developing ICT-enabled distance-learning schemes	At least 20% of target health facilities per district are covered per year	% frontline health workers have had short on-site courses and peer support				Quarterly support supervision reports	Staffing is full to allow for the training of health workers with minimum interruption to service delivery.
1.3.7 Update midwifery and nursing pre-service and in-service national training curriculum and cover new RMNCAH competence requirements and rural health issues to improve competencies and interest in rural practice.	Updated midwifery and nursing pre-service and in-service national training curriculum	% midwives and nurses trained based on the updated midwifery and nursing pre-service national training curriculum				Midwifery and nursing pre-service and in-service national training curriculum	Effective collaboration of readiness between health training institutions and professional bodies
1.3.8 For VHTs: (1) develop and roll out rationalised training module on expanded RMNCAH package (including use of digitized technologies), (2) incentivize VHTs to meet RMNCAH performance standards within the expanded community package (ICCM-plus, commodity distribution, pregnancy mapping, etc.)	A rationalized training module on the expanded RMNCAH package	% VHTs trained based on the out-rationalised training module on the expanded RMNCAH package				Rationalized training module on expanded RMNCAH package	Harmonised time of development of key documents
1.4 RMNCAH Infrastructure and Equipment							

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.4.1 Procurement of targeted equipment: a) low-cost portable obstetric ultrasound machines for all HC IIIs and IVs and training package for midwives, b) newborn intensive care units for GHs, c) special care units for 100 high-volume HC IVs, general hospitals, d) SCUs for HC IVs, e) KMC beds for all HC IIIs and IVs	A four-level RMNCAH delivery and referral system full equipment	# HC IVs and HC IIs that have procured low-cost portable obstetric ultrasound machines per district # GHs per region equipped with newborn intensive care units # HC IVs and GHs per region equipped with special care units for 100 high-volume HCs				Medical equipment and asset inventory	An integrated planning and procurement system (region) for a functional four-level RMNCAH delivery and referral system
1.4.2 Establishment of blood storage facilities at all HC IVs to ensure timely availability of supply and other products like fresh frozen plasma and platelets	All HC IVs	# HC IVs per region with an established and functional blood storage facility				Blood storage facilities	A prioritized procurement and installation process
1.4.3 Procurement of smartphones for VHTs to contact health facilities for referrals, use mobile phone-based alerts and audit services, rapid SMS reporting	All VHTs	% VHTs per district equipped with and utilizing smartphones for referrals and reporting				VHT reports and referrals made using smartphone-based platforms	VHT dropout rates are managed
1.4.4 Establish a facility digital asset inventory system to track equipment availability, functionality, and servicing requirements	All health facilities	% facilities region/district using digital asset inventory system to track equipment availability, functionality, and servicing requirements				Routine health facility asset inventory records/ reports	Simplicity and reliability of the digital asset inventory system
1.4.5 Equip 16 regional hospitals with training aids/simulators to perform as pre- and in-service competence training hubs	16 regional hospitals	# Regional hospitals with training aids/simulators to perform as pre- and in-service competence training hubs				Administrative reports	Supportive environment for the functionality of training aids/simulators to perform as pre- and in-service competence training hubs
1.4.6 Renovation of a few grossly dilapidated health facilities in selected districts	TBD	# and proportion of HFs renovated per district annually				Planning and needs assessment reports for construction and renovation	Renovations prioritized in infrastructure plans

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.4.7 Equip and strengthen the Regional Equipment Maintenance Workshops to maintain all equipment being procured and distributed to districts	17 Regional Equipment Maintenance Workshops	# regions with functional Equipment Maintenance Workshops				Supervision reports	Internal capacity is built within the regions for the maintenance of medical equipment available in the region.
1.5 RMNCAH Commodity Security and Technologies							
1.5.1 Establish and/or integrate additional access points to commodities	An integrated distribution system	% FP and self-care commodities integrated into the private sector distribution strategy.				Facility assessment reports for reproductive health commodities and services.	Enabling environment of PPP
1.5.2 Develop a comprehensive RMNCAH self-care commodity security and safety strategy for the five years.	Five-year RMNCAH commodity security strategy document	Five-year RMNCAH commodity security strategy document disseminated and in use				Five-year RMNCAH commodity security strategy document	Availability and harmonization of key RMNCAH documents
1.5.3 Establish and support an effective government-led regulatory and stewardship subcommittee to steer and monitor the digital health development partnership among government health services, private IT platforms, and public and private sectors to harness ICT potential	A regulatory and stewardship subcommittee to steer and monitor digital health development	A functional regulatory and stewardship subcommittee to steer monitoring of digital health development partnership				Report by the regulatory and stewardship subcommittee	Supportive system for multi-sectoral engagement
1.5.4 Research on the use of new technology under m-health and e-health in supporting service delivery improvements and community engagement; focus less on answering "what" and more on "how" questions through operations and implementation research	TBD	# New technologies under m-health and e-health developed, piloted, and adopted for use				New technologies in m-health and e-health	A supportive environment for research and innovation in m-health and e-health
1.6 Health Management Information							

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.6.1 Develop and tailor the reporting tools and configuration of RMNCAH reporting into the existing Uganda EMR platform	Tailored RMNCAH tools configured for reporting in Uganda EMR	3 level indicators (region, district, facility)				HMIS	Tools are compatible with the existing Uganda EMR platform
1.6.2 Roll out the RMNCAH dashboard embedded in DHIS2 to the remaining 10 regions	17 regions	# regions where the RMNCAH dashboard has been rolled out and is in use				HMIS	Effective training of the relevant cadres in the use of the RMNCAH dashboard Strengthened RMNCAH's data demand and use infrastructure
1.6.3 Digitalize and operationalize the Community Health Information Systems with a simplified mobile application dashboard	A functioning and simplified mobile application dashboard for Community Health Information Systems	A functioning and simplified mobile application dashboard for Community Health Information Systems				HMIS	VHTs are well-trained, equipped, and incentivized to collect and submit community data
1.6.4 Implement a home-based record of the history of health services received by an individual in the family initially kept in the household (paper or electronic) but gradually integrated into the health information system and complement records maintained by health facilities	TBD	# and proportion of health facilities implementing a home-based record of the history of health services received by an individual in the family.				CAPA	Capacities of VHTs strengthened to support the implementation of home-based records of the history of health services received by an individual in the family
1.6.5 Together with the Division of Health Information and NITA-U, develop a platform for national and district health managers to access interlink data from RMNCAH sensitive sectoral information systems	TBD	% national and district health managers accessing and utilizing interlink data from RMNCAH sensitive sectoral information systems				HMIS	Capacities and core competencies of national and district health managers in data use built A strengthened RMNCAH's data demand and use infrastructure
1.6.6 Deploy the RMNCAH Equity Assessment building on existing sentinel sites and efforts	TBD	# regions/districts conducting RMNCAH equity assessment per year				Annual assessment reports	The functionality of existing sentinel sites and more will be set up
1.7 Community Engagement for RMNCAH							

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.7.1 Develop, digitize, and disseminate the RMNCAH CAPA manual that prioritizes community and family-oriented models of care as a mainstay of practice with a focus on prevention and health promotion	RMNCAH CAPA implementation manual	% health facilities implementing CAPA in their catchment areas				Action plans	Health facility staff trained and appreciate CAPA
1.7.2 Training in the implementation of CAPA	At least 20% of health facility- in-charges trained per district per year	% health facility-in-charges trained and disseminated RMNCAH data for comprehensive RMNCAH social and behavioral change among target communities.				Training manual and training reports	Availability of RMNCAH CAPA implementation manual
1.7.3 Harmonize and disseminate a comprehensive RMNCAH social and behavior change (RMNCAH&N SBCC) strategy that incorporates IT and practices on health determinants	RMNCAH SBCC strategy	# districts/health facilities using RMNCAH SBCC strategy				Quarterly reports, annual performance reports	A comprehensive RMNCAH social and behavior change (RMNCAH&N SBCC) strategy is developed and disseminated at all levels
1.7.4 Extensive awareness campaigns on RMNCAH self-care commodities and technologies	TBD	% targeted population having knowledge of RMNCAH self-care commodities and technologies				Survey reports	Population groups are profiled and targeted for RMNCAH self-care commodities and technologies. Appropriate modes of awareness campaigns for targeted populations are used
1.7.5 Reach out to and engage the underserved, disadvantaged, and marginalized populations (see Shift 2)							
1.8 RMNCAH service delivery emphasizing evidence-based, high-impact interventions							
1.8.1 Develop guidelines, pilot, and scale up system for remodeling facility and community RMNCAH service delivery organization toward integrated people-centered RMNCAH services across the continuum of care and differentiated care	Guidelines developed	# and proportion of health facilities delivering integrated people-centred RMNCAH services across the continuum of care and differentiated care				Supervision reports	Appropriate guidelines are developed, piloted, and adopted
1.8.2 Support the development of a centrally coordinated system of regionalized RMNCAH care services integrated with coordinating RMNCAH care, HRH training, regional service delivery-ambulance network, multilevel quality improvement, and simplified effective RMNCAH referral	17 centrally coordinated systems of regionalized integrated RMNCAH	# regions with a functional, centrally coordinated system of regionalized integrated RMNCAH care				Regional support supervision reports	Regional teams are fully constituted and resources to support the development of a centrally coordinated system of regionalized RMNCAH care

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
pathways. Develop guidelines and scoping study; procure mentoring and training aids; support supervision to establish 17 regional referral hospital skills hubs in line with national regional support policy guidelines	care services developed						services integrated with coordinating RMNCAH care.
1.8.3 Train the regional mentoring teams and support the quarterly mentoring visits (5) for training, support supervision, and management for VHTs to: a) rationalize VHTs initial and continued training, including adolescent /young people VHTs, b) retool and procure critical equipment, c) mobilize, train, integrate, and provide tools for adolescent and young people (AYP) peer educators, and providers through the AYP Constituency in the RMNCAH CSO coalition	5 cadres per region are trained to conduct support supervision and quarterly mentoring visits	# regions with trained teams in conducting support supervision and quarterly mentoring visits				Training reports	Regional teams are fully constituted to allow training support, supervision, and mentoring.
1.8.4 Scale up differentiated service delivery (DSD) for increasing diversity of needs of demographic groups/locations; develop guidelines, provide training and mentoring, and adjust existing RMNCAH data systems for various delivery approaches.	All health facilities adopt DSD	# and proportion of health facilities providing DSD per district and region annually				Supervision reports Surveys	Population groups are profiled and targeted for DSD
1.8.5 Scale up school health promotion services, including stronger linkages of health services within the schools or partnerships between schools and nearby HCs	75% of schools reached	# and proportion of schools reached with school health promotion per district/region annually				Quarterly activity reports	Sufficient multi-sectoral collaboration with MOES
1.8.6 Develop guidelines, pilot, and scale up system for remodeling facility and community RMNCAH service delivery organization toward delivery of integrated people-centred across the continuum of care and differentiated care	Developed guidelines	% health facilities per region/district implementing integrated people centred RMNCAH services across the continuum of care and differentiated care based on the new guidelines				Quarterly reports	Support systems to accommodate and facilitate the adjustment process
1.8.7 Develop guidelines, scoping study, procurement of mentoring and training aids, and support supervision to establish 17 regional referral hospital skills hubs in line with the national regional support policy guidelines	Consolidated guidelines	# Regional referral hospitals with established and functional skills hubs in line with the established policy guidelines				Quarterly support supervision reports	Timely development and dissemination of guidelines at all levels
2.1 Focusing First on Districts with Highest Maternal and Child Mortality							

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
2.1.1 Establish functioning bEmONC in all HC IIIs and cEmONC in HC IVs within a coordinated referral system of regionalized RMNCAH service and hold biannual joint reviews	50%	% functional HC IVs offering C/S and blood transfusion per region				Administrative reports	Established and functional blood storage facilities at all HC IVs
2.1.2 Roll out quality initiatives that elevate and standardize RMNCAH&N care delivery at all HFs and effective use of scaled MPDSR and community verbal autopsy	90%	% HFs holding MPDSR				HMIS quarterly reports	Facilities have an adequate number of staff to conduct MPDSR
2.1.3 Comprehensive community delivery (VHT) system and community engagement to address access barriers and data-driven community-led actions	100%	% HFs using VHT data for community-led action				Quarterly health facility plans and report Periodic surveys	Adequate training of health facility staff in CAPA
2.1.4 Continuously measure the disparities through strengthening BDR through NIRA and DHIS2, community HMIS, and use of composite indices to identify overburdened districts/regions; track progress in reduction of disparities	All districts (100%)	% of national and district health managers analyzing and using BDR data for RMNCAH programming % health facilities notifying all births in the birth registration system				Quarterly RMHCAH performance review reports	CRVS fully rolled out A linked and fully functional database (NIRA and DHIS2)
2.2 Increasing access for high-burden populations							
2.2.1 shift to targeted delivery channels through task-shifting to community-led (peers) or --based (VHTs, outreach, and satellites) service delivery to ensure services reach marginalized and disadvantaged	All health facilities (100%)	% health facilities per region/district implementing community-led service delivery				Quarterly reports Survey reports	Increased community awareness and demand for RMNCAH services
2.2.2 Engage and contract private health care midwives (CSOs, PNFP, and PHP), especially through district-level RBF, to expand access	All districts engaging private care midwives	% private sector actors enrolled in RBF				Annual performance reports	Private sector facilities are profiled
2.3 Addressing the broader multi-sectoral context							
2.3.1 Establish a nurturing care lead office to drive the implementation of strategies needed to incorporate Nurturing Care into daily routines, policy development,	Nurturing care lead office	A functional nurturing care lead office				Administrative reports	Clearly defined structure, instruments, and terms of

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
2.1.1 Establish functioning bEmONC in all HC IIIs and cEmONC in HC IVs within a coordinated referral system of regionalized RMNCAH service and hold biannual joint reviews	50%	% functional HC IVs offering C/S and blood transfusion per region				Administrative reports	Established and functional blood storage facilities at all HC IVs
2.1.2 Roll out quality initiatives that elevate and standardize RMNCAH&N care delivery at all HFs and effective use of scaled MPDSR and community verbal autopsy	90%	% HFs holding MPDSR				HMIS quarterly reports	Facilities have an adequate number of staff to conduct MPDSR
2.1.3 Comprehensive community delivery (VHT) system and community engagement to address access barriers and data-driven community-led actions	100%	% HFs using VHT data for community-led action				Quarterly health facility plans and report Periodic surveys	Adequate training of health facility staff in CAPA
2.1.4 Continuously measure the disparities through strengthening BDR through NIRA and DHIS2, community HMIS, and use of composite indices to identify overburdened districts/regions; track progress in reduction of disparities	All districts (100%)	% of national and district health managers analyzing and using BDR data for RMNCAH programming % health facilities notifying all births in the birth registration system				Quarterly RMHCAH performance review reports	CRVS fully rolled out A linked and fully functional database (NIRA and DHIS2)
2.2 Increasing access for high-burden populations							
2.2.1 shift to targeted delivery channels through task-shifting to community-led (peers) or --based (VHTs, outreach, and satellites) service delivery to ensure services reach marginalized and disadvantaged	All health facilities (100%)	% health facilities per region/district implementing community-led service delivery				Quarterly reports Survey reports	Increased community awareness and demand for RMNCAH services
2.2.2 Engage and contract private health care midwives (CSOs, PNFP, and PHP), especially through district-level RBF, to expand access	All districts engaging private care midwives	% private sector actors enrolled in RBF				Annual performance reports	Private sector facilities are profiled
2.3 Addressing the broader multi-sectoral context							
2.3.1 Establish a nurturing care lead office to drive the implementation of strategies needed to incorporate Nurturing Care into daily routines, policy development,	Nurturing care lead office	A functional nurturing care lead office				Administrative reports	Clearly defined structure, instruments, and terms of

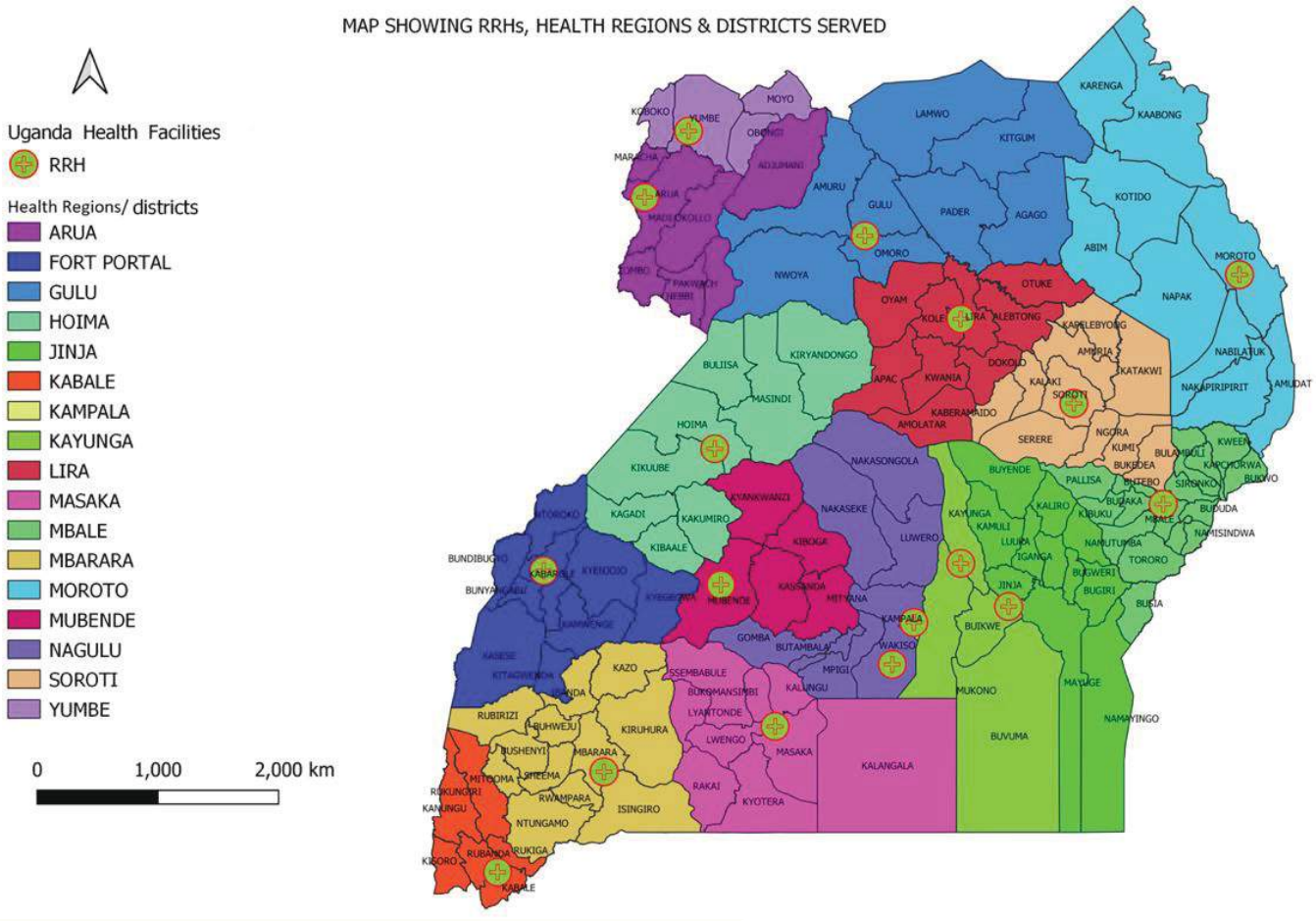
Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
program coverage, monitoring, and continuous quality improvement.							reference for the nurturing care lead office
2.3.2 Strengthen formalized engagement and partnership with other sectors and the private sector (CSOs, TCMPs, PHP, schools, workplaces, businesses, etc.) at the district level in the implementation of the NCF	TBD	# MOUs signed with private sector facilities				Administrative records	Good multi-sectoral collaboration
2.3.3 Inclusion of NCF indicators within the community HMIS	TBD	# NCF indicators included in the community HMIS				HMIS reports	Valid national nurturing care environment measurements for all age groups are based on reliable indicators.
2.3.4 Strengthen the clinical response to child, gender- and sexual-based violence through cascaded training of health care providers (facility and community levels) on management of sexual- and gender-based violence, update GBV referral pathways, data protection protocols, and service quality improvement	TBD	% health care providers per region/district trained and providing clinical response to child, gender- and sexual-based violence.				Training reports	Effective cascade training of health care providers on clinical response to child, gender- and sexual-based violence
2.4 Strengthening Mutual Accountability							
2.4.1 Roll out implementation of Maternal and Perinatal Death Surveillance and Response Guidelines 2017	100% rollout in the relevant health facilities	% health facilities per region/district with access to and implementing Maternal and Perinatal Death Surveillance and Response Guidelines 2017				Guidelines 2017 are available at health facilities and readily accessible to healthcare providers.	Timely rollout of Maternal and Perinatal Death Surveillance and Response Guidelines 2017 at all levels
2.4.2 Support 17 annual regional RMNCAH reviews and one national review with results from community scorecards and patient satisfaction surveys	17 regional and 1 national	# Performance reviews successfully held per year				Annual performance review reports	Interventions to improve data use are fully implemented.
2.4.3 Develop facility management committee guidelines and tools for inclusiveness; community feedback, reporting, action, follow-up; IT-based RMNCAH community scorecard and its use in social accountability	100% of HUMC and HBs	# Facility management committees per region/district using the new facility management committee guidelines				The facility management committee reports	Fully constituted and functional facility management committees fully oriented on the new guidelines.

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
2.4.4 Establish and support a technical working group for performance accountability tracking and action on indicators for RMNCAH: (1) eliminating preventable maternal and child deaths, (2) eliminating inequities within populations, (3) improving care using available resources, (4) reaching adolescents and young people, (5) extending nurturing care framework.	1 TWG at national level	# RMNCAH analytical reports produced per year				Analytical reports	Improved capacity and core competencies of technical teams in data use Availability of quality RMNCAH data

Annex 3: National Performance Targets in the NDPIII

Indicator	Baseline	Baseline	'20/21	'21/22	'22/23	'23/24	'24/25
Impact Indicators							
Reduced Maternal Mortality ratio (per 100,000)		336	311	286	261	236	211
Reduced Under-5 Mortality Rate (per 1,000)		64	59	55	50	46	42
Total Fertility Rate		5.4	5.0	4.9	4.8	4.6	4.5
Reduced teenage pregnancy		25	22	20	18	16	15
Reduced unmet need for family planning		28	26	22	18	14	10
Thematic Indicators							
Total users for modern contraceptive methods (excluding condoms and fertility awareness methods) in '000,000		2.93	3.12	3.32	3.53	3.75	4.00
Reduced prevalence of under-5 stunting		29%	27%	25%	23%	21%	19%
Under-5 Vitamin A second-dose supplementation		30%	35%	38%	42%	46%	50%
DPT3 Coverage		95%	98%	99%	100%	100%	100%
Human Papilloma Virus vaccination coverage for 10-year-old girls		40%	50%	65%	60%	65%	70%
% pregnant women receiving iron/folate supplement		50%	55%	60%	65%	68%	70%
Basic sanitation coverage (improved latrine coverage)		19%	50%	55%	61%	68%	75%
Improved hand-washing facility (household)		34%	50%	38%	42%	46%	75%
% workplaces with breastfeeding corners		0%	5%	10%	15%	20%	25%
Improved average % availability of a basket of 41 tracer commodities at all reporting facilities		79%	82%	85%	88%	90%	93%
% health facilities with 95% availability of 41 basket of EMHS, including lab, vaccines, and blood transfusion supplies		46%	55%	60%	70%	75%	80%
% health facilities in the country utilizing the e-LMIS and (ERP) and reporting into the PIP		30%	35%	40%	45%	60%	70%
Number of functional National and Regional Call Centres with EmONC referral streamlined		0	2	5	10	14	14
% functional HC IVs (offering C/S and blood transfusion)		50%	60%	70%	80%	85%	90%
% sub-counties with HC IIIs		50%	55%	60%	65%	70%	75%
% functional imaging and radiotherapy equipment in hospitals		65%	68%	70%	72%	74%	75%
% RRHs with functional ICUs/HDUs		20%	100%	100%	100%	100%	100%
% approved staffing levels filled by qualified health workers		73%	80%	82%	84%	85%	86%
% staff with signed performance agreements and appraisals for performance management in health service delivery		80%	80%	85%	90%	95%	100%

Indicator	Baseline					
	Baseline	'20/21	'21/22	'22/23	'23/24	'24/25
% public and private hospitals, HC IVs, and high-volume HC IIIs utilizing the Electronic Medical Record System	0%	10%	20%	30%	40%	50%
Timeliness of weekly surveillance reports	60%	75%	78%	80%	85%	85%
% private health providers (private for-profit) facilities reporting into the DHIS2	20%	25%	30%	35%	40%	45%
% quarterly RMNCAH performance reports analyzed and actioned	0%	75%	100%	100%	100%	100%
Increased children under 5 years registered and issued Birth Certificates	40%	70%	75%	80%	85%	90%
Percentage of deaths in a given year continuously reported, registered, and certified with key characteristics	2%	10%	40%	50%	60%	70%
% hospitals using the ICD 11 Classification of Diseases and Medical Certification of Cause of Death	0%	10%	20%	30%	40%	50%
Adolescent birth rate (aged 15–19 years)	132					125
Adolescent pregnancy rate	25%					15%
Increase in couple years of protection ('millions)	3.2	4.5	5.7	7	8.2	9.5



Annex 4: Health Regions

RRH	Population	Districts Served and Catchment Population Including Refugee Population
1) Arua	2,185,390	Arua (411,578) Madi Okollo (164,200) Nebbi (282,600) Maracha (208,300) Pakwach (196,800) Terego (339422) Zombo (283,100) Koboko (5,739 Refugees) Madi Okollo (124,453 Refugees) Terego (69,198 Refugees)
2) Fort Portal	3,347,271	Bundibugyo (263,800) Bunyangabu (195,100) Kabarole (337800) Kamwenge (335,200) Kasese (793,200) Kitagwenda (178,300) Kyegegwa (442,000) Kyenjojo (525,400) Ntoroko (76,000) Kamwenge (76,510 Refugees) Kyegegwa (124,961 Refugees)
3) Gulu	1,846,720	Agago (251,200) Amuru (216,800), Gulu (325,600), Kitgum (223,600) Lamwo (143,800), Nwoya (236,000), Omoro (196,400), Pader (197,300), Lamwo (56,020 Refugees)
4) Hoima	2,855,757	Buliisa (149,300) Hoima (374,500) Kagadi (430,200) Kakumiro (473,400) Kibaale (198,200) Kikuube (358,700) Kiryandongo (313,800) Masindi (340500) Kikuube (127,291 Refugees) Kiryandongo (71,866 Refugees)

RRH	Population	Districts Served and Catchment Population Including Refugee Population
5) Jinja	4,263,000	Bugiri (480,400) Bugweri (191,600) Buyende (414,600) Jinja (515,100) Iganga (402,600) Kaliro (288,500) Kamuli (558,500) Luuka (267,100) Mayuge (565,100) Namutumba (306,500) Namayingo (237,000)
6) Kabale	1,489,100	Kabale (248,700) Kanungu (277,300) Kisoro (315,400) Rubanda (208,500) Rukiga (105,400) Rukungiri (333,800)
7) Kayunga	2,450,900	Buikwe (474,100) Buvuma (128,900) Kayunga (407,700) Mukono (701,400) Nakasongola (523,600) Luwero (215,200)
8) Lira	2,444,900	Amolatar (170,100) Alebtong (266,100) Apac (226,600) Dokolo (215,500) Kole (284,300) Lira (478,500) Kwania (216,600) Oyam (453,700) Otuke (133,500)
9) Masaka	2,029,400	Bukomansimbi (156,600) Masaka (335,700) Kalangala (67,200) Kalungu (194,100) Kyotera (261,000) Lwengo (290,500) Lyantonde (110,500) Rakai (317,700) Sembabule (296,100)
10) Mbale	4,381,600	Budaka (253,100) Bududa (271,100) Bukwo (119,100) Bulambuli (230,600) Busia (384,000) Butaleja (300,500) Butebo (121,200) Kapchorwa (123,800) Chibuku (250,600) Kween (109,500) Manafwa (175,200) Mbale (586,300) Namisindwa (231,500) Pallisa (353,400) Sironko, Tororo (597,500)
11) Mbarara	3,451,999	Buhweju (144,100) Bushenyi (248,300) Ibanda (277,300) Isingiro (596,400) Kazo (217,600) Kiruhura (185,700) Mbarara (390,700) Mitooma (194,300) Ntungamo (540,800) Rubirizi (144,100) Rwampara (144,600) Sheema (220,500) Isingiro (147,599 Refugees)
12) Moroto	1,168,600	Abim (153,500) Amudat (134,900) Kaabong (125,400) Karenga (68,500) Kotido (206,500) Moroto (118,500) Nabilatuk (89,700) Nakapiripirit (113,300) Napak (158,300)
13) Mubende	1,684,000	Kasanda (312,700) Kiboga (171,200) Kyankwanzi (282,800) Mityana (362,500) Mubende (554,800)
14) Entebbe	3,717,900	Butambala (107,800) Gomba (173,800) Mpigi (286,600) Nakaseke (234,600) Wakiso (2,915,200)
15) Soroti	2,227,800	Amuria (225,000) Bukedea (259,300) Kaberamaido (132,700) Kalaki (138,700) Kapelebyong (103,8000) Katakwi (194,600) Kumi (284,800) Ngora (165,8000) Serere (359,500) Soroti (363,600)
16) Yumbe	1,903,372	Adjumani (235,900) Koboko (258,000) Moyo (109,500) Obongi (49,100) Yumbe (663,600) Adjumani (224,044 Refugees) Yumbe (238,279 Refugees) Obongi (124,949 Refugees)

Annex 5: Synergies with Other NDPIII Programs

Program	Areas to strengthen synergies
Agro-Industrialization	Linking with the recruited and facilitated agricultural extension workers up to parish level; increasing the proportion of households that are food secure from 60% to 80%; operationalizing the parish development model; management of domestic pests, vectors, and diseases, and enforcing micronutrient industrial food fortification of the already identified food vehicles. Construct and regularly maintain community access and feeder roads for market access.
Climate Change, Natural Resources, Environment, and Water Management	Maintain and/or restore a clean, healthy, and productive environment; reduce human and economic loss from natural hazards and disasters; assure the availability of adequate and reliable quality freshwater resources for all uses; scale up the use of renewable energy through off-grid electrification and liquefied petroleum gas.
Private Sector Development	Sustainably lower the costs of doing business, especially private sector providers; increase access to long-term finance; support the formation of cooperatives; strengthen the organizational and institutional capacity of the private sector to drive strengthening-system capacities to enable and harness benefits of coordinated private sector activities; improve data availability on the private sector; and improving dialogue between the private sector and
	government; create appropriate incentives and regulatory frameworks to attract the private sector to finance green growth.
Transport Infrastructure and Services	Construct and upgrade strategic transport infrastructure; rehabilitate and maintain transport infrastructure; implement cost-efficient technologies to provide transport infrastructure and services.
Energy Development	Expand and rehabilitate the distribution network (grid expansion and densification, last mile connections, evacuation of small generation plants, quality of supply projects); establish mechanisms to reduce the end-user tariffs; promote the use of new renewable energy solutions (solar water heating, solar drying, solar cookers, wind/water pumping solutions, solar water pumping solutions).
Digital Transformation	Digitalise and roll out e-services to all sectors, MDAs, and local governments (LGs); extend ICT infrastructure coverage countrywide and last mile connectivity in health facilities; develop and enhance national common core infrastructure (data centres, high power computing centres, specialized labs); increase ICT penetration (Internet penetration to 70%, countrywide 4G coverage, tele density to 80 percent, digital television signal coverage from 56 to 95%, radio signal coverage from 60 percent to 95%, 70% broadband availability in Government MDAs/LGs); reduce the cost of ICT devices and services (unit cost of Internet from US$237 to US$70, unit cost of low entry smart phones from UGX 100,000 to UGX 60,000, and cost of a computer from UGX 1,600,000 to UGX 800,000).
Sustainable Urbanization and Housing	Decrease the percentage of urban dwellers living in slums and informal settlements from 60% to 40%; improve urban safe water and waste management services and associated infrastructure.
Innovation, Technology Development, and Transfer	Strengthen research and development (R&D) capacities and applications; increase development, transfer, and adoption of appropriate technologies and innovations; support academia and research institutions to acquire R&D infrastructure; develop and maintain a national STI Information Management System (including a database of new and ongoing scientific research, technologies innovations, and indigenous knowledge from public and private sectors); establish a framework where MDAs implement STEI joint initiatives between their R&D departments, academia, and industry.
Community Mobilization and Mindset Change	Review and implement a comprehensive community mobilization (CMM) strategy; conduct awareness campaigns and enforce laws enacted against negative and/or harmful religious, traditional/cultural practices and beliefs; strengthen the institutional capacity of central, LG, and nonstate actors for effective mobilization of communities; establish a national incentives framework including rewards and sanctions for best performing workers, leaders, and communities.
Governance And Security Programme	Increase the Democratic Index from 6.5% to 8.6%; increase the percentage of youth engaged in national service from 40% to 65%; strengthen citizen participation and engagement in the democratic processes; strengthen compliance with the Uganda Bill of Rights.
Public Sector Transformation	Reduce corruption as measured by the corruption perception index from 26% to 35%; strengthen accountability for results across government; streamline government structures and institutions for efficient and effective service delivery; strengthen human resource management function of government for improved service delivery; deepen decentralization and citizen participation in local development; increase transparency and eliminate corruption in the delivery of services.

Annex 6: Costing Assumptions

Share of programs for total HRH cost		
Program	**Estimated personnel time, Minutes**	**Share**
Maternal/newborn and RH	25,841,523,504	55%
Child health	8,880,721,403	19%
Immunization	490,285,587	1%
Nutrition	10,590,037,900	23%
Adolescent health	469,280,555	1%
School Health Programme	459,495,166	1%
Total	46,731,344,114	

Share of different levels of service providers from total outpatient visits per year		
Facilities delivering interventions	**Total baseline # of outpatients per year**	**Share**
Health Centre II	1,813,245,244	9%
Health Centre III	6,507,861,765	33%
Health Centre IV	954,957,976	5%
General Hospital	3,779,305,924	19%
Regional Referral Hospital	2,769,318,996	14%
National Referral Hospital	2,711,132,411	14%
Super Specialized Hospital	1,355,566,206	7%

Unit Costs based on the GOU Procurement and Disposal guideline rates for 2020/21

Exchange rate 3,650 Inflation rate 3% Scale 1,000

Budget Head	Type	Type	Amount UGX	Amount US$
Hall Hire National	Meeting/Training	National	900,000	246.58
Hall Hire Regional	Meeting/Training	Regional	600,000	164.38
Hall Hire District	Meeting/Training	District	300,000	82.19
Hall Hire Community	Meeting/Training	Community	80,000	21.92
Refreshments and meals	Meeting/Training	National	50,000	13.70
Meals and refreshments	Meeting/Training	Regional	35,000	9.59
Tea and Bites	Meeting/Training	Regional	10,000	2.74
Refreshments	Meeting/Training	Community	2,000	0.55
Transport refunds	Local Travel	National	40,000	10.96
Transport	Local Travel	Regional	25,000	6.85
Transport District	Local Travel	District	20,000	5.48
Transport Community	Transport-SCHWs	All	5,000	1.37
Fuel costs	Fuel -Petrol	All	3,800	1.04
Per diem	Facilitator / Technical officers	All	141,000	38.63
Per diem for driver	Driver	All	80,000	21.92
SDA	Driver	All	22,000	6.03
Engagement meeting	Targeting 40 persons for 2 days		2,800,165	767.17
Capacity building			1,533,000	420.00
Capacity building subregional			803,000	220.00
Honorarium			100,000	27.40

Budget Head	Type	Type	Amount UGX	Amount US$
Facilitator Allowance	Facilitator	All	150,000	41.10
Consultant's fee			1,642,500	450.00
Community facilitators	Community level activity		50,000	13.70
Conference package			75,000	20.55
Advocacy meetings			1,725,000	472.60
Technical resource person			150,000	41.10
Stationery for large meetings			100,000	27.40
Workshop materials			400,000	109.59
Community outreaches	Cost per Parish		200,000	54.79
Communication				80.00
Printing costs			8,000	2.19
Research assistants			100,000	27.40
Communications and logistics			250,000	68.49
Review meetings	Cost per person		35,000	9.59
Supervision tools.			50,000	13.70
Desktops			3,000,000	821.92
Laptops			3,800,000	1,041.10
Printing forms			25,000	6.85
Field allowances			100,000	27.40
Media Press			2,000,000	547.95
Community Dialogue			300,000	82.19

Annex 7: Composite Coverage Index (CCI) Calculations

In addition to tracking the performance of the Sharpened Plan II using the above indicators, there shall be overall tracking using the composite coverage index (CCI). The CCI is the weighted average of the percentage coverage of 13 interventions along four stages of the continuum of care: reproductive care, maternal care, childhood immunization, and managing childhood illness.

The interventions are:

1. BCG coverage < 1 year (%)
2. DPT-HepB-Hib 3 coverage (%) <1 year
3. Fully immunized coverage < 1 year (%)
4. The proportion of children under 5 years with up-to-date immunization
5. The proportion of <5 with confirmed Malaria RDT received and ACT
6. The proportion of pregnant women attending ANC 1 in the first trimester
7. The proportion of ANC 1 mothers who received at least 3 doses of SP for IPTP
8. Facility deliveries

9. The proportion of mothers who delivered in the facility and received family planning in postpartum (timing)

10. Percentage of mothers initiating breastfeeding within 1st hour after delivery

11. Percentage of perinatal deaths notified.

12. Percentage of pregnant women with Hb level >11g/dl or diagnosed with anemia at ANC 1st visit

13. The proportion of adolescents and young people who received the HPV vaccine

CCI is calculated according to the formula:

$$\frac{1}{4}\left(FPS+\frac{SBA+ANCS}{2}+\frac{2DPT3+MSL+BCG}{4}+\frac{ORT+CPNM}{2}\right)$$

Each stage receives the same weight, and within each stage, the indicators have equal weights, except for DTP3, which receives a weight of two because it requires more than one dose. Substituting into this formula respective indicators and data extracted from DHIS2 for the year 2020 for each district, district-level baselines for CCIs were obtained.

Limitations: Incomplete data and low reporting rates in the DHIS2 on some indicators, e.g., indicators on family planning.

Annex 8: Mid-Year Population Projections and Demographics over Five Years

Demographic Variable	%	2020	2021	2022	2023	2024	2025
Total population	100	41,583,600	42,885,900	44,212,800	45,562,000	46,930,900	48,317,300
Children under 1 year	3.6	1,507,600	1,535,300	1,561,600	1,586,100	1,608,300	1,627,800
Children under 5 years	17.1	7,129,300	7,270,400	7,409,400	7,545,300	7,675,400	7,798,600
Older children (6–12)		8,186,500	8,379,000	8,578,500	8,801,300	9,044,100	9,301,700
Adolescents (10–19)	24	14,580,200	14,970,800	15,343,500	15,709,400	16,097,100	16,493,400
Expected pregnancies	5	2,079,180	2,144,295	2,210,640	2,278,100	2,346,545	2,415,865
Women (15–49)	20.2	8,399,887	8,662,952	8,930,986	9,203,524	9,480,042	9,760,095
Older people (60+)	4.1	1,525,700	1,588,000	1,661,100	1,734,200	1,806,200	1,872,800

Annex 9: Forty Priority Districts with RMNCAH Composite Coverage Index Less Than 60

District	Region	Projected Population	RMNCAH Composite Service Index Score
Amudat District	Karamoja	134,900	43%
Pakwach District	West Nile	196,800	46%
Kazo District	Ankole	217,600	47%
Kassanda District	North Central	312,700	47%
Namutumba District	Busoga	306,500	48%
Kampala District	Kampala	1,680,600	49%
Kyankwanzi District	North Central	309,900	49%
Kotido District	Karamoja	218,300	50%
Buvuma District	North Central	122,000	51%
Nakapiripirit District	Karamoja	113,300	51%
Nakasongola District	North Central	215,200	51%
Nakaseke District	North Central	256,000	51%
Mubende District	North Central	519,100	51%
Wakiso District	South Central	2,893,900	52%
Amuru District	Acholi	216,800	52%
Butebo District	Bukedi	171,000	52%
Lwengo District	South Central	371,700	52%
Bukomansimbi District	South Central	156,600	53%
Agago District	Acholi	251,200	53%
Buyende District	Busoga	313,800	53%
Kalangala District	South Central	67,200	54%
Masindi District	Bunyoro	340,500	54%
Kyenjojo District	Tooro	509,800	54%
Pader District	Acholi	197,300	54%
Tororo District	Bukedi	597,500	54%
Kagadi District	Bunyoro	415700	54%
Luuka District	Busoga	267100	55%
Koboko District	West Nile	242,000	55%
Bukwo District	Bugisu	119,100	56%
Kalaki District	Teso	138,700	56%
Arua District	West Nile	517,700	56%
Mayuge District	Busoga	443,200	56%
Nebbi District	West Nile	282,600	57%
Hoima District	Bunyoro	374,500	57%
Luwero District	North Central	523,600	58%
Mukono District	North Central	701,400	58%
Ntoroko District	Tooro	67,000	58%
Lira District	Lango	450,900	59%
Kabarole District	Tooro	284,300	59%
Amolatar District	Lango	170,100	59%

Annex 10: Glossary of Key Terms

Accountability: The obligation to report, or give an account of, one's actions – for example, to a governing authority through scrutiny, contract, management, regulation, and/or to an electorate.

Adolescent health: Adolescents are young people between the ages of 10 and 19; they are often considered healthy. Nevertheless, many adolescents die prematurely due to accidents, suicide, violence, pregnancy-related complications, and other preventable or treatable illnesses (WHO 2018).

Care coordination: A proactive approach in bringing care professionals and providers together around the needs of service users to ensure they receive integrated and person-focused care across various settings.

Child health: Child health is a state of physical, mental, intellectual, social, and emotional well-being, not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that allow them to reach their fullest developmental potential (WHO 2018).

Continuity of care: The degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences.

Continuous care: Care provided to people over time across their life course.

Empowerment: The process of supporting people and communities to take control of their own health needs, resulting, for example, in the uptake of healthier behaviors or the ability to self-manage illnesses.

Engagement: Involving people and communities in the design, planning, and delivery of health services that, for example, enable them to make choices about care and treatment options or to participate in strategic decision-making on how health resources are spent.

Integrated health services: Health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, and rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.

Intersectoral action: The inclusion of several sectors, in addition to health, when designing and implementing public policies that seek to improve health care and quality of life.

Maternal health: Maternal health refers to women's health during pregnancy, childbirth, and postpartum (WHO 2018).

Mutual accountability: The process by which two (or multiple) partners agree to be held responsible for the commitments that they have made to each other.

Neonatal health: During the first 28 days of life, the child is at the highest risk of dying. It is thus crucial that appropriate feeding and care are provided during this period to improve the child's chances of survival and lay the foundations for a healthy life.

People-centred care: An approach to care that consciously adopts individuals', carers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing clinical encounters and attention to the health of people in their communities and their crucial role in shaping health policy and health services.

P**erson-centred care:** Care approaches and practices that see the person as a whole with many levels of needs and goals, with these needs coming from their social determinants of health.

Population health: An approach to health care that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Primary health care: Refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology, and a central role played by the health system.

Reproductive health: Within the framework of WHO's definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions, and systems at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

Reproductive Child Health Department. Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging: Sharpened and Investment Case Plan II, 2022/23 – 2026/27. Ministry of Health, Kampala (Uganda): MOH; 2023.

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