



THE REPUBLIC OF UGANDA  
**MINISTRY OF HEALTH**

# THE NATIONAL ESSENTIAL HEALTH CARE PACKAGE FOR UGANDA

August 2024

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## ABBREVIATIONS AND ACRONYMS

<b>AHSPR</b>	Annual Health Sector Performance Report
<b>DALYS</b>	Disability Adjusted Life Years
<b>DHIS2</b>	District Health Information Software 2
<b>EMHS</b>	Essential Medicines and Health Supplies
<b>FY</b>	Financial year
<b>GBV</b>	Gender-based violence
<b>GoU</b>	Government of Uganda
<b>HC</b>	Health Centre
<b>HCDP</b>	Human Capital Development Program
<b>HDP</b>	Health Development Partners
<b>HMIS</b>	Health Management Information System
<b>HPAC</b>	Health Policy Advisory Committee
<b>LG</b>	Local Government
<b>MDAs</b>	Ministries, Departments, and Agencies
<b>MoH</b>	Ministry of Health
<b>NCD</b>	Non-Communicable Disease
<b>NDP II</b>	Second National Development Plan
<b>NDP III</b>	Third National Development Plan
<b>NHA</b>	National Health Accounts
<b>NHIS</b>	National Health Insurance Scheme
<b>NHP II</b>	Second National Health Policy
<b>NHP III</b>	Third National Health Policy
<b>NRH</b>	National Referral Hospital
<b>NTD</b>	Neglected tropical disease
<b>OOP</b>	Out of pocket
<b>PHC</b>	Primary Health Care
<b>PHP</b>	Private Health Practitioner
<b>PIAP</b>	Programme Implementation Action Plan
<b>PNFP</b>	Private Not-For-Profit
<b>RRH</b>	Regional Referral Hospital
<b>SDGs</b>	Sustainable Development Goals

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<b>TB</b>	Tuberculosis
<b>UDHS</b>	Uganda Demographic and Health Survey
<b>UHC</b>	Universal Health Coverage
<b>UHI</b>	Uganda Heart Institute
<b>UNEHCP</b>	Uganda National Essential Health Care Package
<b>UNMHCP</b>	Uganda National Minimum Health Care Package
<b>UNHS</b>	Uganda National Household Survey
<b>UNPS</b>	Uganda National Panel Survey

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## OPERATIONAL DEFINITIONS

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<b>Primary Health Care:</b>	Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford.
<b>Universal Health Coverage:</b>	All persons in Uganda have equitable access to comprehensive quality health and related services that they need, without financial constraints — all delivered through a multisectoral approach.
<b>Essential Health Care Package:</b>	A selected package of health services that a government provides or aspires to provide to its citizens. This term is often used interchangeably with the term Health Benefit package.
<b>Uganda National Essential Health Care Package:</b>	A package of essential, cost effective, affordable, preventive, promotive, rehabilitative, curative, and palliative services provided universally to the population in Uganda relative to need, through a multisectoral and collaborative approach.

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## FOREWORD

An Essential Health Care package is a selected package of health services that a government provides or aspires to provide to its citizens. The package reflects the government's commitment to ensuring a healthy and productive population and provides a strong framework for directing planning and investment for health service delivery. The Uganda National Minimum Health Care Package (UNMHCP) was developed in 1999 and has undergone periodic reviews overtime. As Uganda continues to undergo significant changes in its social, demographic, economic, and epidemiological structure, it has re-defined its national strategic direction through the Vision 2040, the National Development Plan III, and the National Health Policy III. The country is also committed to achieving the Sustainable Development Goals (SDG) and Universal Health Coverage (UHC) agendas by the year 2030. In light of these changes, the Ministry of Health set out to review the existing UNMHCP and develop a new Uganda National Essential Health Care Package (UNEHCP) that reflects the country's commitment to the SDG and UHC agenda, recognizes the current constraints to effective service delivery (resources, technologies, and system capacities, among others), and is aligned to Uganda's new national strategic direction.

The UNEHCP has been defined as a package of essential, cost-effective, affordable, preventive, promotive, rehabilitative, curative, and palliative services provided universally to the population in Uganda relative to need, through a multisectoral and collaborative approach.

The goal of the UNEHCP is to increase UHC coverage in Uganda from 69% to 85% by 2030 through delivery of an affordable and responsive health benefits package. The life course approach has been used aiming at improving health as well as reduce morbidity and mortality during all stages of life.

The package comprises of seven clusters of services: 1) Health promotion, disease prevention, and community health initiatives; 2) Management and control of communicable diseases; 3) Management and control of non-communicable diseases; 4) Reproductive, maternal, newborn, child, and adolescent health; 5) Surgical and anaesthesia care; 6) Emergency, high dependency, and critical care; and 7) Geriatric care. The services in the package will be provided by the public and private sectors to meet population needs at different stages of the life cycle in accordance with the service delivery standards of the country.

I therefore call upon all the health sector and non-health sector actors with key roles to play in determining the health of Ugandans to internalize the content and work together towards achieving UHC in Uganda.

For God and my Country,



Dr. Jane Ruth Aceng Ocerro  
**MINISTER OF HEALTH**



## PREFACE

The UHC goal requires an articulation of the health care benefit package which not only represents the government's commitment to the people, but also guides resource allocation and investment in the health sector. As a sector, we believe that the developed package offers the country an opportunity to optimally invest and deploy resources to achieve value for resources while achieving the ultimate objective of improving population health.

This essential health care package provides a framework for directed planning and investment for health service delivery. It will guide the country to (re) focus resources to critical service areas and packages that address need and optimize population health outcomes. We are cognizant of the fact that a number of elements within the service package are beyond the mandate of the Ministry of Health, and so delivering this package requires a multisectoral and multi-institutional effort and a well-developed framework for coordination. The health sector therefore commits to work with other key sectors and stakeholders to achieve UHC.

I urge all stakeholders to support the sector in ensuring effective delivery of the package through increasing funding to the health sector and investments in health systems strengthening and technology; prioritizing community mobilization, health promotion, disease prevention, and mindset change; integrating of service delivery; providing quality services; strengthening referral pathways; and enhancing public private partnerships for health.

Health is Wealth,



Dr. Diana Atwiine

**PERMANENT SECRETARY**

## ACKNOWLEDGEMENTS

The Essential Health Care Package that has been developed is a culmination of a protracted process involving consultation, engagement, and consensus with various sector stakeholders who have provided input at the different stages of the process.

The Ministry of Health would like to extend its appreciation to all the stakeholders who supported the development of the Uganda National Essential Health Care Package by providing technical and financial support. I recognize the contribution of all the stakeholders, including Ministries, Local Governments, Health Development Partners, technical working groups, academia, civil society, and researchers who richly participated and contributed to this process. I also appreciate the technical support provided by the Thanzi la Onse project through the Health Economics Policy Program.

Special gratitude goes to the Steering Committee chaired by Dr. Charles Olaro, Director Health Services Clinical Services; Dr. Sarah Byakika Kyeyamwa, Commissioner Health Services for Planning, Financing, and Policy; and her departmental team that worked closely with the Uganda Health Systems Strengthening (UHSS) Activity and Makerere University School of Public Health to ensure that the package is holistic, inclusive, and aligned to key National Policy Documents.

Lastly, the MoH appreciates the U.S. Agency for International Development UHSS Activity, implemented by Palladium, who funded the development of the UNEHCP.



Dr. Henry G. Mwebesa

**DIRECTOR GENERAL HEALTH SERVICES**

## 2 INTRODUCTION

### 2.1 Background

Uganda is committed to achieving the Universal Health Coverage (UHC) goal by 2030. UHC emphasizes access to good quality health care according to need, while at the same time limiting exposure to financial risk for those who seek care. Achieving UHC is a cornerstone of the Sustainable Development Goals (SDGs), which have been defined as the new global development goals. In light of this, the Third National Health Policy (NHP III), the National Development Plan 2020–25 (NDP III), Human Capital Development Program (HCDP) Implementation Plan, and the Uganda UHC Roadmap 2020–2030, have been developed. It is envisaged that this policy framework will serve as a critical element in Uganda’s pathway to achieving the health-related SDGs and attaining UHC. These strategic documents articulate the priority agendas and investments that will be pursued for the coming period in light of the UHC goal. The UHC goal requires an articulation of the health care benefit package which not only represents government commitment to the people, but also guides resource allocation and investment in the health sector.

The current Uganda National Minimum Health Care Package (UNMHCP) was developed in 1999. The epidemiological, demographic, and socioeconomic dynamics in Uganda have necessitated a comprehensive review of the existing package and development of the Uganda National Essential Health Care Package (UNEHCP) that is aligned to Uganda’s new national strategic direction as presented in the Vision 2040 and NDP III, and that reflects Uganda’s commitment to the UHC and SDG agenda. In developing the Essential Health Care Benefits Package, the Ministry of Health (MoH) is cognizant of the fact that a number of elements within the service package are beyond the mandate of the Ministry, and so delivering this package requires a multisectoral and multi-institutional effort, and a well-developed framework for coordination.

### 2.2 Rationale for the UNEHCP

The UNEHCP provides a framework for directed planning and investment for health service delivery. With significant resource constraints in the short and medium term, the UNEHCP will guide the country to (re) focus resources to critical service areas and packages that address need and optimize population health outcomes. If well implemented, the UNEHCP will allow for provision of a comprehensive package within a well-defined service provision framework and referral pathway to ensure efficient utilization of health care resources.

### 2.3 The UNEHCP Development Process

The task was undertaken with oversight and guidance from the UNEHCP Development Advisory Committee chaired by the Director Health Services, Clinical Services, and the MoH Department of Planning, Financing, and Policy. Starting in May 2021, the process was consultative and participatory and included a series of wide-ranging consultative workshops, panel discussions, and key informant interviews with key stakeholders, including civil society

representatives, Health Development Partners (HDPs), other international partners, professional associations, and experts in different fields of medicine — such as surgeons, mental health practitioners, paediatricians, gynaecologists, and academicians. It was also guided by evidence generated through an extensive review of literature or relevant documents, including but not limited to the current UNMHCP, National Health Accounts (NHA) studies, NHP III, and international evidence on developing and implementing the essential health care benefit packages. Evidence from work done on an optimum benefit package for Uganda by the University of York, MoH, and Makerere University School of Public Health was also reviewed.

The draft report was peer reviewed by several stakeholders, to ensure that the developed package reflects the stakeholder discussions as well as the country context. The final draft of the UNEHCP was presented to the Top Management Committee of the MoH for final approval.

The steps that were undertaken are summarised below:

- i) **Step One.** Setting goals and criteria for selecting packages of services and interventions. This was done in collaboration with the stakeholders. The criteria included burden of disease, cost effectiveness, equity and financial protection, and feasibility.
- ii) **Step Two.** Operationalizing the criteria and agreeing on methods for option appraisal.
- iii) **Step Three.** Building consensus on the shape of the package (service type and scope and delivery levels, eligible population, access controls, and provider network).
- iv) **Step Four.** Collating all existing evidence and new evidence and identifying any missing evidence that needed to be brought to the discussion.
- v) **Step Five.** Conducting an appraisal and costing of potential lists of interventions and agreeing upon alternative scenarios for costing.
- vi) **Steps 6 and 7.** Deliberating with stakeholders for consensus on the final UNEHCP.

## 2.4 Structure of the UNEHCP

Chapter one outlines the rationale for the development of the UNEHCP and the development process of the package. Chapter two summarizes a brief overview of Uganda's macroeconomic and fiscal context and describes the key highlights of the situation analysis for Uganda's health sector, particularly focusing on key health sector indicators that are relevant to this work. Chapter three outlines the key components of the six clusters of the UNEHCP. Furthermore, it details the level of delivery for different components of the package as well as the target groups. Chapter four provides a summary of the cost of implementation of the different clusters within the UNEHCP projected over a 10-year period. Chapter five highlights the implementation arrangements for the delivery of the package, whereas chapter six details the indicators that will be used to monitor the implementation of the package.

## 3 SITUATION ANALYSIS

### 3.1 Macroeconomic and Fiscal Context of Uganda

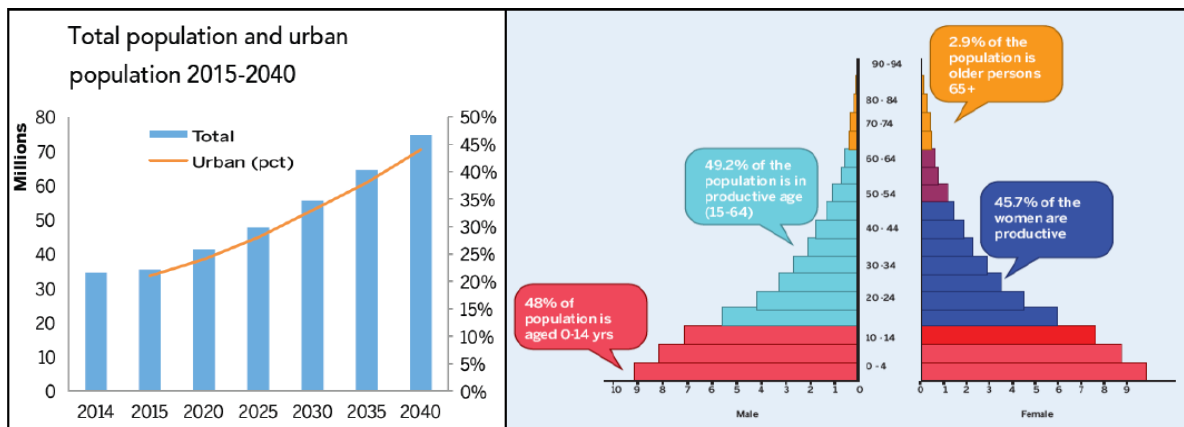
Uganda is a low-income country with an estimated nominal size of the economy standing at UGX 128 trillion as of financial year (FY) 2018/19 (National Planning Authority, 2020). Since 2018, the country's economic outlook has been more positive given a recovery in private sector credit, favourable weather conditions, increase in Foreign Direct Investment, and the continued robust government investment in infrastructure (PwC, 2019). However, the COVID-19 pandemic greatly affected its Gross Domestic Product growth from 6.8% registered in FY 2018/19 to the 3.3% registered in FY 2020/21 (Bank of Uganda, 2021). The reduction in growth was primarily driven by the lockdown measures that were implemented to curb the spread of the virus (National Planning Authority, 2021). Uganda's ratio of domestic revenue to gross domestic product is still low, projected to range from 12.9% in FY 2020/21 to 15.3% in FY 2023/24 (Ministry of Finance, Planning, and Economic Development, 2021). Revenue collection has significantly reduced since some businesses are still struggling to recover from the effects of COVID-19. Low revenue collections have implications on the country's ability to finance its services, including providing health care services to the citizens. The country's estimated per capita income was USD 817 as of 2020 (World Bank, 2021). The proportion of Ugandans living below the national poverty line declined from 31.1% in 2006 to 19.7% in 2013, when the economy was growing at an average of 7% per year, however, the statistic rebounded with an increase in the poverty rate to 21.4% in 2017 (Uganda Bureau of Statistics, 2018). Using the international poverty threshold of USD 3.20 per day, nearly 75% of Ugandans would be categorized as poor. There is notable widening income inequality across regions and high unemployment. Unemployment and income inequalities worsen the dependency ratio and decrease capital accumulation, for the small working population. Furthermore, they decrease the population's potential to invest in health promotion activities and health-seeking practises that require cash contributions.

### 3.2 Demographic Profile

As of 2020, Uganda's population was estimated to be 42.5 million, with an annual population growth rate of 3.34%. The country's fertility rate is 4.9 births per woman, and the life expectancy is 64 years (Uganda Bureau of Statistics, 2020). Uganda's population is generally young, with 53.1% below the age of 18 years and only 3.7% above 60 years (Uganda Bureau of Statistics, 2019). Uganda could also benefit from the demographic dividend if it skilled its population, enabling them to engage in productive activities. Indeed, the Country's NDP III outlines several strategies that are aimed at enhancing the human capital of the country to derive increased benefits from its youthful population.



**Figure 1: Demographic profile for Uganda**



Source: Draft Health Sector Development Plan II (2021)

Uganda’s demographic structure indicates that a high proportion of its population is within the reproductive age group, which implies that its population is also likely to grow even more rapidly if family planning use is not increased. This high population growth rate has implications for health care needs, planning, and resources. With the current demographic structure, the service requirements for maternal and child health care as well as adolescent reproductive health care are likely to be immense. For example, if every year, about 1.6 million pregnancies are expected, this translates into nearly 17 million visits to the health care system annually for various reasons — including pregnancy and child care services, neonatal care, vaccination, etc. Similarly, the increased life expectancy indicates that the aging population will increasingly require geriatric care.

### 3.3 Epidemiologic Profile

Uganda’s burden of disease is characterised by communicable diseases, childhood illnesses, and, of recent, non-communicable diseases (NCDs). Over the past two decades, Uganda has succeeded in reducing its maternal mortality ratio (from 506 per 100,000 live births in 2000 to 336 per 100,000 live births in 2016 and 189 per 100,000 live births in 2022), under five mortality (from 151 per 1,000 live births in 2000 to 64 per 1,000 in 2016 and 52 per 1,000 live births in 2022) and infant mortality (from 88 per 1,000 live births in 2000 to 43 per 1,000 in 2016 and 36 per 1,000 live births in 2022). Neonatal mortality has reduced only slightly from 33 per 1,000 live births in 2000 to 27 per 1,000 live births in 2016 and 22 per 1,000 live births in 2022. Maternal mortality is mainly attributed to haemorrhage (46%), hypertensive disorders (11%), puerperal sepsis (6%), and abortion-related complications (5%) (MoH, 2021). These statistics demonstrate that while Uganda is on the right trajectory, a lot still needs to be done.

Table 1 displays the most common causes of death and disability and their risk factors according to the global burden of disease studies. The five most common causes of death among all ages reported in the Annual Health Sector Performance Report (AHSPR) 2020/2021 were malaria (10.9%), pneumonia (6.4%), other neonatal conditions (5.3%), anaemia (4.5%), and asthma (3.9%). Although not among the top five causes, premature babies (3.2%) and

septicaemia (3.1%) are also important causes of mortality. Prematurity has been a main cause of newborn mortality over the years.

A comparison of the 2020/2021 and the 2010/2011 AHSPRs indicates that the percentage contribution of malaria, pneumonia, and anaemia to hospital-based mortality has decreased by 10%, 1.4%, and 2%, respectively. On the other hand, the percentage contribution of neonatal conditions and road traffic accidents has increased by 2.3% and 1%, respectively. The increase in road traffic accidents is most likely due to increase in due to boda bodas (motorcycles), which have become a major form of transport. It is also worth noting that according to the above mentioned AHSPRs, HIV/AIDS-related causes — which were the second most common cause of hospital-based mortality in 2010/2011 (9.4%) — are no longer among the top 20 causes of hospital-based mortality whereas cardiovascular diseases, which were not among the top 10 causes in 2010/2011, now contribute 7% to hospital-based mortality.

**Table 1: Burden of disease estimates from 2019**

No.	Most common causes of deaths & disability combined	Most common causes of deaths	Causes of death & disability (disability adjusted life years)	Risk factors for most deaths & disability combined
1	Neonatal disorders	Neonatal disorders	HIV/AIDS	Malnutrition
2	Malaria	Malaria	Neonatal disorders	Air pollution
3	HIV/AIDS	HIV/AIDS	Malaria	Unsafe sex
4	Lower respiratory infections	Lower respiratory infections	Tuberculosis	Water, sanitation, and hygiene
5	Diarrheal diseases	Tuberculosis	Lower respiratory infections	Alcohol use
6	Congenital defects	Stroke	Stroke	High blood pressure
7	Tuberculosis	Diarrhoeal diseases	Diarrhoeal diseases	High fasting plasma glucose
8	Sexually transmitted infections	Ischemic heart disease	Ischemic heart disease	High body mass index
9	Measles	Congenital defects	Diabetes	Occupational risks
10	Road injuries	Sexually transmitted infections	Depressive disorders	Tobacco

### 3.4 Social Determinants of Health

Burden of disease studies indicate that more than 75% of Uganda’s disease burden is preventable and could be averted at the community level. Interventions that address the social determinants of health and wellbeing can generate potential savings to households and the health care system. The saved resources can then be reprioritized to provide other critical essential services with a focus on improving access to safe water, sanitation, and hygiene; air quality; housing; occupational health; nutrition; and physical activity; and reducing alcohol intake, trauma, and injury. It has been noted that the UNMHCP, as re-defined and applied in the 2016 Health Sector Service Standards for the different levels of health service delivery, did not adequately address the broader social determinants of health. As such, intersectoral interventions and strong multisectoral collaboration together with re-orientation of the health



care system need to be emphasized. The MoH has indeed re-echoed the need to address the key determinants of health as highlighted in Figure 2.

**Figure 2: Determinants of health in Uganda**

<p><b>PHYSICAL ENVIRONMENT</b></p> <ul style="list-style-type: none"> <li>• 2-3/100 people die in road traffic accidents</li> <li>• Poor housing conditions:             <ul style="list-style-type: none"> <li>○ 29% access electricity</li> <li>○ 95% use solid fuel for cooking</li> <li>○ 52% have cement screed floors</li> </ul> </li> <li>• Poor hygiene and sanitation:             <ul style="list-style-type: none"> <li>○ 52% have treated water</li> <li>○ 78% access improved water source</li> <li>○ 34% have hand washing facility with soap and water</li> <li>○ 19% have an improved toilet</li> </ul> </li> <li>• Poor urban environment quality (air, buildings, water, safety, vermin, commercial food quality, and safety)</li> </ul>	<p><b>BEHAVIOURAL AND BIOLOGICAL CO</b></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Risk / Protective</b></p> <ul style="list-style-type: none"> <li>• 90% tobacco non-smoking</li> <li>• 5.8% use alcohol</li> <li>• Sexual activity</li> <li>• Lack of physical exercise</li> <li>• Poor oral health practices</li> <li>• Poor response to health problems</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Responses to Health</b></p> <ul style="list-style-type: none"> <li>• Poor care and screening seeking</li> <li>• Low treatment compliance</li> <li>• Self and unprescribed medication</li> <li>• Low genetic disease cognition</li> </ul> </td> </tr> </table>		<p><b>Risk / Protective</b></p> <ul style="list-style-type: none"> <li>• 90% tobacco non-smoking</li> <li>• 5.8% use alcohol</li> <li>• Sexual activity</li> <li>• Lack of physical exercise</li> <li>• Poor oral health practices</li> <li>• Poor response to health problems</li> </ul>	<p><b>Responses to Health</b></p> <ul style="list-style-type: none"> <li>• Poor care and screening seeking</li> <li>• Low treatment compliance</li> <li>• Self and unprescribed medication</li> <li>• Low genetic disease cognition</li> </ul>
<p><b>Risk / Protective</b></p> <ul style="list-style-type: none"> <li>• 90% tobacco non-smoking</li> <li>• 5.8% use alcohol</li> <li>• Sexual activity</li> <li>• Lack of physical exercise</li> <li>• Poor oral health practices</li> <li>• Poor response to health problems</li> </ul>	<p><b>Responses to Health</b></p> <ul style="list-style-type: none"> <li>• Poor care and screening seeking</li> <li>• Low treatment compliance</li> <li>• Self and unprescribed medication</li> <li>• Low genetic disease cognition</li> </ul>			
<p style="text-align: center;"><b>SOCIAL ECONOMIC</b></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Socio Cultural</b></p> <ul style="list-style-type: none"> <li>• Unfavourable social norms and attitudes towards healing, stigma, gender</li> <li>• Poor health cognition</li> <li>• Dwindling family and support networks</li> <li>• Low trust in public services</li> <li>• Poor parenting skills</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Economic</b></p> <ul style="list-style-type: none"> <li>• Low health literacy</li> <li>• High unemployment</li> <li>• Industry and works construction, toxic waste</li> <li>• Insufficient workplace safety</li> <li>• Exposure to negative mass media</li> <li>• Low use of health technologies</li> </ul> </td> </tr> </table>	<p><b>Socio Cultural</b></p> <ul style="list-style-type: none"> <li>• Unfavourable social norms and attitudes towards healing, stigma, gender</li> <li>• Poor health cognition</li> <li>• Dwindling family and support networks</li> <li>• Low trust in public services</li> <li>• Poor parenting skills</li> </ul>	<p><b>Economic</b></p> <ul style="list-style-type: none"> <li>• Low health literacy</li> <li>• High unemployment</li> <li>• Industry and works construction, toxic waste</li> <li>• Insufficient workplace safety</li> <li>• Exposure to negative mass media</li> <li>• Low use of health technologies</li> </ul>	<p style="text-align: center;"><b>Key Determinants of Disease in Uganda</b></p> <p style="text-align: center;"><b>DIET AND NUTRITION</b></p> <ul style="list-style-type: none"> <li>• 40% population undernourished</li> <li>• 32% of women and 16% of men are anaemic (iron deficiency)</li> <li>• Among children:             <ul style="list-style-type: none"> <li>○ 53% anaemic</li> <li>○ 29% stunted</li> <li>○ 10% underweight</li> <li>○ 9% deficient in Vitamin A</li> <li>○ deficient in Zinc</li> </ul> </li> </ul>	
<p><b>Socio Cultural</b></p> <ul style="list-style-type: none"> <li>• Unfavourable social norms and attitudes towards healing, stigma, gender</li> <li>• Poor health cognition</li> <li>• Dwindling family and support networks</li> <li>• Low trust in public services</li> <li>• Poor parenting skills</li> </ul>	<p><b>Economic</b></p> <ul style="list-style-type: none"> <li>• Low health literacy</li> <li>• High unemployment</li> <li>• Industry and works construction, toxic waste</li> <li>• Insufficient workplace safety</li> <li>• Exposure to negative mass media</li> <li>• Low use of health technologies</li> </ul>			

### 3.5 Uganda’s Health Care Financing Landscape

Uganda’s main sources of health care financing are public funds, private funds (voluntary prepayment and out-of-pocket (OOP) expenditures), and donor (external resources) as detailed in Figure 3. There are a number of key points that emerge from the financing trend presented in Figure 3 and Table 2: 1) Per capita funding for health has reduced over the last 10 years; 2) Per capita expenditure on health is currently at USD 36.9, which is far below the international targets and commitments to achieve UHC; 3) Generally, the health sector is under-financed and the allocation from the Government of Uganda’s (GoU’s) budget has no prospects of reaching the 15% Abuja commitment to health financing; 4) Private expenditure is still high, estimated at 41.4% (Figure 3), of which the largest portion is met by households through OOP, making households vulnerable to catastrophic expenditure and impoverishment (Kwesi et al., 2020); 5) External funding continues to constitute a large health financing portfolio for Uganda (41.4%), which presents challenges related to sustainability, prioritization, and reliability for the medium and long term.

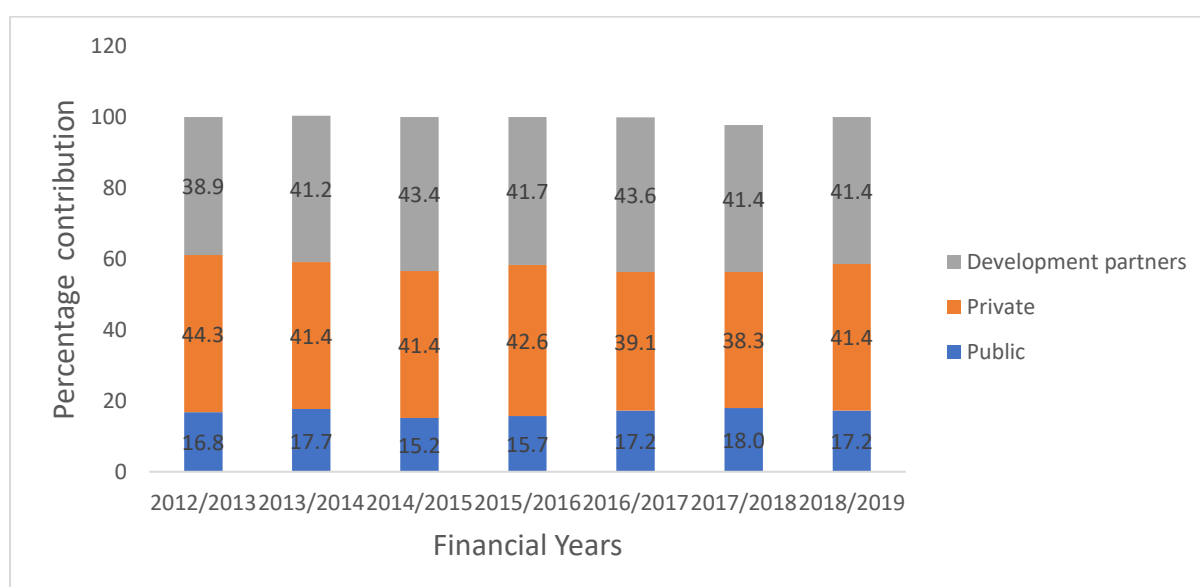
**Table 2: Key health financing indicators 2014/15 - 2018/19**

	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19
CHE (UGX millions)	4,944,945	5,309,654	4,607,623	5,107,226	5,273,022
THE (UGX millions)	4,866,846	5,174,058	4,749,592	5,241,586	5,492,478
GDP (UGX millions)	76,712,725	86,549,765	108,518,000	119,907,000	128,499,000
GHE (as a % of TGE)	8.7	6.4	8.9	6.7	7.2
Population (millions)	34,856,813	35,902,519	37,328,592	38,535,758	39,779,408
THE per capita (UGX thousands)	143,299	147,869	127,237	136,019	138,073
THE per capita (USD)	51	51.4	36	37.2	36.9

Key: Current Health Expenditure (CHE), Total Health Expenditure (THE), Gross Domestic Product (GDP), Total Government Expenditure (TGE)

Source: NHA Reports, 2016 and 2020

**Figure 3: Health financing trends**



Source: NHA Reports, 2012/2013–2018/2019

Uganda has a Health Financing Strategy 2015–2025, which proposes a number of innovative approaches and reforms to health financing in Uganda. Results-based financing, one of the proposed initiatives, is a purchasing method that can promote more efficient use of resources and foster strategic purchasing of cost-effective services. The health sector, with support from HDPs, is currently rolling out results-based financing under the Uganda Reproductive Maternal and Child Health Investment Project (URMCHIP) and Enhancing Health in Acholi Sub-Region project, with all 135 districts and Kampala City Council Authority covered. However, the URMCHIP results-based financing program is focused largely on services that fall under reproductive, maternal, newborn, child, and adolescent health, hence other services within the UNMHCP get only spill-over benefits from this initiative. The Government is also in the process of establishing the National Health Insurance Scheme (NHIS). In March 2021, Parliament passed the NHIS bill. However in September 2021, it was returned to the MoH for resubmission to the new Parliament in line with expected stipulated legislative procedures upon expiry of the term of office of a Parliament before the President’s assent to the bill.

### 3.6 Policy Environment and Context

The national development and strategic direction for the country is guided by the Vision 2040, which is the overall framework for the development and transformation of Uganda. To achieve the Vision 2040, the National Planning Authority developed the NDP III. The goal of this plan is to “*increase household income and improve quality of life through increasing productivity, inclusiveness, and wellbeing of the population*”. In the NDP III, human capital development has been emphasized as critical to national development and transformation of the society. Indeed, the health sector’s contribution is entrenched in the fourth objective of the NDP III: “*Enhance the productivity and social wellbeing of the population*”. The health sector will contribute to the NDP through the HCDP, as reflected in Table 3.

**Table 3: NDP objectives for the health sector**

Objective	Outcomes
<b>Objective 1: Improve the foundations for human capital development</b>	Reduced prevalence of under-five stunting from 28.9% to 19%
	Reduced neonatal mortality rate from 27 deaths per 1,000 live births to 19 deaths per 1,000 live births
	Reduced under-five mortality rate from 64 deaths per 1,000 live births to 42 deaths per 1,000 live births
<b>Objective 4: Improve population health, safety and management</b>	Reduced maternal mortality ratio from 336 deaths per 100,000 live births to 211 deaths per 100,000 live births
	Reduced unmet need of family planning from 28% to 10% and increased contraceptive prevalence rate from 35% to 50%
	Reduced mortality due to high-risk communicable diseases (malaria, tuberculosis, and HIV/AIDS) from 60% in 2017 to 30%
	Increased access to safe water supply from 70% to 85% (rural) and from 74% to 100% (urban)
	Increased access to basic sanitation from (improved toilet) 19% to 40% and hand washing from 34% to 50%
	Increased proportion of the population accessing universal health care from 44% to 65%

*Source: NDP III. Human Capital Development Programme Implementation Action Plan*

At the sub-program level, the MoH has recently developed the NHP III, HCDP Implementation Action Plan, and Uganda UHC Roadmap 2020–2030, which are strategic documents that serve as a basis for planning and resource investments within the health sector. The overriding objective of the NHP III is to have “*a healthy and productive population that contributes to socio-economic growth and national development,*” while the mission is to “*provide high quality and accessible health services to all people in Uganda, including addressing broader determinants of health to attain socio-economic development and a prosperous life*”. The NHP acknowledges that the country is faced with a range of challenges that include a rapidly growing population with key demographic changes in its young and elderly population groups, epidemiological transitions, and an increase in unhealthy lifestyles as well as socio-economic challenges. The priorities of the NHP III include enhancing health prevention and health promotion, effective multisectoral action, reinvigorated Primary Health Care (PHC) and population health management, integrated health systems and care, empowering households to

take charge of their health, and sustainable health financing. The main objective of the UHC roadmap is to define a critical path by providing clarity on the strategic actions and sequencing for the main interventions and milestones to the attainment of UHC in Uganda by 2030. One of the strategic actions in the roadmap is to “Improve the quality, availability, and breadth of essential health care services and increasingly specialized services”. The major shifts in this program are to: 1) Reduce the volume of care through effective prevention and health promotion; 2) Clarify what service packages to expand in the “essential health care package”; 3) Boost the quality of the services package; and 4) Mitigate OOP expenditures.

### 3.7 Progress with the Implementation of the UNMHCP

Uganda has been implementing the UNMHCP, which was established in the country’s first National Health Policy in 2000. The UNMHCP comprised of a range of services that had been classified into four clusters: 1) Health promotion, environmental health, and community health initiatives; 2) Prevention and control of communicable diseases; 3) Prevention and control of NCDs, disabilities, injuries, and mental health problems; and 4) Maternal and child health (Table 4). These services are provided across various levels of the health care delivery system.

**Table 4: Key components of the UNMHCP**

Cluster	Components
<b>Cluster 1:</b> Health promotion, environmental health, disease prevention, and community health initiatives, including epidemic and disaster preparedness and response	Health promotion and education
	Environmental health
	Control of diarrhoeal diseases
	School health
	Epidemics and disaster preparedness and response
	Occupational health
<b>Cluster 2:</b> Prevention, management, and control of communicable diseases	Sexually transmitted infections / HIV/AIDS
	Tuberculosis
	Malaria
	Diseases targeted for eradication / elimination (leprosy, guinea worm, sleeping sickness, onchocerciasis, schistosomiasis, trachoma, lymphatic filariasis, and poliomyelitis)
<b>Cluster 3:</b> Prevention, management, and control of NCDs	NCDs
	Injuries, disabilities, and rehabilitative health
	Gender-based violence (GBV)
	Mental health and control of substance abuse
	Integrated essential clinical care
	Oral health
	Palliative care
<b>Cluster 4:</b> Maternal and child health	Sexual and reproductive health and rights
	Newborn health and child survival
	Management of common childhood illnesses
	Expanded Program on Immunization
	Nutrition

Source: Health Sector Service Standards and Service Delivery Standards, 2016

The package has been used as a guide to direct health sector priorities and health systems investments to enhance the provision of services. It is, however, difficult to fully assess the extent to which the package has been implemented given the large number of interventions and the challenge of relevant data. However, there are key issues that were noted from the document review, the stakeholder interactions, and key informant interviews, which are summarized below:

- i. Size of the existing package:** The service delivery packages under the UNMHCP have been updated periodically in line with the changing demographics and epidemiology as well as available data on cost-effective interventions. There are, however, concerns that the existing package is too large and not feasible given the Ugandan economic and, specifically, the health financing contexts, in the short to medium term. In its current form, the package is broad and not clearly defined to focus on priority services that could be delivered within the existing context (Makerere University School of Public Health, 2016) using the life course approach. Otherwise, the package represents an attempt to increase coverage, but at the same time leads to a situation where less and less is offered moreover with compromised quality. It would be prudent to narrow the package and focus resources on addressing the needs of the poor and vulnerable (Ssengooba, 2004; Maynard & Bloor, 1996).
- ii. Emphasis on communicable conditions:** It has also been noted that the existing UNMHCP package is more explicit about the communicable diseases compared to the NCDs and their risk factors, and yet the burden of disease has changed overtime. The epidemiological transition has generated new disease trends and patterns specifically NCDs, which would imply that the package needs to be aligned to this new reality. Interventions must be identified and implemented to address the risk factors for NCDs including lifestyle, occupational hazards, road traffic accidents, environmental health and pollution, etc. (Kadowa, 2017).
- iii. Misalignment between resources and burden of disease:** The previous package took into consideration the burden of disease measured in Disability Adjusted Life Years (DALYS) lost. In that analysis, the largest burden in terms of DALYS lost was attributed to selected NCDs and maternal and neonatal health conditions. However, resource allocation and alignment does not reflect this pattern. The distribution of resources is more skewed towards communicable diseases, particularly HIV and other sexually transmitted infections (43%), malaria (21%), nutritional deficiencies (4%), injuries (4%), NCDs (13%), maternal conditions (9%), and other unspecified diseases and conditions (4%) (NHA, 2018).
- iv. Financing landscape for the UNMHCP:** In terms of financing, it has been noted that the UNMHCP is financed by the government (17%), donors (41%), and households (41%). Although public funding is the most reliable source of funding for achieving UHC, the per capita public funding for health has largely remained below the estimated optimal level of funding — yet population needs have changed overtime. Inadequate financing is a critical challenge of the UNMHCP implementation and achieving the main objective of the minimum package. The estimated costs of delivering the UNMHCP is generally beyond

the available resources. For example, in 2008/09, delivering the package was estimated to cost USD 41.2 per capita, but the budget allocation was USD 12.5 (Brown et al., 2009). According to the NHA, the targeted per capita health expenditure in 2019/20 was USD 151 but it was actually USD 43 in 2018, representing a significant gap in resource requirements to deliver services (NHA, 2018). Besides the limited funding portfolios, the funding mechanism for delivering services in Uganda is such that funding allocations are provided to providers — Local Governments (LGs) and facilities — on a quarterly basis. In some circumstances, most of the funding is earmarked, with limited leeway for reallocations based on locally relevant and context-specific needs (Zikusooka et al., 2009; GoU, 2016b). To these, add the challenge of emerging trends in health care technologies such as new vaccine introductions, new medicines and products, and new technological advancements that are adopted as a result of discourse, dynamics, and commitments to global agenda. The new adoptions come with fixed (and often) high prices, which translate into substantially high costs of service delivery. Ultimately, new medicines and products enlarge the already constrained budgets (Nazerali and Oteba, 2005), because these have to be included in the essential child packages.

- v. **Clarity on service delivery costs:** The package is delivered by both public and private facilities; in which case the private sector complements the public sector effort. However, lack of clear cost estimates for delivering services in the private sector limits the effectiveness of public-private partnerships that try to advocate for increased government support towards the private sector (U.S. Agency for International Development Cardio Markets, 2014). Cost estimates in the Health Sector Development Plan, are mainly linked to specific interventions and investment domains along the health system building blocks. This could limit the flow of resources to some specific benefit package elements (Loewenson et al., 2018; Kadowa, 2017). The government subsidies to the non-state actors to complement provision of the UNMCHP have also remained relatively low overtime (Ssenyonjo et al., 2018). While government funding has increased in absolute terms, the share of the government allocation to the health sector has not increased; rather, it has been declining overtime. These realities have not only constrained the government to adequately deliver the UNMHCP commitment but have also exposed households to vulnerabilities associated with OOP expenditures and financial catastrophe, and ultimately undermined the actual objective of reaching out to the poor (GoU, 2016a).
- vi. **Capacity to deliver the UNMHCP:** While the UNMHCP was designed for and indeed is being implemented by both the private and public sector (whole sector), and access to health facilities in the country has now increased to 86% (proportion of people residing within 5 kilometres from a health facility), the public and private facilities do not have the capacity to offer all services stipulated within the package. The general service readiness of health facilities to offer services was estimated at only 52% according to the 2018 Service Availability and Readiness Assessment survey, indicating that facilities do not have adequate capacity and resources to deliver all the envisaged components. Furthermore, services delivered within the private sector attract user fees, making it hard for the population to access the basic packages through the private sector. Informal payments within the public sector have also persisted, acting as obstacles for unfettered access to

essential care (McPake et al., 1999; Kadowa, 2017). Furthermore, there are inherent workforce challenges hampering the delivery of the minimum package — number of health workers, skills mix, geographical allocation, retention, attraction, and motivation and performance management. The staffing norms have not been revisited, and yet the catchment populations of some areas have increased remarkably. Delivery of the package has also been hampered by suboptimal functionality of some of the delivery structures. There are reported stock-outs of essential supplies and dysfunctional equipment and diagnostic technologies. The situation is made worse by the inadequate capacity of the LGs, which are expected to plan, budget, and execute the service delivery mandate but have limited resources and capacities to fulfil this mandate (Matsiko, 2010; GoU 2015a).

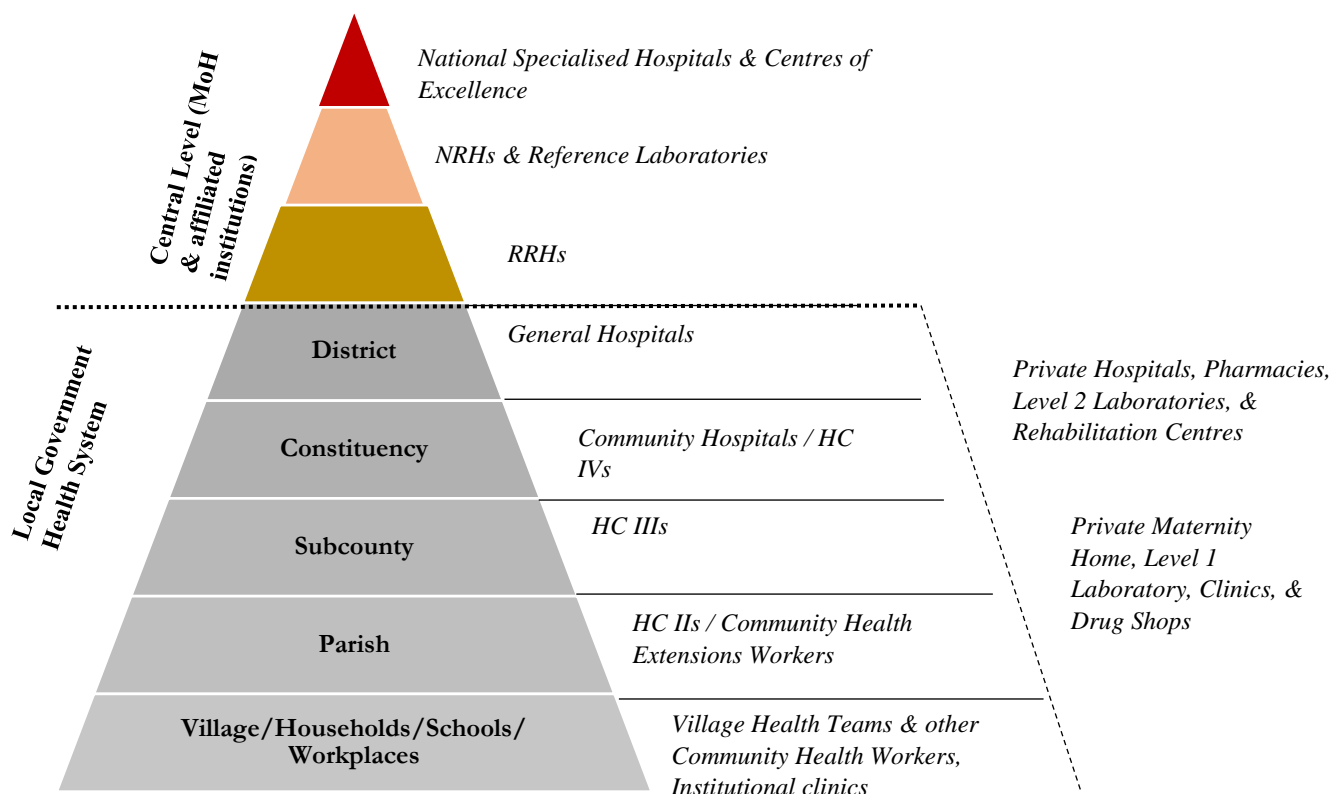
**vii. Integrated service delivery:** Although it has been noted that some reasonable degree of integration has been achieved, some degree of verticalization still exists. For example, malaria control, HIV/AIDS, tuberculosis (TB) / leprosy, and immunization are relatively still delivered vertically. It has been noted that more effort is required to integrate service delivery especially at operational level (Kadowa, 2017).

**viii. Multisectoral approach to delivery of the package:** Existing policy documents such as the UHC Roadmap emphasize the key role played by non-health sectors — such as education and sports, gender and social development, housing and urban development, agriculture, water and environment, works and transport — in promoting good health and the need for multisectoral planning and implementation. The current NDP III is also aligned to the health-in-all policies thinking and is structured around a multisectoral approach to delivery; however, implementation using this multisectoral approach is yet to be fully realized with regard to implementation of the UNMHCP.

### 3.8 Uganda's Health Care Delivery System

Broadly speaking, the country's health system is structured into four layers (Figure 4). The lowest level of care is provided by the village health teams that facilitate health promotion, service delivery, community participation, and empowerment. At the LG levels are general hospitals, Community Hospitals (HC IVs), Health Centre (HC) IIIs and IIs, with HC IIs providing the first level of interaction between the formal health sector and communities. These provide outpatient and community outreach services. The HC IIIs provide basic preventive, promotive, and curative services. The next levels are the Community Hospitals and General Hospitals, which provide all the services provided by the HC IIIs in addition to more complicated services such as surgeries and blood transfusions. The regional referral hospitals (RRHs) provide a higher level of care with more specialised clinical services as well as teaching and research. The national referral hospitals (NRHs) and national specialized hospitals are the most comprehensive, as they provide the highest level of specialist services in addition to all the other clinical and diagnostic services. The patients are expected to seek care from lower levels, with referrals made to higher level facilities only if the services are not available. However, this referral pathway is generally not followed, and patients often self-refer and bypass facilities expected to address their health needs (Ssenyonjo et al., 2018). This lack of a robust gatekeeping framework has resulted in misuse of resources, as doctors and specialists spend a lot of time attending to cases that would ordinarily be handled at PHC facilities.

**Figure 4: Structure of Uganda's health care delivery system**



The services are provided by both the public and private sector. The public sector includes Government health facilities and health service departments of different Ministries, Departments, and Agencies (MDAs). The private health sector comprises of Private Not-for-Profits (PNFPs), Private Health Practitioners (PHPs), and Traditional Contemporary Medicine Practitioners. About 48% of the population in Uganda seeks care from private hospitals/clinics/pharmacies/drug shops, compared to public health facilities (34%). Up to 14% of the population seek care from pharmacies or drug shops, and about 2.6% from other sources including the Traditional Contemporary Medicine Practitioners (UNHS, 2017).

Health service delivery is decentralised within LGs as per the Local Governments Act of 1997. Some central-level functions have also been delegated to national autonomous institutions such as the National Drug Authority, the National Medical Stores, and the Uganda Blood Transfusion Services (Nabukeera, 2016). The mandate to deliver health care services is vested in the LGs as per the decentralization policy. The 1995 Constitution and Local Governments Act of 1997 (now Local Governments Act (Cap 243)) as amended provide for the district as the unit of decentralization and it spells out the functions devolved to LGs and the applicable funding mechanisms. The legal framework provides for involvement of the people in the way they are governed including decision-making, identifying their own problems, setting priorities, and planning for the implementation and monitoring of these priorities. However, there are existing challenges relating to limited fiscal and decision spaces with LGs struggling to undertake their mandate given the limited resources available to them and the conditional



Central Government grants, with limited leeway to re-align funding to locally relevant and emerging service delivery challenges.

## 4 THE UNEHCP

An Essential Health Care Package is a set of priority services and or interventions/programs that have been identified to be cost-effective, affordable, and feasible, and address the existing burden of disease of a country. As already highlighted in the previous sections, the UNEHCP has been developed through an elaborate process involving stakeholders following a review of the existing UNMHCP. The UNEHCP is based on an analysis of the structure of the existing health care delivery system, the strengths, weaknesses, opportunities, threats, as well as experiences from implementing the existing package. The UNEHCP has been defined as a package of essential, cost-effective, affordable, preventive, promotive, rehabilitative, curative, and palliative care services provided universally to the population in Uganda relative to need, through a multisectoral and collaborative approach.

### 4.1 Goal of the UNEHCP

The goal of the UNEHCP is to increase UHC Service coverage index<sup>1</sup> in Uganda from 44% by 2015 to 85% by 2030 through delivery of an affordable and responsive health benefits package.

### 4.2 Specific Objectives of the UNEHCP

The objectives of the UNEHCP are to:

- i) Define a package of essential, cost-effective, and affordable health and non-health services that improve health and wellbeing, to be provided through a multisectoral and collaborative approach.
- ii) Ensure equitable access to quality primary, secondary, tertiary, and quaternary health services that meet priority needs of the population at different stages of the life cycle.
- iii) Guide resource investments in the health sector to achieve optimal output and assure value for resources.
- iv) Enable equitable, efficient, and sustainable mobilization and utilization of resources for the delivery of essential health services and the protection of individuals from catastrophic health expenditures.

### 4.3 Criteria for Consideration of Service Packages and Interventions

From the literature and experiences from other settings, key criteria were elicited for consideration. From these sources, it was noted that the commonly used criteria include cost

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<sup>1</sup> Defined by the SDG UHC service delivery tracer indicators.

effectiveness, effectiveness, disease burden, equity, and budget impact analysis (Hayati et al., 2018; Ochalek et al., 2018; Youngkong et al., 2012). The criteria are summarized in Table 5.

Weights were applied to each criteria to reflect the value that is placed on the criteria in terms of being critical in determining which interventions to include in the package. The exclusion criteria included interventions that are not aligned to the MoH service delivery guidelines and interventions that are not feasible to implement in Uganda over the next 10 years.

**Table 5: Criteria for selection of service packages and interventions**

<b>Criteria</b>	<b>Explanation and Data Source</b>
<b><i>Burden of disease</i></b>	Used to identify the disease conditions that contribute the highest burden of mortality and morbidity to the population. Information related to disease burden was identified from the Global Burden of Disease 2019 estimates and MoH Health Management Information System (HMIS) database as presented in the AHSPRs of the Uganda health sector.
<b><i>Cost effectiveness</i></b>	Used to quantitatively rank and compare health interventions according to the per capita cost of the intervention and according to the health gains that they yield per dollar spent. The cost-effectiveness data was extracted from two cost-effectiveness databases (Tufts Cost-Effectiveness Analysis Registry and WHO-CHOICE).
<b><i>Equity and financial risk protection</i></b>	Used to compare health interventions and the extent to which they benefit key, vulnerable, and less-advantaged populations — either geographically, socio-economically, or both. Targeting is critical in ensuring that the most deserving groups access interventions, and this is ultimately core in protecting the population against catastrophic health expenditure.
<b><i>Budget impact</i></b>	Used to assess the impact that the interventions would have on the health budget. A full budget impact analysis was not undertaken; however, an analysis of the costs of implementing different packages was undertaken, taking into consideration variations in inputs, costs of the inputs, and coverage of the interventions. At least three scenarios were modelled and presented for consideration.
<b><i>Feasibility of implementation</i></b>	Focused on implementation feasibility of an intervention in the short, medium, and long term. Feasibility was assessed with regard to the health systems' capacity to deliver the intervention (human, infrastructure, and others), resource requirements, and public and political acceptability, among others. While the assessment may have been subjective, it nonetheless offered guidance on perceptions of respondents / experts on how quickly (or not) service delivery packages and models can be changed to rhyme with a fast-changing environment.

### 4.3.1 Costing

The UNEHCP costing approach took into consideration the entire framework of provision of service packages and interventions. Inputs into the costing analysis were identified from document / literature review, stakeholder engagement, expert opinions and panels, review of databases, etc. Stakeholders and experts in specific fields on health service delivery and management were contacted to provide technical guidance on the costing and financing aspects that would best suit the implementation for the packages given the limited resources. Through these consultations, additional resources or inputs required for delivering health services were identified, such as equipment, human resources, capital infrastructure, and time.

An activity-based costing approach was used to complete the analysis, where key inputs for each activity were identified, quantified, and costed. This ensured that all aspects of an activity were monetized to facilitate resource estimates. Wear and tear for use of long-term assets were factored into the computations by amortizing the capital assets over their life while in use. The

scope of the service was estimated by extrapolating the service coverages based on the resource's availability as well as the ease with which the constraints would be addressed. Unit cost data was based on a compendium of services provided by the GoU MDAs and PNFP sector players. The costs of the medicines and supplies were based on the indicative price indices from the major suppliers for health products and supplies and indicative expenditure trends obtained through detailed reviews of project expenditures from various funding agencies.

### 4.3.2 Scenario Analysis

Three scenarios were analysed, and Scenario 2 was selected as the most feasible and affordable package for Uganda.

**Scenario 1 (base-case):** The first package included interventions that met the cutoff above. Coverage levels are close to the current levels, and expected resources are closely aligned to the funds currently available with very minimum health system improvements.

**Scenario 2:** The second package included interventions that met the cut off above. Some key interventions in this scenario target only high-risk groups. Secondly, this was a package developed with the assumption that some of the key constraints in the first scenario could be addressed so as to allow increased delivery and subsequently an increased uptake of the services, with doubling of service uptake for services where current coverage is less than 50%. These included improvements in key human resource placements, refurbishments, and equipping of the health facilities, particularly the HC IVs, General Hospitals, RRHs, regional centres / hubs, and select high-volume, lower facilities — in addition to improvements in the logistics and supply chain management systems.

**Scenario 3:** The third package included interventions aimed to achieve much higher coverage (80% and above) and cover a larger target group (low-risk and high-risk patients for some interventions). The package required more health system investments since it aims at achieving national delivery of the interventions. This was an ambitious scenario which presupposes that those constraints have been addressed, resources to the health sector have been markedly increased, and there are adequate resources to scale up all major services across the country.

## 4.4 Eligible Population

The eligible population will include all persons in Uganda. The life-course approach aims at improving health and reduce morbidity and mortality during key stages of life, including pregnancy, childhood, adolescence, adulthood, and older individuals. Services will be provided to meet population needs at different stages of the life cycle, as summarized below:

- i) **Pregnant women and lactating mothers:** It is approximated that 16 pregnant women die in Uganda daily — yet the major causes of maternal mortality in Uganda are preventable. If delivery is managed in a facility that is able to handle complications that arise during delivery and the postnatal care period or referral to the appropriate level in time, this mortality could be significantly reduced.

- ii) Newborn babies (0–28 days):** Prematurity and neonatal conditions are among the main causes of neonatal mortality. Special attention needs to be paid to ensuring that risk factors for prematurity are identified and mitigated and the essential care required by newborn babies provided at all levels of the health care delivery system.
- iii) Children (29 days–59 months):** Children at this age are prone to several illnesses. Attention therefore needs to be paid to ensuring that they are immunized first of all, screened for genetic conditions, protected from exposure to disease-causing agents, and then treated appropriately when exposed.
- iv) Older children and adolescents (5–19 years):** This is the fastest-growing age group. They are prone to risky behaviour and injuries. Interventions that can prevent intentional and non-intentional injury and services for timely management of these injuries are key for preventing morbidity and mortality in this age group. Furthermore, adolescents are currently faced with a myriad of life skills, substance use, and reproductive health challenges. School health programs and adolescent- and youth-friendly services are available only in a few locations and need to be expanded nationwide.
- v) Youth (20–26 years):** This is a critical period of development, with long-lasting implications for a person’s economic security, health, and wellbeing. Young adults are also key contributors to the nation’s workforce, and many are parents who will play an important role in the healthy development of the next generation. Behaviours associated with morbidity and mortality across the lifespan tend to emerge or peak during young adulthood, with important immediate and long-term health consequences. For example, use of tobacco and low levels of fitness and poor nutrition increase the probability of developing diseases such as cardiovascular and pulmonary disease and cancer later in life. This age group marks the peak in substance use; it is also the typical age of onset of psychotic disorders and they have higher rates of serious psychological distress.
- vi) Adults (27–59 years):** Young and middle-aged adults are taking the brunt of NCDs and need to be targeted to ensure they maintain healthy behaviours.
- vii) Elderly (60+ years):** The proportion of elderly people in Uganda is gradually increasing. As people age, they are more likely to experience multiple morbidities. Older age is also characterized by the emergence of several complex health states, commonly called geriatric syndromes. The provision of comprehensive geriatric care services is critical to promote health by preventing and treating diseases and disabilities in older adults.

## 4.5 Type and Scope of the Package

The UNEHCP will be provided under seven clusters as summarized in Table 6. Categorization of the services within the clusters enhances coordination as well as integrated planning and budgeting for the services. Three new clusters have been introduced to increase coverage of services that previously received limited attention within the Minimum Health Care Package. They include surgical and anaesthesia care, emergency, critical and high dependency care, and

geriatric care. Emergency medicine is a specialty concerned with the care and treatment of acutely ill or injured patients who need immediate medical attention, whereas geriatric care focuses on the provision of care that meets the needs of the elderly population. The proportion of elderly people in Uganda has continued to increase as life expectancy improves. In view of the increasing incidence of NCDs, interventions that address risk factors for NCDs have also received more emphasis. The package has also been designed in line with the PHC implementation approach with PHC defined as “universally available and affordable preventive, basic curative services and rehabilitative care that the majority of the population needs”. PHC is “an overall approach which encompasses the three aspects of: multisectoral policy and action to address the broader determinants of health; empowering individuals, families, and communities; and meeting people’s essential health needs throughout their lives”. PHC services form the minimum set of services that should be provided to all citizens equitably to address the highest burden of disease among most of the population.

The different interventions will be provided at different levels of the health care system, hence the level where the service will be provided is specified. In addition, whereas the entire population is eligible to receive the services within the UNEHCP, some services target specific groups. In such cases the target groups are specified. A positive list of the interventions / services included under each of the clusters is provided to make the UNEHCP more explicit. This list has also been aligned to the International Classification of Diseases to standardize reporting of common disease conditions. Table 6 provides an outline of the key components of the UNEHCP, the subsequent tables provide details of the services under each cluster.

**Table 6: Key components of the UNEHCP**

<b>Cluster 1: Health Promotion, Disease Prevention, and Community Health Initiatives</b>	
C1.1: Health promotion and education C1.2: Environmental health and sanitation C1.3: Emerging environmental health problems C1.4: Immunization C1.5: Prevention and control of communicable diseases	C1.6: Prevention and control of NCDs C1.7: Nutrition services C1.8: Epidemic and disaster preparedness and response C1.9: Occupational health and safety
<b>Cluster 2: Management and Control of Communicable Diseases</b>	
C2.1: Management of sexually transmitted infections / HIV/AIDS C2.2: Management of tuberculosis C2.3: Management of malaria C2.4: Management of the neglected tropical diseases (leprosy, guinea worm, sleeping sickness, onchocerciasis, schistosomiasis, trachoma, lymphatic filariasis, tungiasis, etc.)	C2.5: Management of zoonotic diseases C2.6: Management of common mycoses and viral infections C2.7: Management of infections of the ear, skin, nervous, respiratory, digestive, musculoskeletal, and genitourinary systems
<b>Cluster 3: Management and Control of NCDs</b>	
C3.1: Management of endocrine and metabolic diseases C3.2: Management of cardiovascular diseases (hypertensive diseases and other cardiovascular diseases) C3.3: Management of disabilities and rehabilitative health C3.4: Management and palliative care for benign and malignant neoplasms	C3.5: Management of mental and behavioural disorders C3.6: Management of neurodevelopmental disorders C3.7: Management of haematological disorders C3.8: Management of nutritional disorders C3.9: Management of non-infectious diseases and disorders of the ear, skin, respiratory, nervous, digestive, musculoskeletal, and genitourinary system

<b>Cluster 4: Reproductive, Maternal, Newborn, Child, and Adolescent Health</b>	
C4.1: Routine antenatal care services C4.2: Management of haemorrhage C4.3: Management of maternal disorders related to pregnancy C4.4: Maternal care related to the foetus, amniotic cavity, or delivery problems C4.5: Delivery care services C4.6: Emergency obstetric care services	C4.7: Postnatal care C4.8: Family planning services C4.9: Management of the newborn and infections of the newborn C4.10: Promotion of breastfeeding and complementary feeding C4.11: Management of common childhood illnesses C4.12: Management of GBV
<b>Cluster 5: Surgical and Anaesthesia Care</b>	
C5.1: General surgery C5.2: Paediatric surgery C5.3: Ear, nose, and throat (ENT) surgical procedures C5.4: Ocular surgery C5.5: Neurosurgery C5.6: Oral and maxillofacial surgery	C5.7: Thoracic and cardiovascular surgery C5.8: Orthopaedic and trauma surgery C5.9: Genito-urinary surgery C5.10: Anaesthesia C5.11: Plastic and reconstructive surgery
<b>Cluster 6: Emergency, High Dependency, and Critical Care</b>	
C6.1: Management of cardiovascular related emergencies C6.2: Management of respiratory emergencies C6.3: Management of severe acute exacerbations of diseases of the gastrointestinal tract C6.4: Management of emergency complications of diabetes mellitus C6.5: Management of emergency disorders of the genitourinary system C6.6: Management of emergency mental, neurological, and substance abuse disorders and conditions	C6.7: Management of emergency drug use disorders C6.8: Management of acute convulsive seizures and epilepsy C6.9: Management of severe thermal and chemical injuries (burns) C6.10: Management of envenomation injuries, poisoning, and toxic and environmental exposure and injuries C6.11: Management of severe infections C6.12: Management of premature births C6.13: Management of severe mechanical injury C6.14: Evacuation and referral services C6.15: Critical care
<b>Cluster 7: Geriatric Care</b>	
C7.1: Management of central nervous disorders C7.2: Management of depression C7.3: Management of orthopaedic disorders C7.4: Management of respiratory disorders C7.5: Management of dental problems C7.6: Management of diseases of the visual system C7.7: Management of hearing impairment	C7.8: Management of cardiovascular diseases C7.9: Cancer prevention and management C7.10: Management of nutritional disorders C7.11: Management of endocrine disorders C7.12: Social care and support C7.13: Enhancing locomotor capacity C7.14: Urinary incontinence C7.15: Support for care givers of elderly patients

## 4.6 Cluster 1: Health Promotion, Disease Prevention, and Community Health Initiatives

This cluster has maintained a focus on health promotion, disease prevention, and community health initiatives. As noted in the background section, Uganda still has a high burden of preventable illnesses that impose high treatment costs on an already constrained resource. It is estimated that 60% of the mortality in Uganda is due to preventable conditions. Therefore, initiatives geared at addressing the social determinants of health and key drivers of poor health and promoting healthy lifestyles are critical. These components will be addressed through promoting health education and promotion as well as multisectoral implementation of key strategies by multiple stakeholders that include communities, religious leaders, the private sector, and other key sectors — such as education and sports, gender, housing and urban development, agriculture, water and environment, works and transport, etc. The interventions in this cluster also address emerging health threats, including air pollution, climate change, and emerging and reemerging diseases such as Ebola, Marburg, COVID-19.

**Table 7: Services in cluster one**

Services	Level of delivery	Target Group
<b>C1.1: Health Promotion and Education</b>		
C1.1.1: Health education on prevention and early detection of communicable diseases and NCDs, including mental health, neurological disorders and substance abuse, nutrition and early child development, TB prevention and control, prevention of zoonotic diseases, cancer prevention, and community sensitization on GBV prevention	Individual, community, school, health facility (HC III – Hosp)	All
C1.1.2: Education on health and wellbeing, environmental sanitation, pollution and its effects, climate change, and workplace safety	Individual, community, school, health facility, workplaces	All above five years old
C1.1.3: Health education on proper feeding, nutrition dietary diversification, and food hygiene and safety	Individual, community, school, health facility (HC III – Hosp)	All above five years old
C1.1.4: Age-appropriate information on sexual and reproductive health and rights and behaviour change communication	National, district, health, facility, schools, community	All above five years old
C1.1.5: Social and behaviour change communication for health and wellbeing	National, district, health facility, schools, community	All above five years old
<b>C1.2: Sanitation and Hygiene</b>		
C1.2.1: Home visiting to promote improved latrines, safe refuse disposal, appropriate housing conditions.	Household, community	All
C1.2.2: Promotion of personal hygiene including regular handwashing and menstrual hygiene.	Household, schools, community	All above five years old
C1.2.3: Provision of sanitation facilities (public toilets with handwashing facilities and bathrooms) in all social institutions (health facilities, schools, prisons) and public spaces.	Community, schools, institutions	All
C1.2.4: Safe water provision at the household level	Household, community	All
C1.2.5: Safe water provision in all public and social institutions (health facilities, schools, workplaces, marketplaces, hotels, restaurants etc.)	HC II – Hosp, schools, community	All
C1.2.6: Safe refuse disposal in public spaces (e.g., health facilities and markets)	All health facilities, community, schools, institutions	All
C1.2.7: Promotion of environmental sanitation (improved drainage in urban slums, solid and liquid waste disposal)	Community	All
C1.2.8: Food inspection and certification	Community	All
<b>C1.3: Emerging Environmental Health Problems (e.g., pollution and climate change)</b>		
C1.3.1: Promotion of safe housing conditions	Community, household, schools	All
C1.3.2: Safe use and disposal of reusable plastics	Community	All
C1.3.3: Tree and forest planting	Community	All
C1.3.4: Promotion of the use of clean fuel for domestic use	Community, household	All youth and adults

Services	Level of delivery	Target Group
<b>C1.4: Immunization</b>		
C1.4.1: Routine childhood and adulthood vaccination as per the national schedule		
<ul style="list-style-type: none"> <li>Routine childhood vaccination provided through the Uganda National Expanded Program on Immunisation schedule (oral polio, injectable polio, BCG, DPT-Hib-HepB, PCV, Rotavirus, measles-rubella, and other approved vaccines)</li> </ul>	Community, health facilities (clinics, HC II – General Hospital)	Children under one year
<ul style="list-style-type: none"> <li>Human papilloma virus vaccination</li> </ul>	School, health facilities (clinics, HC II - Hospital)	All females aged 10 years
<ul style="list-style-type: none"> <li>Tetanus toxoid vaccination</li> </ul>	Health facilities (clinics, HC II - Hospital)	Pregnant women, 10-year-old males and females
<ul style="list-style-type: none"> <li>Yellow fever vaccination</li> </ul>	Health facilities (clinics, HC III - Hospital)	All
C1.4.2: Emergency vaccination		
<ul style="list-style-type: none"> <li>Cholera vaccination</li> </ul>	Health facilities (clinics HC III - Hospital)	People in high-risk areas
<ul style="list-style-type: none"> <li>Meningococcal vaccination</li> </ul>	Health facilities (clinics, HC III - Hospital)	Populations residing in the hot spot belt
<ul style="list-style-type: none"> <li>COVID-19 vaccination</li> </ul>	Health facilities (clinics, HC III - Hospital)	All target population
<ul style="list-style-type: none"> <li>Hepatitis B vaccination in all high burden areas</li> </ul>	Health facilities (clinics, HC III - Hospital)	All eligible negative persons
<b>C1.5: Prevention of Communicable Diseases</b>		
C1.5.1: Prevention of Sexually Transmitted Infections and HIV		
<ul style="list-style-type: none"> <li>Testing and counselling for HIV</li> </ul>	Community, health facilities (clinics, HC III - Hospital)	Pregnant and lactating women, exposed newborns, all sexually active individuals, all for provider-initiated testing
<ul style="list-style-type: none"> <li>Testing and treatment for sexually transmitted infections</li> </ul>	Community, health facilities (clinics, HC III - Hospital)	Pregnant women, all sexually active / all exposed individuals
<ul style="list-style-type: none"> <li>Safe male circumcision</li> </ul>	Community, health facilities (clinics, HC III - Hospital)	All uncircumcised males
<ul style="list-style-type: none"> <li>Antiretroviral therapy for elimination of mother-to-child transmission</li> </ul>	Accredited clinics, HC III – Hospital	Pregnant and lactating women, all exposed newborns born to HIV-positive women
<ul style="list-style-type: none"> <li>HIV post-exposure prophylaxis</li> </ul>	Community, health facilities (clinics, HC II - Hospital)	Medical workers, rape victims, most-at-risk populations
<ul style="list-style-type: none"> <li>HIV pre-exposure prophylaxis</li> </ul>	Community, health facilities (clinics, HC III - Hospital)	Key populations, discordant couples, most-at-risk populations
<ul style="list-style-type: none"> <li>Condom distribution</li> </ul>	Community, health facilities (clinics, HC II - Hospital), higher learning institutions, workplaces, hotel industry	All sexually active persons
<ul style="list-style-type: none"> <li>Social and behaviour change communication for HIV prevention</li> </ul>	Community, health facilities (clinics HC, III - Hospital), schools, higher learning institutions, workplaces, communal gatherings	All adolescents, youths, and adults
C1.5.2: Prevention of nosocomial infections		
	Health facilities (clinics, HC II – Hospital), nursing homes	All



Services	Level of delivery	Target Group
<b>C1.5.3: Prevention of TB</b>		
<ul style="list-style-type: none"> <li>Active search for TB cases</li> </ul>	Community, health facilities (clinics, HC III - Hospital)	All
<ul style="list-style-type: none"> <li>Screening for TB and drug-resistant TB</li> </ul>	Health facilities (clinics, HC III - Hospital)	All
<ul style="list-style-type: none"> <li>Preventive therapy for children in contact with TB patients and other close contacts</li> </ul>	Health facilities (clinics HC III - Hospital)	Children in contact with TB patients
<ul style="list-style-type: none"> <li>Preventive therapy for HIV-positive people, including pregnant women</li> </ul>	Health facilities (clinics HC III - Hospital)	All HIV-positive individuals
<b>C1.5.4: Prevention of malaria</b>		
<ul style="list-style-type: none"> <li>Use of long-lasting insecticide treated nets</li> </ul>	Household, health facilities (clinics, HC II - Hospital), schools / institutions / hotels	All
<ul style="list-style-type: none"> <li>Indoor residual spraying</li> </ul>	Household, schools, institutions, hotels	All, especially people in malaria-endemic districts and those at risk
<ul style="list-style-type: none"> <li>Destruction of mosquito breeding sites</li> </ul>	Households, community, institutions	All
<ul style="list-style-type: none"> <li>Social and behaviour change communication for malaria prevention and management</li> </ul>	Household, community, health facilities (clinics, HC II - Hospital), schools/institutions	All
<b>C1.5.5: Integrated vector control</b>		
<ul style="list-style-type: none"> <li>Household vector control (cockroaches, fleas, rodents, bed bugs, etc.)</li> </ul>	Household, schools, institutions, hotels, workplaces	All
<b>C1.5.6: Prevention of neglected tropical diseases</b>		
<ul style="list-style-type: none"> <li>Mass drug administration for trachoma, leishmaniasis, schistosomiasis, sleeping sickness, lymphatic filariasis, and onchocerciasis</li> </ul>	Community, schools	All persons above one year of age in endemic districts
<ul style="list-style-type: none"> <li>Vector management using traps and larvicide</li> </ul>	Community	All in endemic districts
<b>C1.5.7: Prevention of worm infestation</b>		
<ul style="list-style-type: none"> <li>Deworming of all children under five</li> </ul>	Household, community, schools, (clinics, HC II - Hospital)	Children under five years old
<b>C1.5.8: Prevention of NCDs: Interventions for reduction of risk factors for NCDs</b>		
<ul style="list-style-type: none"> <li>Enforcement of Substance abuse and tobacco control laws</li> </ul>	Household, community, schools, hotel industry, police, public transport systems, workplaces	All above five years old
<ul style="list-style-type: none"> <li>Enforcement of age restrictions for alcohol consumption</li> </ul>	Household, community, schools, alcohol vendors, hotel industry	Boys and girls below 18 years
<ul style="list-style-type: none"> <li>Individual and group physical activity (e.g., jogging, walking, football)</li> </ul>	Individual, household, community, schools, institutions, workplaces	All
<ul style="list-style-type: none"> <li>Healthy eating</li> </ul>	Households, schools, institutions, hotel industry, workplaces	All
<b>C1.5.9: Institutional screening for NCDs</b>		
<ul style="list-style-type: none"> <li>Fasting blood sugar testing</li> </ul>	Individuals, health facilities (clinics, HC III - Hospital)	At-risk children and adults
<ul style="list-style-type: none"> <li>Blood pressure measurement</li> </ul>	Individuals, health facilities (clinics, HC II - Hospital)	All adults, pregnant women
<ul style="list-style-type: none"> <li>Screening for cardiovascular diseases (ECG)</li> </ul>	Health facilities (clinics, HC IV - Hospital)	All
<ul style="list-style-type: none"> <li>Screening for diabetic and hypertensive retinopathy and assessment</li> </ul>	Health facilities (clinics, HC III - Hospital)	Diabetic patients
<ul style="list-style-type: none"> <li>Screening for sickle cells</li> </ul>	Health facilities (clinics, HC III - Hospital)	All newborns , all adults intending to get married

<b>Services</b>	<b>Level of delivery</b>	<b>Target Group</b>
<b>C1.5.10: Cancer screening</b>		
<ul style="list-style-type: none"> <li>• Cervical cancer screening (HPV DNA / PAP smear / VIA)</li> </ul>	Health facilities (clinics, HC III - Hospital)	All females aged 40 years and above
<ul style="list-style-type: none"> <li>• Routine breast examination</li> </ul>	Individual	All females 18 years and above
<ul style="list-style-type: none"> <li>• Annual clinical breast examination</li> </ul>	Health facilities (clinics, HC II - Hospital)	All females 18 years and above
<ul style="list-style-type: none"> <li>• Simple breast ultrasound</li> </ul>	Health facilities (clinics, HC IV - Hospital)	All females aged 40 years and above
<ul style="list-style-type: none"> <li>• Mammography</li> </ul>	Health facilities (Hospital)	All females aged 40 years and above
<ul style="list-style-type: none"> <li>• Annual cancer of the prostate testing (PSA)</li> </ul>	Hospitals	All men aged 40 years and above
<ul style="list-style-type: none"> <li>• Faecal occult blood testing for colorectal cancer</li> </ul>	Health facilities (clinics, HC III - Hospital)	All men aged 45 years and above
<ul style="list-style-type: none"> <li>• Rectal examination for benign prostate hyperplasia</li> </ul>	Health facilities (clinics, HC III - Hospital)	All men aged 40 years and above
<ul style="list-style-type: none"> <li>• Skin cancer screening</li> </ul>	Health facilities (clinics HC II - Hospital)	All people with albinism
<b>C1.5.11: Mental health support services</b>		
<ul style="list-style-type: none"> <li>• Psychosocial support for prevention of suicide</li> </ul>	Households, community, health facilities (clinics, HC III - Hospital), specialized institutions	All persons affected by mental conditions
<ul style="list-style-type: none"> <li>• Identification and referral of persons with mental illness, neurological, and substance abuse issues</li> </ul>	Households, community, schools, health facilities (clinics, HC II - Hospital)	All ages
<ul style="list-style-type: none"> <li>• Counselling of persons with mental, neurological, and substance abuse issues</li> </ul>	Households, community, health facilities (clinics, HC II - Hospital), specialized institutions	Persons with mental, neurological, and substance abuse issues
<b>C1.5.12: Nutritional services</b>		
<ul style="list-style-type: none"> <li>• Nutrition counselling and education</li> </ul>	Community, schools, health facilities (clinics, HC II - Hospital)	All above five years old, pregnant women, elderly
<ul style="list-style-type: none"> <li>• Growth monitoring and promotion</li> </ul>	Households, community, schools, health facilities (clinics, HC II - Hospital)	Children under five years old
<ul style="list-style-type: none"> <li>• Body mass index assessment</li> </ul>	Health facilities (clinics, HC II - Hospital), school / institutions, workplaces	All above five years old
<ul style="list-style-type: none"> <li>• Mid-upper arm circumference measurement</li> </ul>	Community, health facilities (clinics, HC II - Hospital)	Children under five years old
<b>C1.5.13: Micronutrient deficiency control</b>		
<ul style="list-style-type: none"> <li>• Fortification of food with Vitamin A (sugar), iodine (salt), iron, and zinc (wheat)</li> </ul>	Food factories, Uganda Bureau of Standards, Ministry of Trade and Industry	All
<ul style="list-style-type: none"> <li>• Vitamin A supplementation</li> </ul>	Community, health facilities (clinics, HC II - Hospital)	Children below 5 years old
<ul style="list-style-type: none"> <li>• Folic acid and iron supplementation</li> </ul>	Health facilities (clinics, HC II - Hospital)	Women of reproductive age
<b>C1.6: Epidemics and Disaster Preparedness and Response</b>		
C1.6.1: Monitoring of people movement in relation to international health regulations	Points of entry/Ministry of Internal Affairs, MoH	All
C1.6.2: Screening & management of diseases of public health importance (e.g., haemorrhagic fevers, COVID-19, SARS)	Points of entry/Ministry of Internal Affairs, MoH, community, health facilities (clinics, HC II - Hospital), isolation centres	All travellers, all at risk populations
C1.6.3: Investigation of disease outbreaks	Community, health facilities, LGs, MoH, relevant MDAs	All
C1.6.4: Disease surveillance and response	Community, health facilities, LGs, (clinics, HC II - Hospital), MoH/national	All

Services	Level of delivery	Target Group
C1.6.5: Disaster management and response (public health aspects)	Community, LGs, MoH, Office of the Prime Minister / National	All
<b>C1.7: Occupation Health and Safety</b>		
C1.7.1: Workplace wellness program	Workplaces	All workers
C1.7.2: Inspection and certification	Workplaces; Ministry of Gender, Labour, and Social Development; LGs	All workers
C1.7.2: Provision and promotion of use of protective gear	Workplaces	All workers

## 4.7 Cluster 2: Management and Control of Communicable Diseases

The second cluster focuses on the management and control of communicable diseases and other common conditions. Although the country has made progress in addressing communicable diseases, they still contribute to 43% of mortality according to the AHSPR 2020/2021. The UNEHCP will maintain a focus on HIV, TB, and malaria since these diseases still impose high morbidity and mortality in the country. However, the package also covers the management and control of other common infections and conditions that are common causes of morbidity and contribute to high admissions and high cost of care. Lastly, Uganda is signatory to several global commitments aimed at eliminating and eradicating several neglected tropical diseases (NTDs) and so these diseases have been maintained.

**Table 8: Services in cluster two**

Services	Level of delivery	Target group
<b>C2.1: STI and HIV/AIDS Management</b>		
C2.1.1: First-line and second-line antiretroviral therapy for children and adults	Accredited health facilities (special clinics, HC III - Hospital)	All HIV-positive individuals
C2.1.2: Management of opportunistic infections (cryptococcal meningitis, pneumocystis carinii pneumonia, HIV and TB co-infection, HIV and Hepatitis B co-infection)	Health facilities (clinics, HC III - Hospital)	All HI- positive individuals
<b>C2.1.3: Syndromic diagnosis and treatment of STIs</b>		
<ul style="list-style-type: none"> <li>Urethral discharge syndrome</li> </ul>	Health facilities (clinics, HC II - Hospital)	All sexually active persons
<ul style="list-style-type: none"> <li>Abnormal vaginal syndrome (vaginitis and cervicitis)</li> </ul>	Health facilities (clinics, HC II - Hospital)	All sexually active persons
<ul style="list-style-type: none"> <li>Genital ulcer syndrome (chancroid, syphilis, genital herpes, granuloma inguinale)</li> </ul>	Health facilities (clinics, HC II - Hospital)	All sexually active persons
<ul style="list-style-type: none"> <li>Management of warts (condylomata lata, condylomata acuminata etc.)</li> </ul>	Health facilities (clinics, HC III - Hospital)	All sexually active persons
<ul style="list-style-type: none"> <li>Pelvic inflammatory diseases</li> </ul>	Health facilities (clinics, HC II - Hospital)	All sexually active persons
<ul style="list-style-type: none"> <li>Management of inguinal swelling (chancroid, lymphogranuloma venereum)</li> </ul>	Health facilities (clinics, HC II - Hospital)	All sexually active persons
<b>C2.2: Management of TB</b>		
C2.2.1: Screening for TB disease	Community, health facilities (clinics, HC II - Hospital)	All
C2.2.2: Diagnosis of TB disease	Health facilities (HC III - Hospital)	All
C2.2.3: First-line treatment of sensitive TB disease (initiation of treatment and continuation in stable patients)	Health facilities (Clinics, HC III – Hospital)	TB patients
C2.2.4: First-line treatment of complicated TB	Health facilities (Hospitals)	TB patients

<b>Services</b>	<b>Level of delivery</b>	<b>Target group</b>
C2.2.5: Monitoring of patients for treatment response and adherence including provision of directly observed therapy	Community Health facilities (Clinics, HC III - Hospital)	TB patients
C2.2.6: Treatment of drug resistance and multidrug resistance, TB patients (second-line TB treatment initiation and continuation of treatment)	Health facilities (Hospital - RRH, NRH)	TB patients
<b>C2.3: Management of Malaria</b>		
C2.3.1: Management of simple malaria	Community, health facilities (clinics, HC II - Hospital)	All age groups
C2.3.2: Pre-referral treatment and referral of complicated malaria cases	Community, health facilities (clinics, HC II - Hospital)	All age groups
C2.3.3: Management of complicated malaria	Health facilities (clinics, HC IV - Hospital)	All age groups
<b>C2.4: Management of NTDs</b>		
C2.4.1: Case management for leprosy, trachoma, leishmaniasis, schistosomiasis, trypanosomiasis (sleeping sickness), lymphatic filariasis, onchocerciasis	Health facilities (specialized facilities, clinics, HC III - Hospital)	All age groups
<b>C2.5: Management of Zoonotic Diseases</b>		
C2.5.1: Management of zoonotic diseases (brucellosis, anthrax, zoonotic influenza viruses, viral haemorrhagic fevers, and rabies)	Health facilities (clinics, HC IV - Hospital)	All age groups
<b>C2.6: Management of Common Mycoses and Viral Infections</b>		
C2.6.1: Management of viral infections acute poliomyelitis, infectious meningitis, infectious encephalitis, acute viral hepatitis, chronic viral hepatitis, herpes simplex infections, measles, rubella, molluscum contagiosum, chicken pox, and yellow fever	Health facilities (clinics, HC III - Hospital)	All age groups
C2.6.2: Management of common mycoses (candidiasis of the skin and mucous membranes, tinea nigra, dermatophytosis, pityriasis versicolor)	Health facilities (clinics, HC II - Hospital)	All age groups
<b>C2.7: Management of Infections of the Ear, Skin, Visual, Nervous, Respiratory, Digestive, Musculo-Skeletal, and Genitourinary System</b>		
C2.7.1: Management of infectious diseases of the external ear (otitis externa and otitis media)	Health facilities (clinics, HC II - Hospital)	All age groups
C2.7.2: Management of common bacterial, fungal, viral and parasitic diseases of the skin. Scabies, impetigo, cellulitis, athlete's foot, ringworm, erysipelas, bacterial folliculitis, furuncles, carbuncles, herpes simplex, herpes zoster, pediculosis, tungiasis	Health facilities (clinics, HC II - Hospital)	All age groups
C2.7.3: Management of infectious diseases of the visual system (infectious blepharitis, dacryocystitis, conjunctivitis, hordeola (sties), periorbital cellulitis, endophthalmitis, infectious keratitis, uveitis, ocular herpes, etc.)	Health facilities (clinics, HC II - Hospital)	All age groups
C2.7.4: Management of infectious diseases of the respiratory system (chronic and acute sinusitis, acute pharyngitis, acute laryngitis, acute tonsillitis, acute bronchitis, pneumonia, acute bronchiolitis)	Health facilities (clinics, HC II - Hospital)	All age groups
C2.7.5: Management of infectious diseases of the digestive system; diseases of the oral facial complex; and diseases of the teeth, gingiva, oesophagus, stomach, duodenum, large intestine, small intestine, anal canal, and liver	Health facilities (specialized clinics, HC III - Hospital)	All age groups
C2.7.6: Management of infectious diseases of the musculoskeletal system (osteomyelitis, myositis, pyomyositis, septic arthritis)	Health facilities (clinics, HC II - Hospital)	All age groups
C2.7.7: Management of infectious diseases of the Genito urinary system.		
<ul style="list-style-type: none"> <li>Infectious diseases of the female genital system (vulvitis, vaginitis, cervicitis, pelvic inflammatory diseases)</li> </ul>	Health facilities (clinics, HC II - Hospital)	All females
<ul style="list-style-type: none"> <li>Infectious diseases of the male genital system (orchitis) acute pyelonephritis, urethritis</li> </ul>	Health facilities (clinics, HC II - Hospital)	All females

## 4.8 Cluster 3: Management and Control of NCDs

The third cluster maintains the focus on the management and control of NCDs, which have been on the rise over the years as a result of adoption of unhealthy lifestyles and other risk factors. Additionally, other NCDs — such as mental health disorders, substance abuse disorders, child mental health disorders, and cancers — have also been given more prominence.

**Table 9: Services in cluster three**

Services	Level of delivery	Target group
<b>C3.1: Management of Endocrine Diseases and Metabolic Diseases</b>		
C3.1.1: Management of Type 1 and Type 2 diabetes mellitus	Health facilities (clinics, HC III - Hospital)	All age groups
C3.1.2: Management of complications of diabetes mellitus	Health facilities (special clinics, HC IV - Hospital)	All age groups
C3.1.3: Management of Addison's disease	Hospital	All age groups
C3.1.4: Management of Cushing's syndrome	Hospital, RRH	All age groups
C3.1.5: Management of hypothyroidism, nontoxic goiter, thyrotoxicosis, thyroiditis	Health facilities (clinics, hospitals)	All age groups
<b>C3.2: Management of Cardiovascular Diseases (Hypertensive Diseases and Other Cardiovascular Diseases)</b>		
C3.2.1: Management of essential hypertension	Health facilities (clinics, HC III - Hospitals)	All age groups
C3.2.2: Management of hypertensive diseases (hypertensive heart disease, congestive heart failure, hypertensive renal disease, hypertensive crisis, hypotension)	HC IV – Hospitals	All age groups
C3.2.3: Management of deep vein thrombosis / pulmonary embolism and other diseases of the arteries or veins	Hospitals	All age groups
C3.2.4: Management of infective endocarditis	Hospitals	All age groups
C3.2.5: Management of congestive heart failure	HC IV - Hospitals	All age groups
C3.2.5: Management of pulmonary oedema	HC IV - Hospitals	All age groups
C3.2.6: Management of atrial fibrillation and other cardiac arrhythmias	HC IV - Hospitals	All age groups
C3.2.7: Management of ischemic heart disease, pulmonary heart disease, pulmonary oedema, rheumatic heart diseases, and other diseases of the myocardium	RRHs, NRHs, Uganda Heart Institute	All age groups
<b>C3.3: Disabilities and Rehabilitative Health</b>		
C3.3.1: Physiotherapy for patients with stroke	Household, specialized centres, hospitals	Adults
C3.3.2: Rehabilitation for patients with stroke and other disabilities	Household, specialized centres, hospitals	Adults
C3.3.3: Mental health rehabilitation	Health facilities (specialized centres, hospitals)	All age groups
C3.3.4: Rehabilitation for visual and hearing impairment	Health facilities (specialized centres, hospitals)	All age groups
C3.3.5: Occupation therapy and speech therapy	Health facilities (specialized centres, hospital)	All age groups
C3.3.6: Orthopaedic aids (prosthesis) for persons with disabilities	Health facilities (specialized centres, hospitals)	All age groups

Services	Level of delivery	Target group
<b>C3.4: Management and Palliative care for Benign and Malignant Neoplasms</b>		
C3.4.1: Management of common cancers among children (leukaemia, Hodgkin's disease, Burkitt's lymphoma, nephroblastoma, rhabdomyosarcoma, rhabdomyosarcoma, retinoblastoma, central nervous system tumours)	Health facilities (NRHs, RRHs, Uganda Cancer Institute - Regional cancer treatment centres, HC IV, nonstate actors)	Children
C3.4.2: Management of common cancers among adults (cancer of the oesophagus, gastric cancer, colorectal and anal cancer, breast cancer, cancer of the cervix, melanoma, ovarian cancer, non-Hodgkin's lymphoma, squamous cell cancer of the skin, Kaposi's sarcoma, prostate cancer, head and neck cancers, chronic leukaemia)	Health facilities (NRHs, RRHs, Uganda Cancer Institute - Regional cancer treatment centres)	Adults
C3.4.3: Palliative Care for malignant neoplasms of the lips, oesophagus, stomach, large intestine, hepatobiliary system, pancreas, larynx, lung middle ear, skin, ovary, corpus uteri, cervix uteri, testis, kidney, bladder, eye, thyroid gland	Health facilities (clinics, hospices, HC III – general hospital RRHs, NRHs, Uganda Cancer Institute)	All age groups
C3.4.4: Nociceptive pain management, neuropathic pain, back or bone pain	Household, health facilities (clinics, HC II - Hospital)	All age groups
C3.4.5: Mental physical and spiritual support	Community, hospices	Children and adults
C3.4.6: Advanced care planning and end-of-life care	Hospice, HC III - Hospital	All age groups
<b>C3.5: Management of Mental and Behavioural Disorders</b>		
C3.5.1: Management of substance abuse disorders (e.g., alcohol and cannabis)	Health facilities (RRHs, NRHs, specialized centres), HC IV	Adolescents and adults
C3.5.2: Basic psychosocial support, advice, and follow-up	Households, community, health facilities (clinics, HC II - Hospital), community	All age groups
C3.5.3: Treatment of acute psychotic disorders, mood disorders, schizophrenia, anxiety disorders, stress-related disorders, obsessive-compulsive disorders, elimination disorders, and mental health childhood disorders	Health facilities (clinics, HC III - Hospital)	All age groups
C3.5.4: Management of child abuse	Households, community, specialized centres, health facilities (clinics, HC II - Hospital), police, community, development offices	All children
<b>C3.6: Management of Neuro-Developmental Disorders</b>		
C3.6.1: Developmental speech, learning, and language disorders	Specialized centres	All age groups
C3.6.2: Disorders of intellectual development	Specialized centres	All age groups
C3.6.3: Attention deficit hyperactivity	NRH, RRH, specialized centres, hospitals	All age groups
C3.6.4: Autism spectrum	Specialized centres, hospitals	All age groups
<b>C3.7: Management of Haematological Disorders</b>		
C3.7.1: Management of haematological disorders (sickle cell anaemia, iron deficiency anaemia, folate deficiency anaemia, megaloblastic anaemia, haemolytic anaemia, haemophilia, and thalassemia)	Health facilities (clinics, HC II - Hospital)	All age groups
<b>C3.8: Management of Nutritional Disorders</b>		
C3.8.1: Management of moderate wasting / underweight	Household, health facilities (clinics, HC II - Hospital)	Children
C3.8.2: Management of severe wasting (in patient)	Hospitals	Children

<b>Services</b>	<b>Level of delivery</b>	<b>Target group</b>
C3.8.3: Management of obesity	Household, health facilities (clinics, HC III - Hospital)	All age groups
C3.8.4: Management of mineral deficiencies	Household, health facilities (clinics, HC III - Hospital)	All age groups
<b>C3.9: Management of NCDs and Disorders of the Nervous, Eye, Ear, Skin, Respiratory, Digestive, Musculoskeletal, and Genitourinary systems.</b>		
C3.9.1: Movement disorders, disorders with significant neurocognitive impairment, epilepsy, nodding disease, seizures, cerebrovascular diseases, polyneuropathy, and mononeuropathy	Health facilities (specialized facilities, HC III - Hospital)	All age groups
C3.9.2: Management of central nervous disorders (Parkinson's diseases, Alzheimer's disease, dementia)	Health facilities (RRH, specialised centres.)	Elderly
C3.9.3: Management of diseases of the visual system (chalazion, cataract, retinopathy, glaucoma, disorders of refraction, xerophthalmia, blindness)	Health facilities (specialised centres, HC IV - Hospital)	All age groups
C3.9.4: Management of diseases of the external ear impacted cerumen, diseases of the internal ear (acute vestibular syndrome, Meniere disease, benign positional paroxysmal vertigo), disorders with hearing impairment	Health facilities (clinics, HC III - RRH)	All age groups
C3.9.5: Management of non-infectious diseases and disorders of the digestive system, diseases or disorders of the orofacial complex, diseases of the teeth, gingiva, oesophagus, stomach, duodenum, large intestine, small intestine, anal canal, liver	Health facilities (clinics, HC III - Hospital)	All age groups
C3.9.6: Management of diseases of the respiratory system, chronic diseases of the respiratory system, chronic sinusitis, rhinitis, emphysema, chronic obstructive pulmonary airways diseases, chronic bronchitis, asthma	Health facilities (clinics, HC IV - Hospital)	All age groups
C3.9.7: Management of non-infectious diseases of the skin (dermatitis, eczema, acne, psoriasis, diseases of the nails, disorders of the dermis and subcutis, disorders of cutaneous blood and lymphatic vessels)	Health facilities (clinics, HC II - Hospital)	All age groups
C3.9.8: Management of non-infectious diseases of the musculoskeletal system (arthritis, osteoarthritis, rheumatoid arthritis gout, structural disorders of the spine, bursitis, tenosynovitis, muscle strains and sprains, osteoporosis, osteomyelitis)	Health facilities (clinics, HC IV - Hospital)	All age groups
C3.9.9: Management of non-infectious diseases of the female genital system (vulvitis, vulval pruritis, vaginitis, cervicitis, endometriosis, adenomyosis, dyspareunia, dysmenorrhea, menstrual cycle bleeding disorders, postcoital bleeding, post-menopausal bleeding, menopausal hot flush, primary and secondary female infertility, recurrent pregnancy loss)	Health facilities (clinics, HC II - Hospital)	Adolescent girls and women
C3.9.10: Management of non-infectious diseases and disorders of the male genital system (male infertility, orchitis, male ejaculatory dysfunction, male erectile disorder)	Health facilities (clinics, HC IV - Hospital)	Adult males
C3.9.11: Management of non-infectious diseases of the urinary system (glomeruli diseases — nephritic syndrome, nephrotic syndrome — and renal tubulo-interstitial diseases)	Health facilities (clinics, HC IV - Hospital)	All age groups

## 4.9 Cluster 4: Reproductive, Maternal, Newborn, Child, and Adolescent Health

Cluster four has been expanded to include reproductive, maternal, newborn, child, and adolescent health to cater for the increased attention that is being devoted to current challenges such as the country's high neonatal rate that has stagnated at 27 deaths per 1,000 live births in the last decade, high teenage pregnancy rate that the COVID-19 pandemic has worsened, and the need to continue delivering high-impact maternal and child health interventions to address the country's high maternal and under-five mortality.

**Table 10: Services in cluster four**

Services	Level of delivery	Target group
<b>C4.1: Routine Antenatal Care Services</b>		
C4.1.1: Micronutrient supplementation and fortification	Household, clinics, HC II - Hospital	Pregnant women, women expecting to be pregnant
C4.1.2: Intermittent preventive treatment for malaria in pregnancy	Community, clinics, HC II - Hospital	Pregnant women
C4.1.3: Tetanus toxoid vaccination	Clinics, HC II - Hospital	Pregnant women
C4.1.4: Distribution of long-lasting insecticide treated nets to pregnant women	Household, HC II - Hospital	Pregnant women
C4.1.5: HIV counselling and testing during pregnancy	Clinics, HC II - Hospital	Pregnant women
C4.1.6: Antiretroviral therapy for elimination of mother-to-child transmission	Clinics, HC III - Hospital	HIV-positive pregnant women
C4.1.7: Nutrition assessment and counselling	Community, clinics, HC II - Hospital	Pregnant women
C4.1.8: Identification and referral of high-risk cases	Community, clinics, HC II - Hospital	Pregnant women with high-risk pregnancies
<b>C4.2: Management of Haemorrhage-Related to Pregnancy</b>		
C4.2.1: Management of haemorrhage in early pregnancy	Specialized clinics, HC III - Hospital	Pregnant women
C4.2.2: Management of antepartum haemorrhage	Maternity homes, specialized clinics, HC III - Hospital	Pregnant women
C4.2.3: Management of intrapartum haemorrhage	Maternity homes, specialized clinics, HC III - Hospital	Pregnant women
C4.2.4: Management of post-partum haemorrhage	Maternity homes, specialized clinics, HC III - Hospital	Pregnant women
<b>C4.3: Management of Maternal Disorders Related to Pregnancy</b>		
C4.3.1: Management of excessive vomiting in pregnancy	Specialized clinics, HC III - Hospital	Pregnant women
C4.3.2: Management of gestational diabetes	Specialized clinics, HC III - Hospital	Pregnant women
C4.3.3: Management of Genito urinary infections in pregnancy	Specialized clinics, HC III - Hospital	Pregnant women
C4.3.4: Management of malnutrition in pregnancy	Specialized clinics, HC III - Hospital	Pregnant women
C4.3.5: Management of eclampsia and pre-eclampsia	HC III - Hospital	Pregnant women
C4.2.6: Ectopic Pregnancy	HC IV - Hospital	Pregnant women
<b>C4.4: Maternal Care Related to the Foetus, Amniotic Cavity, or Possible Delivery Problems</b>		
C4.4.1: Postabortion care services	Specialized clinics, HC III - Hospital	Pregnant women
C4.4.2: Maternal care related to multiple gestation	Specialized clinics, HC III - Hospital	Pregnant women
C4.4.3: Maternal care related to premature rupture of membranes	Specialized clinics, HC III - Hospital	Pregnant women



<b>Services</b>	<b>Level of delivery</b>	<b>Target group</b>
C4.4.4: Maternal care related to placenta praevia	Specialized clinics, HC III - Hospital	Pregnant women
C4.4.5: Maternal care related to false labour	Specialized clinics, HC III - Hospital	Pregnant women
C4.4.6: Maternal care related to prolonged pregnancy	Specialized clinics, HC III - Hospital	Pregnant women
<b>C4.5: Delivery Care Services</b>		
C4.5.1: Normal vaginal delivery	Maternity homes, specialized clinics, HC III - Hospital	Pregnant women
C4.5.2: Assisted vaginal delivery	Hospital	Pregnant women
C4.5.3: Induction of labour for premature rupture of membranes and prolonged labour	Specialized clinics, HC IV - Hospital	Pregnant women
C4.5.4: Management of pre-term labour	Maternity homes, specialized clinics, HC IV - Hospital	Pregnant women
C4.5.5: Management of sepsis	Clinics, HC III – Hospital	Pregnant women
C4.5.6: Management of prolonged labour	Specialized clinics, HC IV - Hospital	Pregnant women
C4.5.7: Management of labour complicated by foetal distress	Specialized clinics, HC IV – Hospital	Pregnant women
C4.5.8: HIV counselling and testing during labour	Maternity homes, HC III - Hospital	Pregnant women
<b>C4.6: Emergency Obstetric Care Services</b>		
C4.6.1: Caesarean section	HC IV - Hospital	Pregnant women
C4.6.2: Manual removal of placenta	Clinics, HC III - Hospital	Pregnant women
C4.6.3: Pre-referral management and referral of complicated cases	Clinics, HC II - Hospital	Pregnant women
C4.6.4: Removal of retained products of conception	Clinics, HC III - Hospital	Pregnant women
<b>C4.7: Postnatal Care Services</b>		
C4.7.1: Identification and management of any existing postnatal complications <sup>2</sup>	Clinics, HC III - Hospital	Newly delivered women, newborns
C4.7.2: Referral of complicated cases	Community, clinics, HC III - Hospital	Newly delivered women
<b>C4.8: Family Planning Services</b>		
C4.8.1: Family planning education and counselling	Community, clinics, drug shops, pharmacies, HC II - Hospital	Sexually active males and females, sexually active adolescents
C4.8.2: Short-term family planning methods (pills, condoms, injectable contraceptives)	Community, clinics, drug shops, pharmacies, HC II – Hospital	Sexually active males and females
C4.8.3: Long-term family planning methods (implants, intrauterine devices)	Specialized clinics, HC III – Hospital	Sexually active females
C4.8.4: Emergency contraception	Drug shops, pharmacies clinics, HC II - Hospital	Sexually active females
C4.8.5: Female sterilization	Specialized clinics, HC IV - Hospital	Sexually active females who have reached their desired family size
C4.8.6: Male sterilization	Specialized clinics, HC IV - Hospital	Sexually active males who have reached their desired family size
<b>C4.9: Management of the Newborn and Infections of the Newborn</b>		
C4.9.1: Immediate thermal care, immediate and exclusive breastfeeding, hygienic cord care, Kangaroo Mother Care	Individual, maternity homes, HC III - Hospital	Newborns

<sup>2</sup> Other services (e.g., promotion of breast feeding and family planning) that are provided as part of the postnatal care package have been presented already in the respective sections.

<b>Services</b>	<b>Level of delivery</b>	<b>Target group</b>
C4.9.2: Neonatal resuscitation with bag and mask services	Maternity homes, HC III - Hospital	Newborns
C4.9.3: Treatment of newborns for neonatal sepsis, meningitis, pneumonia, jaundice	Specialized clinics, HC III – Hospital	Newborns
C4.9.4: Neonatal hiperbilirubinemia / neonatal kernicterus	Specialized clinics, HC IV – Hospital	Newborns
C4.9.5: Hypoxic ischemic encephalopathy of newborn / birth asphyxia	Specialized clinics, HC IV – Hospital	Newborns
C4.9.6: Respiratory distress of newborn	Specialized clinics, HC IV – Hospital	Newborns
C4.9.7: Apnoea of prematurity	Specialized clinics, HC IV – Hospital	Newborns
C4.9.8: Hypothermia of newborn	Maternity home, specialized clinics, HC IV - Hospital	Newborns
<b>C4.10: Promotion of Breastfeeding and Complementary Feeding</b>		
C4.10.1: Breastfeeding counselling and support services (at birth, home, and in the workplace)	Individual, community, workplaces, health facility (maternity homes, clinics, HC II - Hospital)	All pregnant and lactating women
C4.10.2: Counselling and support for complementary feeding of children from six months to two years	Household, community, health facilities (clinics, HC II - Hospital)	All women with children below two years old
<b>C4.11: Management of Common Childhood Ailments</b>		
C4.11.1: Treatment for lower and upper respiratory tract infections	Community, clinics, HC II - Hospital	Children
C4.11.2: Treatment for non-bloody diarrhoea	Community, clinics, HC II - Hospital	Children
C4.11.3: Treatment for bloody diarrhoea	Clinics, HC II - Hospital	Children
C4.11.4: Treatment for anaemia	Clinics, HC II - Hospital	Children
C4.11.5: Treatment for measles	Clinics, HC II - Hospital	Children
C4.11.6: Treatment for helminthiasis	Clinics, HC II - Hospital	Children
<b>C4.12: Management of Sexual- and Gender-Based Violence (SGBV)</b>		
C4.12.1: Counselling for SGBV	Community, Community Development Officers, police, clinics, HC II - Hospital	All age groups
C4.12.2: Management of injuries due to SGBV	Clinics, HC II - Hospital	All age groups
C4.12.3: Medico legal examination and documentation	HC IV - Hospital	All age groups
C4.12.4 Referral of SGBV victims for psychosocial and legal support	Community, clinics, HC II - Hospital	All age groups

## 4.10 Cluster 5: Surgical and Anaesthesia Care

A fifth cluster that focuses on surgical care and anaesthesia has been introduced. Injuries are now among the leading causes of mortality, but capacity to offer care for trauma has remained suboptimal. The previous UNMHCP paid limited attention to surgical conditions, yet there is evidence that surgical conditions are responsible for a significant portion of the mortality that is observed. The capacity to offer surgical services has also been very negligible given the limited attention paid to surgical services with gross absences of the required infrastructure, equipment, and personnel required to offer the services.

**Table 11: Services in cluster five**

Service / Surgical Procedure	Level	Target Group
<b>C5.1 General Surgery</b>		
C5.1.1: Wound care: Surgical toilet, debridement and suture, soft tissue injury toilet and suture	Clinics, HC III – general hospital	All age groups
C5.1.2: Incision and drainage of abscesses	Clinics, HC II – Hospital	All age groups
C5.1.3: Emergency and elective Laparotomy	HC IV - hospital	All age groups
C5.1.4: Elective and emergency hernia repair	HC IV - Hospital	All age groups
C5.1.5: Excision of skin tumours, soft lumps and other masses	Specialist Clinics, HC IV – general hospital	All age groups
C5.1.6: Anorectal surgery (piles, fissures, fistula)	HC IV - Hospital	All age groups
C5.1.7: Interventional endoscopy for gastrointestinal bleed control, lesion excision, stenting	GH - RRH	All age groups
C5.1.8: Laparoscopic surgery during cholecystectomy, appendectomy, excisions, fundoplication	RRH - NRH	All age groups
C5.1.9: Gastro-intestinal surgery Cholecystectomy, gastric surgery, pancreatic surgery, splenic surgery, liver surgery, colectomy, colostomy, appendectomy	Hospital	All age groups
C5.1.10: Endocrine Surgery Thyroidectomy, mastectomy, adrenalectomy	GH – NRH	All age groups
<b>C5.2: Paediatric Surgery</b>		
C5.2.1: Orchidopexy	HC IV - Hospital	Neonates & Children <18 years
C5.2.2: Operative and non-operative management of intussusception	RRH - NRH	Children <18 years
C5.2.3: Insertion of feeding tubes for neurological children	HC IV - Hospital	Neonates and older children <18 years
C5.2.4: Colostomy for imperforate anus	RRH - NRH	Neonates
C5.2.5: Management of cloacal exstrophy	NRH	Neonates
C5.2.6: Pull through for anorectal malformations and Hirschsprung disease	NRH	Neonates
C5.2.7: Tumour Surgery	RRH - NRH	Children <18 years
C5.2.8: Repair of abdominal wall defects (gastroschisis and omphalocele)	RRH – NRH	Neonates & Children
C5.2.9: Separation of Siamese twins	RRH – NRH	Neonates & Children
<b>C5.3: ENT Surgery</b>		
C5.3.1: Removal of foreign bodies in the airway, ear, nose and oesophagus	Clinics, HC III – Hospital	All age groups
C5.3.2: Management of epistaxis	Clinics, HC III – Hospital	All age groups
C5.3.3: Nasal bone fracture reduction	Hospital	All age groups

<b>Service / Surgical Procedure</b>	<b>Level</b>	<b>Target Group</b>
C5.3.4: Aural toilet	Clinics, HC III - GH	All age groups
C5.3.5: Adeno tonsillectomy	Hospital	All age groups
C5.3.6: Cortical mastoidectomy	Hospital	All age groups
C5.3.7: Basic functional endoscopic sinus surgery	Hospital	All age groups
C5.3.8: Tracheostomy	HC IV - Hospital	All age groups
<b>C5.4: Ocular Surgery</b>		
C5.4.1: Corneal foreign body removal	Specialized Clinics, HC IV- Hospital	All
C5.4.2: Keratoconus management	Specialized Clinics, HC IV- Hospital	All
C5.4.3: Orbital surgery: Orbital repairs, eyeball removal, enucleation, evisceration	HC IV - Hospital	All
C5.4.4: Oculoplastic surgery	RRH- NRH	All
C5.4.5: Cataract surgery	Specialized Clinics, HC IV - Hospital	All
C5.4.6: Strabismus surgery	RRH	Children
C5.4.7: Ptosis surgery	Specialized Clinics, HC IV - Hospital	Children
C5.4.8: Trichiasis surgery	Specialized Clinics, HC IV - Hospital	All
C5.4.9: Glaucoma treatment and surgery, peripheral iridectomy	Specialized Clinics, HC IV - Hospital	Youth and adults
<b>C5.5: Neurosurgery</b>		
C5.5.1: Burr holes for subdural hematomas	Hospital	All
C5.5.2: Craniotomy for intra cerebral bleed, aneurysmal clipping, tumour surgery, epilepsy surgery	RRH - NRH	All
C5.5.3: Endovascular coiling for cerebral aneurysm	NRH	All
C5.5.4: Endoscopic drainage of intraventricular bleed	RRH	All
C5.5.5: Insertion of ventriculo peritoneal shunt	GH _ NRH	All
C5.5.6: Endoscopic 3 <sup>rd</sup> ventriculostomy	RRH	All
<b>C5.6: Oral Maxillofacial Surgery</b>		
C5.6.1: Tooth scaling and polishing	Dental Clinics, HC IV – Hospital	All
C5.6.2: Tooth extraction and tooth filling	Dental Clinics, HC IV – Hospital	All
C5.6.3: Dental restoration	Dental Clinics, GH – NRH	All
C5.6.4: Incision and drainage of dental abscesses	Dental Clinics, HC IV - Hospital	All
C5.6.6: Tooth crown, bridge, dentures and implants	Dental Clinics, RRHs - NRH	Adults
C5.6.7: Open reduction, internal fixation with titanium plate and screws	Dental Clinics, RRHs – NRHs	All
C5.6.8: Enucleation and marsupialization of dental cysts	GH - RRH	All
C5.6.9: Excision and incisional biopsy of dental tumours	Dental Clinics, GH – NRH	All
<b>C5.7: Cardiothoracic and Vascular Surgery</b>		
C5.7.1: Thoracotomy surgery	RRHs, specialized centres	All
C5.7.2: Upper gastrointestinal endoscopy	RRHs, specialized centres	All
C5.7.3: Embolectomy	RRH - NRH, and specialized centres	All

Service / Surgical Procedure	Level	Target Group
C5.7.3: Major vascular surgery	RRH - NRH, specialized centres	All
C5.7.4: Patent ductus arteriosus ligation	RRH - NRH, specialized centres	All
C5.7.5: Rheumatic heart disease valve repair and replacement	RRH - NRH, specialized centres	All
C5.7.6: Chest drainage	GH - NRH	All
C5.7.7: Oesophageal, lung, chest, tumour surgery,	RRH - NRH, specialized centres	All
C5.7.8: Hiatus hernia surgery	RRH - NRH, specialized centres	All
C5.7.9: Diaphragmatic rupture surgery	RRH - NRH, specialized centres	All
C5.7.10: Feeding gastrostomy	Health facilities (RRH - NRH)	Adults
<b>C5.8: Orthopaedic and Trauma Surgery</b>		
C5.8.1: Cervical, lumbar, and pelvic stabilization	GH - NRH	All
C5.8.2: Limb amputation	GH - NRH	All
C5.8.3: Limb salvage surgery	RRH - NRH	All
C5.8.4: Management of fractures, limb immobilization, reduction of limb fractures, external and internal fixation	Orthopaedic clinics, HC IV - Hospital	All
C5.8.5: Arthroplasty and arthrotomy	RRH - NRH	All
C5.8.6: Sequestrectomy	RRH - NRH	All
C5.8.7: Bone reconstruction	RRH - NRH	All
<b>C5.9: Genitourinary Surgery</b>		
C5.9.1: Management of urinary retention		
• Catheterization	Clinics, HC - IV	All
• Suprapubic cystostomy	Specialized clinics, HC IV - RRH	All
• Prostatectomy	GH - RRH	Adult males aged over 40 years
C5.9.2: Management of priapism		
• Hydration aspiration	HC IV - RRH	Males aged 5–50 years
• Catheterization shunting	RRH	Males aged 5–50 years
C5.9.3: Management of gross haematuria, cystoscopy		
	RRH	Males aged 5–50 years
	RRH	All
C5.9.3: Hydrocelectomy	HC IV - RRH	All males
C5.9.4: Varicocelectomy	RRH	Males aged 20–50 years
C5.9.5: Management of penile, bladder, ureter, and kidney trauma		
• Reconstructive surgery	RRH	All males
• Simple nephrectomy	RRH	All
C5.9.6: Pyeloplasty	NRH	All
C5.9.7: Orchidopexy	HC IV - RRH	Males aged 0–10 years
C5.9.8: Circumcision for paraphimosis	Clinics, HC III - Hospital	All males
C5.9.9: De slough and debridement for Fournier's gangrene	HC IV - Hospital	All males
C5.9.10: Urethroplasty	NRH	All
C5.9.11: Urolithiasis	NRH	Ages five and above
C5.9.12: Urine diversion surgery	NRH	All

Service / Surgical Procedure	Level	Target Group
C5.9.13: Paediatric urology, vesicostomy, posterior urethral valves ablation, bladder exstrophy epistasis complex surgery, hypospadias, epispadias repair, pyeloplasty, orchidopexy, meatoplasty	NRH	0–18 year olds
<b>C5.10: Anaesthesia</b>		
C5.10.1: Safe anaesthesia for all basic and general surgeries	Clinics, HC IV - NRH	All
C5.10.2: Safe anaesthesia for specialized surgeries	GH - NRH	All
<b>C5.11: Plastic and Reconstructive Surgery</b>		
C5.11.1: Burns management (burns resuscitation, toilet)	Clinics, HC III - NRH	All
C5.11.2: Grafting and contracture surgery	RRH - NRH	All
C5.11.3: Reconstructive surgery (cleft lip and palate repair, breast reconstruction or reduction, limb salvage, facial reconstruction, hand surgery)	GH - NRH	All

#### 4.11 Cluster 6: Emergency, Critical, and High Dependency Care

This cluster has been introduced to streamline the national response to emergencies at the pre-hospital and hospital levels in accordance with local and international best practices. Emergency medicine has hitherto received inadequate attention. Timely provision of services during emergencies is critical for reducing mortality due to life-threatening conditions. Both out-of-hospital and facility-based emergency care are essential components of the health care continuum. Emergency medicine services including emergency medical and surgical services, evacuation, and pre-hospital care will be provided through this cluster.

**Table 12: Services in cluster six**

Services	Level of delivery	Target Group
<b>C6.1: Management of Cardiovascular-Related Emergencies</b>		
C6.1.1: Management of hypertensive urgencies and emergencies	Health facilities (HC IV - Hospitals and specialized centres)	Children and adults
C6.1.2: Management of acute exacerbations of ischaemic heart disease	Health facilities (hospitals and specialized centres)	Adults
C6.1.3: Management of acute heart failure	Health facilities (HC IV - Hospitals and specialized centres)	All
C6.1.4: Management of acute stroke	Health facilities (HC IV - Hospitals and specialized centres)	Adults
C6.1.5: Management of venous thrombosis and thromboembolism	Health facilities (hospitals and specialized centres)	Children and adults
C6.1.6: Management of acute arrhythmias	Health facilities (hospitals and specialized centres)	All
<b>C6.2: Management of Respiratory Emergencies</b>		
C6.2.1: Initial management of difficulty in breathing	Health facilities (clinics, HC IV - Hospitals and specialized centres)	All
C6.2.2: Management of severe chronic obstructive pulmonary disease	Health facilities (Hospitals and specialized centres)	Adults

Services	Level of delivery	Target Group
C6.2.3: Management of acute asthma exacerbations	Health facilities (clinics, HC III - Hospitals and specialized centres)	All
<b>C6.3: Management of Severe Acute Exacerbations of Diseases of the Gastrointestinal Tract</b>		
C6.3.1: Management of severe acute exacerbations of diseases of the oral cavity	Health facilities (hospitals and specialized centres)	All
C6.3.2: Management of severe acute gastritis, peptic ulcer disease, and duodenitis	Health facilities (clinics, hospitals, and specialized centres)	All
C6.3.3: Management of severe acute pancreatitis	Health facilities (hospitals and specialized centres)	All
C6.3.4: Management of ileus and intestinal obstruction	Health facilities (hospitals and specialized centres)	All
C6.3.5: Management of severe acute appendicitis	Health facilities (hospitals and specialized centres)	All
C6.3.6: Management of severe acute gallbladder and biliary diseases	Health facilities (hospitals and specialized centres)	All
<b>C6.4: Management of Emergency Complications of Diabetes Mellitus</b>		
C6.4.1: Management of hyperglycaemic and hypoglycaemic emergencies	Health facilities (hospitals and specialized centres)	Patients with diabetes
<b>C6.5: Management of Emergency Disorders of the Genitourinary System</b>		
C6.5.1: Management of urinary retention or obstruction	Health facilities (clinics, hospitals, and specialized centres)	All
C6.5.2: Management of acute kidney injury	Health facilities (hospitals and specialized centres)	All
C6.5.3: Management of testicular torsion	Health facilities (hospitals and specialized centres)	All males
<b>C6.6: Management of Emergency Mental, Neurological, and Substance Disorders and Conditions</b>		
C6.6.1: Management of acute conditions related to alcohol use and alcohol use disorders	Health facilities (HC IV - Hospitals and specialized centres)	Adolescents and adults
C6.6.2: Management of acute conditions related to drug use and drug use disorders	Health facilities (hospitals and specialized centres)	Adolescents and adults
C6.6.3: Management of acute convulsive seizures and epilepsy	Health facilities (clinics, hospitals, and specialized centres)	All
C6.6.4: Management of acute behavioural disturbance	Health facilities (clinics, hospitals, and specialized centres)	All
<b>C6.7: Management of Severe Thermal and Chemical Injuries (burns)</b>		
C6.7.1: Management of severe burns	Health facilities (Hospitals and Specialized Centres)	All
<b>C6.8: Management of Severe Envenomation Injuries, Poisoning, Toxic and Environmental Exposure Injuries</b>		
C6.8.1: Management of severe bites and envenoming injuries	Health facilities (Hospitals and Specialized Centres)	All
C6.8.2: Management of poisoning, toxic and environmental exposure, injuries (including drowning)	Health facilities (clinics, HC III - Hospitals, and specialized centres)	All
<b>C6.9: Management of Severe Infections</b>		
C6.9.1: Management of severe malaria with complications	Health facilities (clinics, hospitals, and specialized centres)	Patients with malaria
C6.9.2: Management of acute viral infections (hepatitis, encephalitis, etc.)	Health facilities (hospitals and specialized centres)	All
C6.9.3: Management of severe bacterial infections with complications (meningitis, typhoid fever, etc.)	Health facilities (hospitals and specialized centres)	All
<b>C6.10: Management of Premature Births</b>		
C6.10.1: Neonatal intensive care	Health facilities (HC IV - Hospital)	Neonates

Services	Level of delivery	Target Group
<b>C6.11: Management of Severe Mechanical Injuries</b>		
C6.11.1: Management of initial serious injury	Health facilities (clinics, hospitals, and specialized centres)	All
C6.11.2: Management of severe head and face injury (including ocular injury)	Health facilities (hospitals and specialized centres)	All
C6.11.3: Management of thoracoabdominal injury	Health facilities (hospitals and specialized centres)	All
C6.11.4: Management of spinal injury (including neck injury)	Health facilities (hospitals and specialized centres)	All
C6.11.5: Management of pelvic injury (including urogenital)	Health facilities (hospitals and specialized centres)	All
C6.11.6: Management of severe extremity injury	Health facilities (hospitals and specialized centres)	All
C6.11.7: Management of severe wounds (excluding burns)	Health facilities (hospitals and specialized centres)	All
<b>C6.12: Evacuation and Referral Services</b>		
C6.12.1: Pre-hospital care	Community, clinics, HC III - HC IV	All
C6.12.2: Evacuation and referral services	HC III - Hospitals	All
<b>C6.13: Critical Care</b>		
C6.13.1: Basic and specialized critical care	HC IV - Hospitals	All

## 4.12 Cluster 7: Geriatric Care

The demographic profile for Uganda is changing and the proportion of the elderly in the country is increasing. As people age, they suffer from multiple morbidities comprising of both communicable diseases and NCDs. In addition, they progressively lose their functional ability. Because of the weak social protection system in the country, a significant proportion of elderly people lack adequate social support and face financial hardships while seeking services. Delivery of an effective package of geriatric services is therefore critical for promoting healthy ageing and improving the quality of life of the elderly population. This will enable the health and social systems to meet the unique health and social care needs of elderly persons.

**Table 13: Services in cluster seven:**

Service/ Surgical Procedure	Level	Target Group
<b>C7.1 Management of Central Nervous Disorders</b>		
C7.1.2 Parkinson's disease, dementia, Alzheimer's disease, delirium, cognitive impairment	Health facilities (clinics, GH - RRH)	Elderly patients
<b>C7.2 Management of Depression</b>		
C7.2.1 Screening for depression	Health facilities (Clinics, GH- RRH)	Elderly patients
C7.2.2 Management of depressive symptoms (Cognitive behavioural therapy, Problem-solving counselling, behavioural activation, life review therapy, mindfulness practice)	Health facilities (GH- RRH)	Elderly patients
C7.2.3 Management of depression	Health facilities (GH- RRH)	Elderly patients
C7.2.4 Assessment and management of social physical environments (reduction of stress, strengthening social support and reducing social isolation, encouraging mobility & promoting functioning in daily activities)	Households and communities	Elderly patients
<b>C7.3 Management of Orthopaedic Disorders</b>		
C7.3.1 Osteoarthritis and osteoporosis	Health facilities (Clinics, GH- RRH)	Elderly patients
C7.3.2 Back pain	Health facilities	Elderly patients



<b>Service/ Surgical Procedure</b>	<b>Level</b>	<b>Target Group</b>
	(Clinics, GH- RRH)	
<b>C7.4: Management of Respiratory Disorders</b>		
C7.4.1: Management of chronic obstructive pulmonary airway disease	Health facilities (clinics, GH - RRH)	Elderly patients
C7.4.2: Management of pneumonia	Health facilities (clinics, GH - RRH)	Elderly patients
<b>C7.5: Management of Dental Problems</b>		
C7.5.1: Tooth extraction and tooth filling	Dental clinics, HC IV - Hospital	All
C7.5.2: Management of periodontal disease	Dental clinics, HC IV - Hospital	All
<b>C7.6: Management of Diseases of the Visual System</b>		
C7.6.1: Screening for visual impairment	Health facilities (clinics, GH - RRH)	Elderly patients
C7.6.2: Promotion of visual hygiene	Health facilities (clinics, GH - RRH)	Elderly patients
C7.6.3: Management of visual impairment (home adaptations, assistive devices)	Health facilities (clinics, GH - RRH)	Elderly patients
C7.6.4: Management of infectious and non-infectious diseases of the eye (cataracts, glaucoma)	Health facilities (clinics, GH - RRH)	Elderly patients
<b>C7.7: Management of Hearing Impairment</b>		
C7.7.1: Testing for hearing loss	Health facilities (clinics, GH - RRH)	Elderly patients
C7.7.2: Management of hearing loss (audiological rehabilitation, hearing devices)	Health facilities (clinics, GH - RRH)	Elderly patients
<b>C7.8: Management of Cardiovascular Diseases</b>		
C7.8.1: Management of hypertension	Health facilities (clinics, GH - RRH)	Elderly patients
C7.8.2: Management of hypertensive diseases (hypertensive heart disease, congestive heart failure, hypertensive renal disease, hypertensive crisis, hypotension)	HC IV - Hospitals	Elderly patients
C7.8.3: Management of deep vein thrombosis / pulmonary embolism and other diseases of the arteries or veins	Hospitals	Elderly patients
C7.8.4: Management of cerebrovascular diseases (strokes, mini strokes, transient ischaemic attacks)	Hospitals	Elderly patients
<b>C7.9: Cancer Prevention and Management</b>		
C7.9.1: Screening for cancers	Health facilities (clinics, GH- RRH)	Elderly patients
C7.9.2: Management of cancers	Health facilities (clinics, GH- RRH)	Elderly patients
C7.9.3: Palliative care	Health facilities (clinics, GH- RRH)	Elderly patients
<b>C7.10: Management of Nutritional Disorders</b>		
C7.10.1: Nutritional assessment	Health facilities (clinics, GH- RRH)	Elderly patients
C7.10.2: Management of malnutrition (nutritional advice, nutrient supplementation)	Health facilities (clinics, GH- RRH)	Elderly patients
<b>C7.11: Management of Endocrine Disorders</b>		
C7.11.1: Management of diabetes and complications of diabetes	Health facilities (clinics, GH- RRH)	Elderly patients
<b>C7.12: Social Care and Support</b>		
C7.12.1: Assessment of social support needs (living conditions, financing, loneliness, elder abuse)	Community and health facilities	Elderly patients
C7.12.2: Support for self-care and self-management	Households, community, hospitals	Elderly patients
C7.12.3: Social care and support (living conditions, financial support, social engagement and support)	Households, community	Elderly patients
C7.12.4: End-of-life care	Community and hospitals	Elderly patients
<b>C7.13: Enhancing Locomotor Capacity</b>		

Service/ Surgical Procedure	Level	Target Group
C7.13.1: Screening for limited mobility	Clinics, hospitals	Elderly patients
C7.13.2: Management of limited mobility (multimodal exercises, mobility assistive devices)	Communities, households	Elderly patients
C7.13.3: Assessment and management of physical spaces (home adaptations to prevent falls and safe spaces for walking)	Communities, households, LGs	Elderly patients
<b>C7.14: Urinary Incontinence</b>		
C7.14.1: Assessment of urinary incontinence	Clinics, hospitals	Elderly patients
C7.14.2: Management of reversible causes of urinary incontinence (delirium, infection, atrophic vaginitis, medication-induced urinary retention, depression, hyperglycaemia, stool impaction)	Clinics, hospitals	Elderly patients
C7.14.3: Conservative management of urinary incontinence (bladder training, pelvic floor muscle training)	Households	Elderly patients
<b>C7.15: Support for Caregivers of Elderly Patients</b>		
C7.15.1: Assessment of the caregiver's mood	Hospitals	Caregivers
C7.15.2: Support to the caregiver (training, counselling, support network)	Communities, hospitals	Caregivers

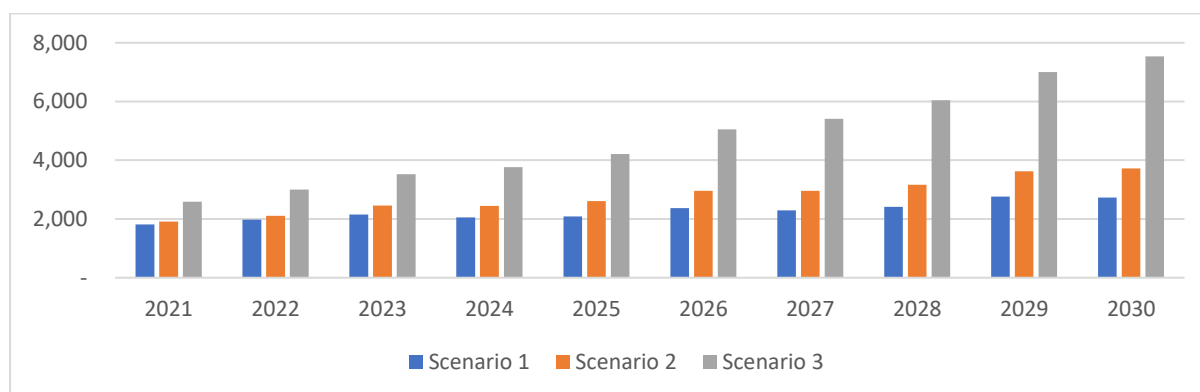
## 5 COSTING OF THE UNEHCP

### 5.1 Cost Estimates for Implementation of the UNEHCP

#### Scenario Comparisons

The resource estimates for the three scenarios are compared as shown in Figure 5.

**Figure 5: Comparison of the costs for the three scenarios (USD)**



Scenario 1 reflects very minimal increases in the scope and coverage of services and alignment to the current resource envelop. The changes in the resources are largely driven by the growth in the population other than scope of services.

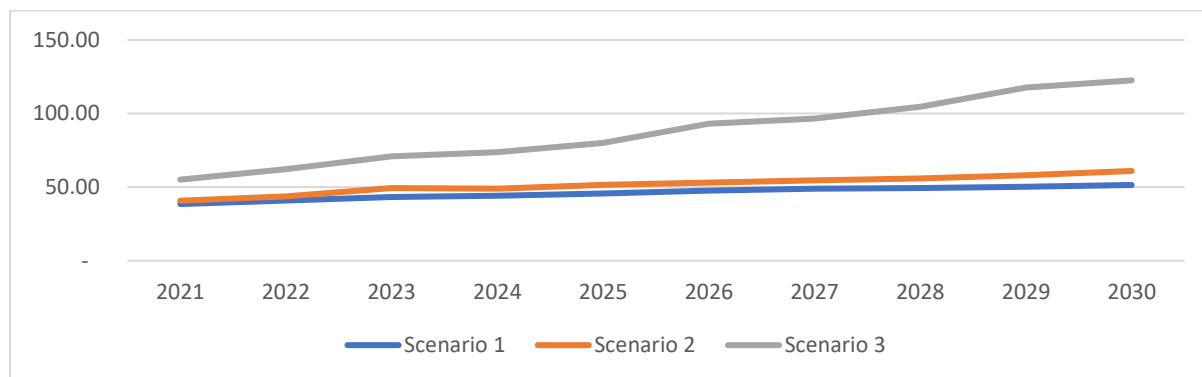
The increases under scenario 2 are designed to match the level of investments in the infrastructure and the human resource gaps as well as a moderate increase in the funding for the health programs.

The exponential increases in resources under scenario 3 are attributed to assumptions where coverage has increased to 80% and above. Additionally, all capacity constraints have been

addressed in the first four years. These include the human resource constraints, infrastructure, a strengthened community system, and a vibrant health information system.

The trend of the per capita expenditure under the third scenario would reflect a rapid growth in expenditures as compared to the other two scenarios as illustrated in Figure 6.

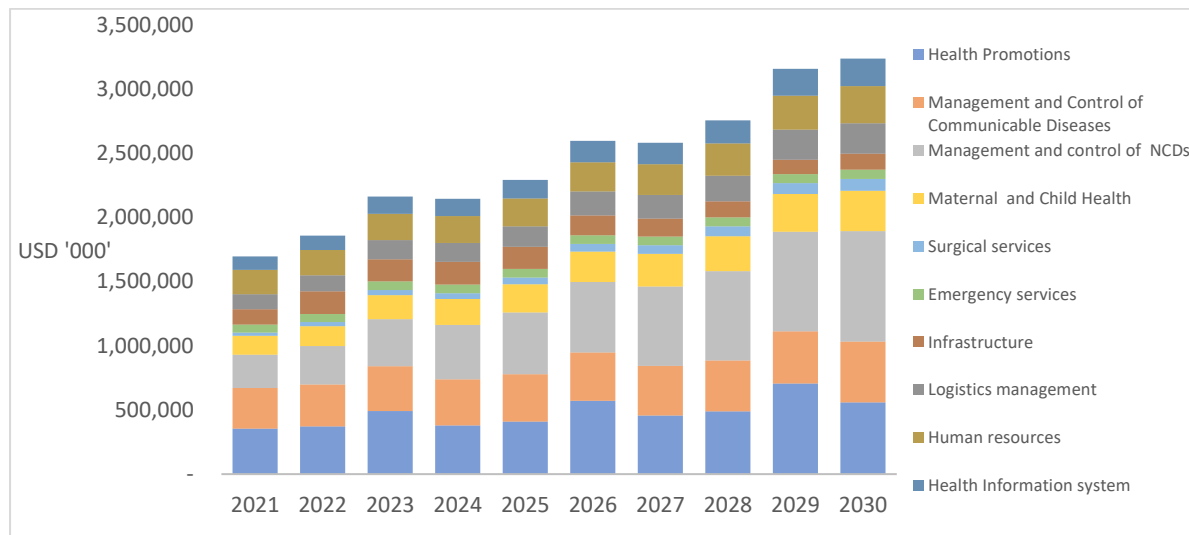
**Figure 6: Comparison of per capita expenditure (USD)**



## 5.2 Preferred Scenario

Scenario 2 is the preferred scenario, since it would allow the country to make progress in expanding the scope of services with moderate additional investments. Figure 7 outlines the resource estimates that would be required for Scenario 2 over the 10-year scale up period.

**Figure 7: Resource estimates for scenario 2**



### Infrastructure Investments

The proposed scenario would require an investment of USD 818.6 billion for the first five years in the areas highlighted below:

- Establishment of centres of excellence by the Uganda Heart and Cancer Institutes.
- Construction of HC IIIs in the 132 sub-counties without a health facility.
- Construction of HC IVs in the 66 constituencies without HC IVs.

- Upgrade of HC IIs in sub-counties without a health facility.
- Rehabilitation / expansion of hospitals and HCs.
- Equipment of all health facilities with appropriate medical and diagnostic equipment.
- Construction of three blood bank centres.

## Human Resources

The estimates for human resources cover the staff remuneration based on the revised staff norms as well the proposed manpower to run the specialized units as they get operationalized. The human resource estimates are aligned to the Human Resources for Health Strategic Plan 2020–2030. The plan estimates the current health worker density at 1.6 workers per 1,000 persons for health workers with active practicing licenses. An additional 44,741 workers would be required to meet the World Health Organization threshold of 2.3 workers per 1,000 persons by 2025. Table 14 outlines the projected workforce requirements.

**Table 14: Projected health workforce requirements**

Cadre	No. of Health Workers with Active Practicing License	Total projected requirement 2030	New Health Workers to Be Trained Cadre
Specialized Doctor and Dentist	1,300	2,624	1,324
General Medical Doctor and Dentist	3,124	5,247	2,123
Pharmacist	900	1,443	543
Degree Nurse / Midwife	1,463	1,574	111
Degree Allied Health Professional	1,265	1,181	-
Diploma Comprehensive Nurse	2,119	2,119	-
Diploma Midwife	4,638	7,053	2,415
Diploma Nurse and Psychiatric Nurse	7,086	13,511	6,425
Certificate Nurse and Psychiatric Nurse	12,240	23,612	11,372
Public Health Nurse	90	3,712	3,622
Certificate Comprehensive Nurse	11,042	11,042	-
Certificate Midwife	10,323	18,365	8,042
Diploma / Certificate Allied Health Staff (Public Health)	812	9,576	8,764
Diploma / Certificate Allied Health Staff (Clinical)	11,044	9,707	-
Diploma / Certificate Allied Health Staff (Diagnostic)	4,172	3,935	-
<b>TOTAL</b>	<b>71,618</b>	<b>114,701</b>	<b>44,741</b>

Source: *Human Resources for Health Strategic Plan 2020–2030*

## 5.3 Cost Estimates for PHC Services

PHC services were also identified and costed. The costing of the PHC is built on the same extensive costing methodology of the UNEHCP described above. The key interventions proposed in the PHC scenario were selected to ensure that essential care can be made available to the majority of the population and is easily accessible to those who are in need.

The PHC costing was designed to answer the following questions:

- a) What resources would be required to implement PHC over a 10-year period?
- b) What would be the costs required for each year or for a specified period?
- c) What inputs in terms of infrastructure, human resources, medicines, and health supplies are required during a specified period of implementation?

For purposes of the PHC costing, two scenarios have been developed — a) Moderate Scenario and b) Universal Coverage Scenario — to guide the decision-making process.

**a) Moderate Scenario**

This scenario was developed with the assumption that only some of the key constraints would be addressed to allow an increased uptake of the services. The assumption included moderate improvements in key human resource placements, refurbishments, and equipping the health facilities, particularly the HCs and General Hospitals. The resource estimates under this scenario are influenced by the assumptions illustrated below:

- i) This scenario assumed a moderate scale up of the key interventions across the period of the plan.
- ii) For interventions with coverage of less than 40%, these were planned to be scaled up by a 50% increase by 2030.
- iii) Infrastructure refurbishments particularly for the 132 sub-counties without any health facility and the 66 constituencies without HC IVs. HC IIs upgraded in sub-counties without a health facility. Hospitals and HCs rehabilitated / expanded.
- iv) Human resource gaps filled up as implementation progresses to at least 80%.

The scenario would require USD 18.1 billion over the 10-year period with a resource growth from USD 1.39 billion in the first year to USD 2.2 billion in the last year of the plan. This would result in an increase in the per capita expenditure of USD 29.5 in the first year with an estimated per capita expenditure of USD 37.03 in the last year.

The resources are allocated to the major clusters as follows: health promotion, disease prevention, and community health initiatives (26%), management and control of communicable diseases (20%), management and control of NCDs (9%), maternal and child health (9%), surgical and anaesthesia services (0.15%), and Emergency services (2%).

**Table 15: Costs for the PHC moderate scenario**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Totals
US\$ in '000'											
Health Promotions	304,700	406,982	441,272	336,891	368,668	523,278	419,573	456,372	658,338	533,800	4,449,873
Management and Control of Communicable Diseases	349,582	312,606	333,626	342,016	350,502	359,281	368,756	378,062	387,428	454,058	3,635,917
Management and control of NCDs	89,478	101,333	117,783	131,278	146,003	162,057	179,622	198,765	219,603	242,410	1,588,334
Maternal and Child Health	105,413	111,579	137,195	147,486	158,547	170,434	183,052	196,367	210,378	225,027	1,645,478
Surgical services	1,212	1,460	1,791	2,079	2,381	2,699	3,034	3,384	3,751	4,134	25,925
Emergency services	27,894	27,967	29,145	29,210	29,279	29,354	29,433	29,517	29,607	29,702	291,108
<b>Totals</b>	<b>878,279</b>	<b>961,928</b>	<b>1,060,812</b>	<b>988,960</b>	<b>1,055,381</b>	<b>1,247,102</b>	<b>1,183,470</b>	<b>1,262,468</b>	<b>1,509,104</b>	<b>1,489,131</b>	<b>11,636,635</b>
<b>Health system strengthening</b>											
US\$ in '000'											
Infrastructure	34,031	73,074	66,422	38,957	43,162	45,321	47,587	49,966	52,464	55,087	506,071
Logistics management	87,828	96,193	106,081	98,896	105,538	124,710	118,347	126,247	150,910	148,913	1,163,663
Human resources	142,706	152,899	152,899	163,092	163,092	169,616	176,401	183,457	190,795	198,427	1,693,384
Health Information system	79,045	76,954	84,865	79,117	84,430	99,768	94,678	100,997	120,728	119,131	939,714
Community engagements	32,507	46,879	45,947	56,245	51,394	56,533	62,187	68,405	75,246	82,771	578,114
Program overheads and management	87,828	96,193	106,081	98,896	105,538	124,710	118,347	126,247	150,910	148,913	1,163,663
<b>Sub Totals</b>	<b>463,945</b>	<b>542,192</b>	<b>562,295</b>	<b>535,204</b>	<b>553,155</b>	<b>620,659</b>	<b>617,546</b>	<b>655,319</b>	<b>741,054</b>	<b>753,241</b>	<b>6,044,610</b>
<b>Grand Totals</b>	<b>1,342,225</b>	<b>1,504,120</b>	<b>1,623,107</b>	<b>1,524,163</b>	<b>1,608,536</b>	<b>1,867,761</b>	<b>1,801,015</b>	<b>1,917,787</b>	<b>2,250,158</b>	<b>2,242,373</b>	<b>17,681,245</b>

### b) Universal Coverage Scenario

This is an ambitious scenario which presupposes that all constraints have been addressed. The resource estimates under this scenario are influenced by the assumptions illustrated below:

- i) This scenario assumes a rapid scale up of interventions to attain universal coverages.
- ii) All infrastructure capacity is in place from HC III to the referral hospitals.
- iii) Financials requirements are duly fulfilled.
- iv) Human resource gaps at the various levels are assumed to be filled.

The UHC scenario would require USD 23 billion over the 10-year period with a resource growth from USD 1.43 billion in the first year to UD 3.29 billion in the last year of the plan. This would generate a per capita expenditure of USD 30.55 in the first year and USD 53.6 in the last year.

The resources are allocated to the major clusters as follows: health promotion, disease prevention, and community initiatives (27%), management and control of communicable diseases (18%), management and control of NCDs (12%), maternal and child health (10%), surgical services (0.11%), and emergency services (1%).

**Table 16: Costs for the PHC universal scenario**

<b>Program Costs</b>											
	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Totals
US\$ in '000'											
Health Promotions	350,381	474,710	537,809	452,952	510,509	703,184	619,241	688,475	943,591	837,622	6,118,474
Management and Control of Communicable Diseases	357,661	330,717	362,343	380,931	399,924	419,561	440,330	461,282	482,666	572,267	4,207,681
Management and control of NCDs	105,787	133,617	169,495	202,912	239,491	279,463	323,216	370,918	422,801	479,446	2,727,147
Maternal and Child Health	106,511	123,600	166,401	191,015	217,795	246,906	278,312	312,032	348,115	386,517	2,377,205
Surgical services	1,212	1,460	1,791	2,079	2,381	2,699	3,034	3,384	3,751	4,134	25,925
Emergency services	46,899	47,003	48,978	49,081	49,193	49,314	49,446	49,587	49,738	49,900	489,138
<b>Sub Totals</b>	<b>968,451</b>	<b>1,111,107</b>	<b>1,286,817</b>	<b>1,278,970</b>	<b>1,419,294</b>	<b>1,701,128</b>	<b>1,713,578</b>	<b>1,885,678</b>	<b>2,250,661</b>	<b>2,329,886</b>	<b>15,945,570</b>
<b>Health system Strengthening</b>											
	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Totals
US\$ in '000'											
Infrastructure	35,835	76,058	70,942	44,757	50,441	52,963	54,022	55,102	56,204	57,329	553,653
Logistics management	96,845	111,111	128,682	127,897	141,929	170,113	171,358	188,568	225,066	232,989	1,594,557
Human resources	154,938	159,015	159,015	163,092	163,092	169,616	176,401	183,457	190,795	198,427	1,717,848
Health Information system	87,161	88,889	102,945	102,318	113,543	136,090	137,086	150,854	180,053	186,391	1,285,330
Community engagements	32,507	46,879	45,947	56,245	51,394	56,533	62,187	68,405	75,246	82,771	578,114
Program overheads and management	96,845	111,111	128,682	127,897	141,929	170,113	171,358	188,568	225,066	232,989	1,594,557
<b>Sub Totals</b>	<b>504,131</b>	<b>593,061</b>	<b>636,213</b>	<b>622,207</b>	<b>662,329</b>	<b>755,428</b>	<b>772,411</b>	<b>834,954</b>	<b>952,430</b>	<b>990,894</b>	<b>7,324,058</b>
<b>Grand Totals</b>	<b>1,472,582</b>	<b>1,704,168</b>	<b>1,923,030</b>	<b>1,901,176</b>	<b>2,081,623</b>	<b>2,456,556</b>	<b>2,485,989</b>	<b>2,720,632</b>	<b>3,203,091</b>	<b>3,320,781</b>	<b>23,269,628</b>

## 5.4 Financing the Strategy

Based on the funding gap analysis, while the resource needs for the UNEHCP grew by an average of 8% annually, the projected inflow dropped by an annual average of 3% over the 10-year period. This resulted into a funding deficit of USD 759 million in the first year, which grew to about USD 2.6 billion in the tenth year of the plan.

**Table 17: Funding gap analysis**

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Totals
USD in '000'											
<b>Resource estimates</b>	<b>1917</b>	<b>2,113.27</b>	<b>2,453.56</b>	<b>2,448.35</b>	<b>2,608.5</b>	<b>2,962.28</b>	<b>2,955.27</b>	<b>3,162.33</b>	<b>3,627.69</b>	<b>3,726.04</b>	<b>27,974.4</b>
<b>Projected funding</b>											
GoU Medium Term Expenditure Framework Projections	331.23	331.23	341.17	347.99	354.95	365.6	372.91	380.37	391.78	399.62	3,616.8
Private health insurance	58.21	58.21	59.37	60.56	61.77	63	64.26	65.55	66.86	68.2	626
Donor funding (on budget)	328.22	328.49	331.78	335.1	338.45	341.83	345.25	348.7	352.19	355.71	3,405.7
Donor funding (off budget)	439.7	407.52	387.32	368.12	349.87	332.54	316.07	300.41	285.54	271.41	3,458.5
<b>Projected resources</b>	<b>1157.4</b>	<b>1125.5</b>	<b>1,119.6</b>	<b>1,111.8</b>	<b>1,105.0</b>	<b>1,103.0</b>	<b>1,098.5</b>	<b>1,095.0</b>	<b>1,096.4</b>	<b>1,094.9</b>	<b>11,107</b>
<b>Funding gap</b>	<b>-759.6</b>	<b>-987.77</b>	<b>-1,333.96</b>	<b>-1,336.55</b>	<b>-1,503</b>	<b>-1,859.28</b>	<b>-1,856.8</b>	<b>-2,067.3</b>	<b>-2,531.29</b>	<b>-2,631.14</b>	<b>-16,867</b>

In the spirit of domestic resource mobilization and financial sustainability, it is anticipated that the GoU will scale up financing for the packages through the current grants, development partners, and public-private partnerships with the private sector players.

The Uganda Health Financing Strategy 2015/16–2024/25 details the innovative financing mechanisms and public financing management interventions that, if well implemented, could contribute additional resources while promoting more efficient use of existing resources.

Lastly, the program-based approach to financing provides an opportunity to leverage resources under the HCDP with interventions by Ministries — such as Water and Environment; Education and Sports; Gender, Labour, and Social Development — that influence health outcomes. Specifically, increased literacy, poverty alleviation, grants for social protection in areas of disability and older persons, support for youth livelihood, and the Parish Development Model could contribute to improved nutrition, a safer environment, and a reduction in poverty and disease.

Harnessing external and private financing (both on and off-budget), where partners support government priorities (as defined in the NDP III and Programme Implementation Action Plan (PIAPs)), could reduce fragmentation of financing pools and duplication in financing the interventions — thereby enhancing allocative efficiency.

While household contributions in the form of OOP expenditure are a potentially significant source of financing, they are not equitable and can be impoverishing and unpredictable. Therefore, this has not been factored into the financing mechanisms.



## 6 IMPLEMENTATION ARRANGEMENTS

### 6.1 Implementation Framework

The delivery of the UNEHCP will be guided by the strategic direction that the MoH has outlined in its policy documents, including but not limited to the NHP III, five-year strategic plans, HCDP-PIAP (2020–2025), Uganda UHC roadmap, and existing Health Sector Service Standards and Service Delivery Standards (2021). The latter stipulates that:

- All levels of health care will provide graded promotive, preventive, curative, rehabilitative, and palliative care services as summarized in Table 18. Services offered at different levels of care may change from time to time according to new updates in the service delivery structure.
- Standards for each level of services will be adhered to as described in detail in the Health Sector Service Standards and Service Delivery Standards.
- Details of staffing per level will follow the Ministry of Public Service’s approved staffing norms.
- Equipment per level will be provided according to the approved National Medical Equipment lists and specifications.
- Essential Medicines and Health Supplies (EMHS) will be provided according to the approved EMHS lists.
- Infrastructure will be aligned to the MoH infrastructure designs or specifications.

**Table 18: Summary of services to be provided by level of care**

Level	Target	N <sup>o</sup> . of Beds	Health Care Services Provided
Community	Household / village / schools / institutions / workplaces	0	<ul style="list-style-type: none"> <li>• Individual / household / school health promotion and education</li> <li>• Environmental health, sanitation, and hygiene</li> <li>• Mitigation of emerging environmental health problems (pollution, climate change)</li> <li>• Household vector control</li> <li>• Prevention of NCDs</li> <li>• Screening for NCDs (blood sugar, blood pressure measurement, breast examination)</li> <li>• Nutrition</li> <li>• Occupational health and safety</li> <li>• Management of NCDs (palliative care, rehabilitation and physiotherapy, psychosocial support for mental illness, neurological and substance abuse issues, management of child abuse)</li> <li>• Management of newborn (immediate thermal care, exclusive breastfeeding, cord care)</li> <li>• Promotion of breastfeeding and complementary feeding</li> <li>• Adolescent reproductive health services (provision of age-appropriate information on sexual and reproductive health and rights)</li> <li>• Management of GBV (reporting, counselling, and referral of SGBV victims for psychosocial and legal support)</li> <li>• Evacuation and referral services (pre-hospital care)</li> </ul>

Level	Target	N <sup>o</sup> . of Beds	Health Care Services Provided
HC II / Community health worker	Parish / ward  (5,000 people)	2	<ul style="list-style-type: none"> <li>• Health promotion and education</li> <li>• Environmental health, sanitation, and hygiene</li> <li>• Community mobilization for outreach services for defined services</li> <li>• Nutrition assessment, counselling, education, and growth monitoring and promotion</li> <li>• Promotion of breastfeeding and complementary feeding</li> <li>• Management of common childhood ailments (Integrated Community Case Management for defined illnesses)</li> </ul>
HC III	Sub-county / division (20,000– 30,000 people)	30 (10 maternity, 10 children, 5 female, 5 male)	<ul style="list-style-type: none"> <li>• Health promotion and education</li> <li>• Environmental health, sanitation, and hygiene</li> <li>• Routine childhood and adult vaccination</li> <li>• Emergency vaccination</li> <li>• Prevention of communicable diseases</li> <li>• Prevention of NTDs and worm infestations</li> <li>• Prevention and screening for NCDs</li> <li>• Nutrition assessment, counselling, education, growth monitoring and promotion for children under five years of age</li> <li>• Disease surveillance and response</li> <li>• Occupational health and safety</li> <li>• Management and control of communicable diseases (malaria, TB, sexually transmitted infections, HIV/AIDS, NTDs, zoonotic diseases, common mycoses, common bacterial and viral infections)</li> <li>• Management and control of NCDs (essential hypertension, palliative care, mental and behavioural disorders, psychosocial support, psychiatric care, anaemias, nutritional disorders, diseases of the nervous system)</li> <li>• Routine antenatal care services</li> <li>• Management of haemorrhage related to pregnancy</li> <li>• Management of maternal disorders related to pregnancy (genitourinary infections, malnutrition)</li> <li>• Maternal care related to the foetus, amniotic cavity, or possible delivery problems (postabortion care, premature rupture of membranes, placenta praevia, false labour)</li> <li>• Normal delivery care services</li> <li>• Emergency obstetric care services (manual removal of placenta, removal of retained products of conception, referral management, referral of complicated cases)</li> <li>• Postnatal care services</li> <li>• Family planning services (education and counselling, provision of short-term methods and long-term methods — implants and intrauterine devices, emergency contraception)</li> <li>• Management of newborn and infections of the newborn (neonatal resuscitation, neonatal sepsis, meningitis, pneumonia, jaundice)</li> <li>• Promotion of breastfeeding and complementary feeding</li> <li>• Adolescent reproductive health services (provision of age-appropriate information on sexual and reproductive health and rights, counselling on family planning including abstinence, sexually transmitted infections and HIV/AIDS counselling, prevention services, treatment)</li> <li>• Management of GBV (counselling, management of injuries due to GBV and sexual abuse, and referral of SGBV victims for psychosocial and legal support)</li> <li>• General surgery (simple wound care, incision, and drainage of abscess)</li> <li>• ENT surgery (removal of foreign bodies in the airway, nose and oesophagus; management of epistaxis; aural toilet)</li> <li>• Genitourinary surgery (circumcision)</li> <li>• Burns management (resuscitation, toilet)</li> </ul>

Level	Target	N <sup>o</sup> . of Beds	Health Care Services Provided
			<ul style="list-style-type: none"> <li>• Management of respiratory emergencies (acute asthma exacerbations)</li> <li>• Management of acute envenomation injuries (bites, poisoning, toxic and environmental exposure and injuries)</li> <li>• Evacuation and referral services</li> <li>• Basic / operational research</li> </ul>
Community Hospital / HC IV	Constituency (100,000–200,000 people)	60 (20 maternity, 20 children, 10 female, 10 male)	<p>In addition to above:</p> <ul style="list-style-type: none"> <li>• Management of complicated / severe malaria</li> <li>• Management and control of NCDs (diabetes, uncomplicated hypertensive diseases, congestive cardiac failure, pulmonary oedema, pain management, advanced care planning and end-of-life care, chronic diseases of the respiratory system, non-infectious diseases of the skin, diseases of the musculoskeletal system, non-infectious diseases of the urinary system)</li> <li>• Management of maternal disorders related to pregnancy (eclampsia and pre-eclampsia, ectopic pregnancy)</li> <li>• Maternal care related to the foetus, amniotic cavity, or possible delivery problems (multiple gestation and prolonged pregnancy)</li> <li>• Delivery care services (induction of labour for premature rupture of membranes and prolonged labour, labour complicated by foetal distress)</li> <li>• Emergency obstetric care services (Caesarean Section)</li> <li>• Family planning services (female sterilization, male sterilization)</li> <li>• Management of newborn and infections of the newborn (neonatal hyperbilirubinaemia, birth asphyxia, respiratory distress, apnoea of prematurity, hypothermia)</li> <li>• Management of gender-based violence (medico-legal examination and documentation)</li> <li>• General surgery (emergency laparotomy, elective and emergency hernia repair, excision of skin tumours, soft lumps and other masses, anorectal surgery)</li> <li>• Paediatric surgery (orchidopexy, insertion of feeding tubes for neurological children)</li> <li>• ENT surgery (tracheostomy)</li> <li>• Ocular surgery (corneal foreign body removal, keratoconus management, cataract surgery, ptosis, trichiasis, glaucoma, peripheral iridectomy)</li> <li>• Oral Maxillofacial surgery (tooth scaling and polishing, tooth extraction and filling, incision and drainage of dental abscesses)</li> <li>• Orthopaedic and trauma surgery (limb immobilization)</li> <li>• Genitourinary surgery (catheterization, suprapubic cystostomy, priapism (hydration aspiration, hydrocelectomy, orchidopexy, management of Fournier's gangrene)</li> <li>• Anaesthesia for emergency and basic surgeries</li> <li>• Management of cardiovascular-related emergencies (hypertensive urgencies and emergencies, acute heart failure, acute stroke, acute arrhythmias)</li> <li>• Management of respiratory emergencies (initial difficulty in breathing)</li> <li>• Management of emergency acute alcohol and drug use disorders</li> <li>• Management of premature births</li> <li>• Diagnostic services (ultra sound, X-ray, clinical laboratory)</li> <li>• Pre- and in-service training</li> <li>• Basic / operational research</li> </ul>

Level	Target	N <sup>o</sup> . of Beds	Health Care Services Provided
General Hospital	500,000 people	200–250  (30 maternity, 30 Obs/Gy, 40 Paediatrics, 40 Medical, 30 Surgery, 30 Emergency 10, 10 Isolation Unit, 10 Mental Unit, 10 Private Wing)	In addition to services offered at HC IV: <ul style="list-style-type: none"> <li>• Management of NCDs (endocrine and metabolic diseases; diseases of the arteries and veins; endocarditis; cardiac arrhythmias; physiotherapy and rehabilitation of patients with stroke and other disabilities; occupational therapy and speech therapy; provision of orthopaedic aids; non-infectious diseases of the visual system; non-infectious diseases of the female genital system, male genital system, and urinary system)</li> <li>• Management of maternal disorders related to pregnancy (excessive vomiting, gestational diabetes)</li> <li>• Maternal care related to the foetus, amniotic cavity or possible delivery problems (postabortion care, premature rupture of membranes, placenta praevia, false labour, prolonged pregnancy)</li> <li>• General surgery (anorectal surgery for fissures and fistula, interventional endoscopy for gastrointestinal bleeding control, gastro-intestinal surgery, endocrine surgery)</li> <li>• ENT surgery (adeno-tonsillectomy)</li> <li>• Ocular surgery (orbital surgery)</li> <li>• Neurosurgery (burr holes for subdural hematomas, insertion of ventricular-peritoneal shunt)</li> <li>• Oral Maxillofacial surgery (dental restoration, tooth filling, root canal therapy, enucleation and marsupialization of dental cysts, excision and incisional biopsy of dental tumours)</li> <li>• Cardiothoracic and vascular surgery (chest drainage)</li> <li>• Orthopaedic and trauma surgery (cervical, lumbar, and pelvic stabilization; limb amputation; reduction of limb fractures; external and internal fixation)</li> <li>• Genitourinary surgery (prostatectomy)</li> <li>• Safe anaesthesia for all general surgeries</li> <li>• Reconstructive surgery (cleft lip and palate repair, breast reconstruction or reduction, limb salvage, facial reconstruction, hand surgery)</li> <li>• Management of cardiovascular-related emergencies (acute exacerbations of ischaemic heart disease, venous thrombosis and thromboembolism, arrhythmias)</li> <li>• Management of respiratory emergencies (severe chronic obstructive pulmonary disease)</li> <li>• Management of severe acute exacerbations of diseases of the gastrointestinal tract</li> <li>• Management of emergency complications of diabetes mellitus</li> <li>• Management of emergency disorders of the genitourinary system</li> <li>• Management of severe burns</li> <li>• Management of severe envenomation injuries (bites, poisoning, toxic and environmental exposure and injuries)</li> <li>• Management of severe parasitic, bacterial, mycotic and viral infections with complications</li> <li>• Management of severe mechanical injuries</li> <li>• Diagnostic services (ultra sound, X-ray, clinical laboratory)</li> <li>• In-service and pre-service training and internship</li> <li>• Basic / operational research</li> </ul>
RRH	Region (2,500,000–3,000,000 people)	500	In addition to services offered at General Hospital, <ul style="list-style-type: none"> <li>• Management of communicable diseases (extrapulmonary and multidrug resistance cases and TB of the central nervous system and other organs)</li> <li>• Management of NCDs (complicated endocrine and metabolic disorders; complicated cardiovascular diseases; rehabilitation for advanced disabilities; benign and malignant neoplasms; substance abuse disorders; neuro-developmental disorders; severe nutritional disorders; central nervous disorders; complicated / severe non-</li> </ul>

Level	Target	N <sup>o</sup> . of Beds	Health Care Services Provided
			<p>infectious diseases of the visual system; non-infectious diseases of the female genital system, male genital system, and urinary system)</p> <ul style="list-style-type: none"> <li>• General surgery (laparoscopic surgery, endocrine surgery)</li> <li>• Paediatric surgery (intussusception, colostomy for imperforate anus, neonatal laparotomy, tumour surgery, repair of abdominal wall defects, separation of Siamese twins)</li> <li>• ENT surgery (cortical mastoidectomy, basic functional endoscopic sinus surgery)</li> <li>• Ocular surgery (oculoplastic surgery, strabismus)</li> <li>• Neurosurgery (craniotomy, endoscopic drainage of intraventricular bleeding, endoscopic third ventriculostomy)</li> <li>• Oral maxillofacial surgery (tooth crown, bridge, dentures and implants, open reduction, internal fixation)</li> <li>• Cardiothoracic and vascular surgery</li> <li>• Orthopaedic and trauma surgery (arthroplasty and arthrotomy, sequestrectomy, bone reconstruction)</li> <li>• Genitourinary surgery (prostatectomy, priapism, catheterization shunting, cystoscopy, Turbx/t, varicocelectomy, reconstructive surgery, simple nephrectomy)</li> <li>• Safe anaesthesia for specialized surgeries</li> <li>• Specialized reconstructive surgery (grafting and contracture surgery, cleft lip and palate repair, breast reconstruction or reduction, limb salvage, facial reconstruction, hand surgery)</li> <li>• Diagnostic services (CT scan, X-ray, Fluoroscopy, mammography, clinical laboratory, pathology)</li> <li>• In-service and pre-service training and internship</li> <li>• Health research</li> </ul>
NRH	National (10 million people)	1,000	<ul style="list-style-type: none"> <li>• Provides tertiary care in various disciplines, including medicine, surgery, paediatrics, community medicine, obstetrics and gynaecology, psychiatry, ENT, ophthalmology, dentistry, emergency medicine, and critical care</li> <li>• Diagnostic services (T Scan, MRI, PET Scan), mammography, ultra sound, pathology, advanced clinical laboratory services in microbiology, haematology, etc.</li> <li>• Postgraduate and undergraduate training and internships</li> <li>• Advanced health research</li> </ul>
National Reference Laboratory	National	N/A	Provides specialized laboratory diagnostic services and research
Specialized Hospital	National	200–600	<ul style="list-style-type: none"> <li>• Provides super specialized services, e.g., nephrology, neurology, endocrinology and metabolic diseases, gastroenterology, respiratory medicine, reproductive, neonatal care, intensive care, nuclear medicines, oncology services, neurosurgery and cardiothoracic surgery</li> <li>• Advanced diagnostic and clinical laboratory services</li> <li>• Postgraduate training and advanced research</li> </ul>

## **6.2 Access Controls**

The UNEHCP has revised the services that will be provided at different levels of the health system. Services should be sought from the appropriate level and only sought from a higher level when they are not available at the lower level. Referrals should be in line with the MoH Referral Guidelines.

## **6.3 Minimum Standards of Care**

All services in the UNEHCP should meet the standards stipulated in the Health Sector Service Standards, Service Delivery Standards, national treatment protocols, service delivery guidelines, manuals, and standard operating procedures. These documents should be regularly updated to include new services in the UNEHCP as well as recent changes in treatment protocols (guidelines).

## **6.4 Provider Network for the Package**

In accordance with the NHP III, the services in the UNEHCP will be provided through the structures routinely used for service delivery in Uganda. These comprise of public and private (PNFP and PHP) health care facilities, community outreaches, and social marketing campaigns. The private sector is particularly useful for providing services in urban areas such as Kampala where the facilities are predominantly private. The private sector will also be particularly relevant where the public sector is not able to meet the demand or does not currently have the capacity to deliver the required services universally to the entire population. The public-private partnership arrangements in the country should be updated to include additional mechanisms for subsidizing the private sector and/or contracting the private sector.

## **6.5 Multisectoral Approach to Delivery of Health Services**

The health sector and other sectors — such as Education and Sports and Gender, Labour, and Social Development — have a key role to play in developing Uganda’s human capital by contributing to objective four of the NDP III, which aims at enhancing the productivity and social wellbeing of the population. The interventions that need to be provided to develop this human capital cannot be provided by one sector alone; rather, it requires cooperation between sectors. The health sector will therefore work with other key sectors to achieve the delivery of some of the interventions, such as access to proper nutrition, safe water, and sanitation as guided in the NDP III and HCDP-PIAP (2020–2025). The implementation will be led by the Ministry of Education and Sports with the MoH as the co-lead. Table 19 outlines the key roles of some of these stakeholders as outlined in the MoH Strategic Plan.

**Table 19: Roles and responsibilities of different stakeholders**

Stakeholders	Roles and responsibilities
Ministry of Education and Sports	<ul style="list-style-type: none"> <li>• Participation in MoH policy development and review</li> <li>• Promote sports and physical exercise</li> <li>• Implementation of the School Health Program</li> <li>• Ensure quality training of health workers</li> </ul>
Ministry of Water and Environment	<ul style="list-style-type: none"> <li>• Development of safe water sources (drilling bore holes, provision of piped water, protection of springs, rainwater harvesting)</li> <li>• Provision of sanitation services in rural growth centres and urban areas and communal toilets</li> <li>• Control and enforce sustainable use of the environment (environmental impact assessment, avoid pollution, ensure sustainability use of wetlands)</li> </ul>
Ministry of Agriculture, Animal Industries, and Fisheries	<ul style="list-style-type: none"> <li>• Ensure food (both plant and animal sources of food) security for the whole population</li> <li>• Control of zoonotic diseases</li> <li>• Participation in development policies and strategies</li> <li>• Joint planning and review of sector performance</li> </ul>
Ministry of Internal Affairs (Directorate of Health Services)	<ul style="list-style-type: none"> <li>• Participation in development policies and strategies</li> <li>• Joint planning and review of sector performance</li> <li>• Ensure wellbeing of refugee populations</li> <li>• Ensure all visitors comply with regulation with respect to required vaccinations and sharing of critical information concerning their health status under special circumstances (e.g., pandemics)</li> </ul>
Ministry of Gender, Labour, and Social Development	<ul style="list-style-type: none"> <li>• Ensure youth and gender are mainstreamed in all sector policies</li> <li>• Advocacy and prevention of GBV</li> <li>• Develop social policies for protection of vulnerable groups</li> <li>• Promote progressive workplace and safety policies that safeguard the workers</li> </ul>
Ministry of Works and Transport	<ul style="list-style-type: none"> <li>• Construction and maintenance of roads for accessing health facilities and referral of patients (e.g., express lanes for ambulances)</li> <li>• Enforcing standards for all buildings</li> </ul>
Ministry of Lands, Housing, and Urban Development	<ul style="list-style-type: none"> <li>• Promote urban and housing designs and infrastructure planning that consider health and wellbeing of the population</li> <li>• Strengthen access to land and other culturally important resources, in particular for women</li> </ul>
Ministry of Information Communication and Technology	<ul style="list-style-type: none"> <li>• Establish IT Backbone</li> <li>• Facilitate data and voice communication</li> </ul>
Ministry of Energy	<ul style="list-style-type: none"> <li>• Ensure access to affordable and clean energy</li> </ul>
Ministry of Trade and Industry	<ul style="list-style-type: none"> <li>• Ensure work and stable employment and entrepreneur opportunities for all people across different socio-economic groups</li> <li>• Ensure importation of goods that meet the quality standards</li> </ul>
Private sector (PHPs, PNFPs, civil society organizations)	<ul style="list-style-type: none"> <li>• Contributing towards policies development, planning, monitoring, and evaluation</li> <li>• Resource mobilization for health care from households, organizations both local and international</li> <li>• Providing or participating in research, community, and social mobilization, advocacy, capacity building including human resources development, logistical support, technical assistance, and other services at all levels</li> <li>• Ensuring proper utilization of resources and accountability</li> </ul>
Community health workers	<ul style="list-style-type: none"> <li>• Mobilize and link community with the formal health service</li> <li>• Provide community-based services approved by the MoH</li> <li>• Reporting on community health data</li> </ul>

Stakeholders	Roles and responsibilities
Households / Individuals	<ul style="list-style-type: none"> <li>• Take care of their health, and practice appropriate health-seeking behaviours</li> </ul>

## 6.6 Health Systems Strengthening

The AHSPR for 2020/2021 indicated that only 45% of the population was accessing universal health care, indicating that more effort is needed to make services fully accessible to the population. Implementation of the package should be phased to allow the country to put in place the resources required for delivery. The resources that should be considered may include human resources to offer primary and specialized health services through skills and competency based basic, specialized, and multidisciplinary pre-service and in service training, improved physical and built environment, digital technologies, consumables, and supply chains. According to the 2019 Uganda Service Availability Readiness Assessment, the capacity of facilities to provide services was only 52%. Availability of standard precautions for infection prevention and control performed the best at 86%. Other areas such as basic amenities (mean availability of 56%) and diagnostic capacity (mean availability of 55%) only had a moderately good performance, whereas areas such as essential medicines (mean availability of 32%) and basic equipment (mean availability of 37%) had a dismally poor performance.

The following actions should therefore be undertaken to ensure effective delivery of the package:

1. **Increase funding to the public sector and PNF sector.** The GoU needs to find innovative ways for funding health services to reduce the financial hardships faced by patients when seeking care. Some of the mechanisms mentioned by stakeholders included health insurance and subsidization of high-cost services in addition to increasing the subsidies provided to the PNF sector to enable them to expand the package of care that they provide.
2. **Invest in systems strengthening.** Deliberate attention needs to be paid to investing in structures and systems required to provide the services included within the UNEHCP to allow the expansion of the services to lower-level facilities that serve most of the population and to higher-level facilities, such as specialized and referral hospitals, that offer more complex services. The following actions should be considered:
  - Scale up training of cadres that are in high demand but limited in supply (allied health professionals, pharmacists, specialist nurses, specialist doctors such as intensive care specialists, anaesthetists, psychiatrists, neurosurgeons, paediatric surgeons, epidemiologists, etc.). The MoH and development partners should consider providing sponsorship for such courses where specialists are grossly inadequate and for fellowship programs within the country that are providing additional training. For example, the Uganda Cancer Institute and Uganda Heart Institute currently provide additional training through fellowships. These actions need to be coupled with mechanisms for providing financial and non-



financial incentives to support retention including bonding of those sponsored by the Government.

- The MoH, Ministry of Public Service, and Health Service Commission should update the staffing norms and civil service structure to reflect the changing disease patterns.
- Increase access to all essential medicines and supplies by increasing financing including nutrition commodities, addressing bottlenecks in the supply chain and increasing capacity for local manufacture.
- Geographical mapping of facilities, type of services provided, and the population served should be undertaken to enhance equitable access to services.
- A phased implementation approach that starts by fully functionalizing regional hubs and then all RRHs by building the appropriate infrastructure, purchasing the required equipment and supplies, and recruiting the required personnel to allow for the delivery of specialized services such as specialized surgeries and cancer treatment.

3. **Invest more in technology.** Recent developments in technology have contributed significantly towards increasing the efficiency and effectiveness with which services are delivered.

- The MoH and the Ministry of Information Communication and Technology should work together to enhance the use of e-health in the delivery of health services.
- The GoU and its development partners should also invest resources that will enable digitization of the health information system. Digitization of the health information system will lead to improved sharing of patient information and subsequently the provision of more patient-centred care. It will also enhance availability of patient data that can be used to inform resource allocation and strategic purchasing of health services.
- Increase the availability of diagnostic, therapeutic, and rehabilitative equipment and further decentralize equipment maintenance to enable the districts to repair their equipment promptly. In addition, regular training on the use, management, and maintenance of equipment should be provided regularly to ensure that all equipment is used optimally.
- The MoH should scale up the use of health technology assessments when introducing new equipment and establish an electronic inventory management system.

4. **Invest more in health promotion, disease prevention, and mindset change.** Deliberate efforts should be made by the MoH, LGs, and development partners to allocate more financial resources for health promotion and disease prevention. This will enable the country to invest in providing the human resources and structures and systems required to provide adequate preventive and promotive care services in a bid to enhance overall health and wellbeing. In addition, more resources should be directed towards increasing health literacy, which can enhance positive health practices that can increase the

prevention of illness and promote timely care-seeking health and wellbeing. The following actions should be considered:

- Develop a multisectoral community health strategy to guide the implementation of activities at the community level and mainstream key health priorities into MDAs, especially activities related to health promotion and health prevention.
- Strengthen community health services around the Parish Development Model supported by the Community Health Workforce in each parish.
- Develop a well-resourced coordination hub at the parish level for the coordination of community-based activities coordinated by an integrative health professional (such as a health assistants) that can support the community-level volunteers better and oversee documentation of health data/information into the Parish Management Information System. The coordination hub should also have the basic equipment, supplies, and an electronic system for recordkeeping and collection of community health-related information.
- Increase spending on health promotion, disease prevention, and PHC in communities, health facilities, schools, and workplaces.
- Establish an integrated national health promotion, communication, and behaviour change program.
- Integrate health and wellbeing policies and interventions in schools and workplaces.
- Invest more in strengthening the capacity to prevent, detect, and respond to public health emergencies.

5. **Prioritize the provision of PHC services.** As the country strives to meet its SDG, NDP, and Vision 2040 aspirations of improving health, wellbeing, and productivity, a shift to PHC-oriented health systems that support first-contact, accessible, continuous, comprehensive, and coordinated patient-focused care would catapult progress. The Government and its development partners should therefore commit to prioritizing funding for PHC services. These services form the foundational package that Uganda can commit to budget and provide, and it addresses the most common causes of morbidity, which if treated early would prevent further illness, complications, and the associated costs.

6. **Provide quality services.** To ensure that quality services are provided, the minimum standards for the services should be clearly stipulated and enforced. The following actions are also recommended:

- Review and revision of the current provider payment mechanisms to strengthen the link between performance and payment.
- Promotion of integrated delivery of services that enhance provision of a continuum of care.
- Development and implementation of an integrated program for in-service training, professional development, and mentorship.
- Inclusion of private providers in on-the-job training programs.

- More involvement of professional bodies, associations, and other umbrella bodies in support supervision and mentorship of both public and private providers.
  - Introduction of specialized nurse training in the training curriculum to enable the provision of quality nursing services for specialized services such as cardiothoracic care, ophthalmology, and laparoscopic surgery.
7. **Strengthen the referral and emergency transport system.** Emergency referral transport is critical for timely referral of patients and for management of disasters. Strict enforcement of the referral pathways has been constrained by failure of some facilities to provide the care that they are expected to provide. The MoH should:
- Strengthen the Emergency Medical Services for the country to enable timely critical emergency care and transportation of critically patients.
  - In collaboration with development partners, ensure that facilities have the resources required to make them fully functional to allow for enforcement of the referral pathway.
8. **Embrace multisectoral planning and implementation.** LGs should embrace multisectoral planning, implementation, and monitoring to support holistic provision of services. The following actions are recommended:
- The MoH should strengthen the technical capacity of the department for health sector partners and multisectoral collaboration to facilitate participation of the private sector, MDAs, and other socio-cultural actors in the delivery of health and nutrition services and systems development interventions.
  - The MoH and the LGs should utilize existing spaces to dialogue with politicians, local leaders, and other key stakeholders to ensure that they understand the key health problems, social determinants for health, and strategies being used by government to combat them so that they support and lobby for resource allocation to these services and provide positive messages when they interact with their communities to enhance mindset change.
9. **Align development partner and government priorities.** To maximize the benefits from support by the development partners, the support provided must be aligned with Government priorities and with the changing disease profile for Uganda. Although NCDs are on the rise, support from development partners towards combating the increase has been minimal, similarly HDP investments in scaling up health promotion and health prevention initiatives country wide has also been minimal. The following actions are recommended:
- Processes for deciding where the HDPs operate should be streamlined and determined based on the needs of different LGs and the support already available from other partners and the Government.
  - Joint planning for on budget and off budget resources both at the national and LG levels.

- Joint coordination and implementation of activities within the LGs under the leadership of the LG Health Teams.
10. **Enhance public-private partnership.** The GoU should strengthen public-private collaboration by:
- Contracting the private sector to provide services where they have a competitive advantage (in urban areas, specialized services).
  - Cost savings could also be made by involving the private sector in manufacture of simple surgical equipment that can be manufactured locally and in expanding initiatives such as fortification of foods (e.g., with vitamin A and zinc) which is cheaper than the use of supplements.
11. **Strengthen health services leadership, governance, and management structures, and norms and systems at the community, facility, LG, and national levels.** This may involve incorporating relevant trainings in the current clinical mentorship programs, structural, and procedural reforms.

## 7 MONITORING AND EVALUATION OF THE DELIVERY OF THE UNEHCP

Monitoring and evaluation of the delivery of the package will be essential for tracking progress made in implementation of the package, and for identifying areas of poor performance where additional investments need to be made.

### 7.1 Data collection

The data collection for monitoring and evaluation will be drawn from a combination of methods that include routine data from the District Health Information Software 2 (DHIS2), data from periodical surveys conducted by the GoU and its development partners. These surveys include the Uganda Demographic and Health Survey (UDHS), Uganda National Household Survey (UNHS), Uganda National Service Delivery Survey, Uganda National Panel Survey (UNPS), Living Standards Survey, Uganda Population HIV Impact Assessment, National Health Accounts, Performance Monitoring and Accountability Survey, and Service Availability and Readiness Assessments. Some of the indicators will also be provided by other sectors where the primary responsibility for delivery lies outside the health sector.

### 7.2 Indicators

The indicators that will be used for monitoring implementation will be aligned to indicators routinely used to track delivery of services as identified in the existing policy documents such as the SDGs, NDP, MoH Strategic Plans and program-specific plans. However, additional indicators may be collected by implementing partners. A selected list of indicators is provided below.

The contribution of the UNEHCP to the global health agenda, Uganda's UHC Roadmap, and health sector goals will be assessed by the UHC index achievements.

**Table 20: Indicators for monitoring implementation of the UNEHCP**

<b>Cluster</b>	<b>Indicators</b>	<b>Data sources</b>	
Health Promotion, Disease Prevention, and Community Health Initiatives	Child stunting as % of under 5s	UDHS	
	Prevalence of wasting U5 (%)	UNPS	
	Prevalence of obesity Women (%)	UNPS	
	Prevalence of obesity Men (%)	UNPS	
	Prevalence of obesity U5 (%)	UNPS	
	Households appropriately treating water (%)	AHSPR	
	Improved sanitation coverage (toilet coverage (%))	AHSPR	
	Children under one year immunized with 3rd dose Pentavalent Vaccine	AHSPR	
	DPT3HibHeb3 coverage (%)	DHIS2	
	Measles immunization coverage under 1 year (%)	DHIS2	
	Children Under One Year Fully Immunized (%)	DHIS2	
	Incidence of road accidents per 100,000	HMIS	
	Use of insecticide-treated bed nets for malaria prevention (%)	UDHS	
	Alcohol abuse Rate (%)	Global Status Report on Alcohol	
	Breast cancer screening in women aged 30-49 years (%)	Report	
	Prostate cancer screening in men above 40 years (%)	Report	
	Under 5 illness attributed to diarrheal diseases	DHIS2	
	Management and Control of Communicable Diseases	Number of new HIV infections per 1,000	DHIS2
		ART coverage (%)	DHIS2
ART retention rate at 12 months		Report	
ART viral Load Suppression Rate among PLHAs on treatment		Report	
HIV positive pregnant women initiated on ARVs for EMTCT (%)		DHIS2	
HIV-exposed infants with PCR test (%)		Report	
ART viral suppression Rate (%)		DHIS2	
TB case notification rate per 100,000		Report	
Tuberculosis incidence per 100000 population		DHIS2	
Leprosy patients presenting to health facilities with Grade 2 disability at the time of diagnosis (%)		Reports	
Mortality due to malaria		AHSPR	
Malaria cases per 1,000 persons per year		DHIS2	
Malaria incidence per 1,000 population		DHIS2	
Management and Control of NCDs		Tobacco nonsmoking rate (%)	STEPS
	Incidence of road accidents per 100,000	DHIS2	
	HPV Vaccination	DHIS2	
	Cervical cancer screening in women aged 30-49 years (%)	Report	
	Prostate Cancer screening in men	Report	
	Hypertension prevalence rate (%)	UNHS	
	Diabetic Prevalence rate (%)	UNHS	
	Annual cancer incident cases (number)	Cancer registry	
Cancer proportional mortality rate (%)	DHIS2		

<b>Cluster</b>	<b>Indicators</b>	<b>Data sources</b>
Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health	Maternal mortality ratio (per 100,000 live births)	UDHS
	Infant mortality rate (per 1,000 live births)	UDHS
	Under-five mortality rate (per 1,000 live births)	UDHS
	Neonatal mortality rate (per 1,000 live births)	UDHS
	Infant mortality rate (per 1,000 live births)	UDHS
	IPT3 or more doses coverage for pregnant women (%)	DHIS2
	ANC 4 coverage (%)	DHIS2
	Maternal deaths among 100,000 health facility deliveries	UDHS
	% of deliveries by skilled health workers	UDHS
	% of deliveries in health facilities	DHIS2 / UDHS
	The proportion of HC IVs offering CEmOC services (Caesarean Section (C/S) and blood transfusion)	DHIS2
	Contraceptive Prevalence Rate	UDHS
	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	UDHS
	Prevalence of violence against children (VAC)	UDHS
Emergency, Critical, and High Dependency care	Functionality of the National and regional ambulance call centres (% of functional Regional Call Centres)	Reports
	No of hospitals with functional Emergency Units	Reports
	% of hospitals with functional ICUs / NICUs	Reports
Geriatric Care	% of hospitals with adequately qualified staff to provide geriatric rehabilitation	Reports
	Malnutrition rate	Reports
	% of elderly receiving valid medical devices	Reports
	% of elderly accessing care satisfied with the care received	Reports
	% of rehabilitants returning home per diagnosis group	Reports

## BIBLIOGRAPHY

1. Bank of Uganda, June 2021, State of the Economy Report
2. Bernard Bashaasha, Margaret Najjingo Mangheni, Ephraim Nkonya 2011, Decentralization and Rural Service Delivery in Uganda, International Food Policy Research Institute (IFPRI)
3. Brown, A., Zikusooka, C., and Bakeera S, Development of the Minimum Service standards for Uganda's Health Sector: Final Report, Ministry of Health, Kampala, 2009.
4. Cashin, C., & Özaltin, A. (2017). At What Price: Costing the Health Benefits Package. In Glassman A., Giedion U., & Smith P. (Eds.), *What's In, What's Out: Designing Benefits for Universal Health Coverage* (pp. 185-200). Washington DC: Brookings Institution Press. Retrieved September 2, 2021, from <http://www.jstor.org/stable/10.7864/j.ctt21kk0p0.19>
5. CHERPS Policy paper
6. Dittrich, R., Cubillos, L., Gostin, L., Chalkidou, K., & Li, R. (2017). The Right to Health and the Health Benefits Package: Accounting for a Legal Right to Health When Designing an HBP. In Glassman A., Giedion U., & Smith P. (Eds.), *What's In, What's Out: Designing Benefits for Universal Health Coverage* (pp. 327-344). Washington DC: Brookings Institution Press. Retrieved September 2, 2021, from <http://www.jstor.org/stable/10.7864/j.ctt21kk0p0.29>
7. Giedion, Ursula, and Javier Guzmán. "Defining the Rules of the Game: Good Governance Principles for the Design and Revision of the Health Benefits Package." *What's In, What's Out: Designing Benefits for Universal Health Coverage*, edited by Ursula Giedion et al., Brookings Institution Press, Washington DC, 2017, pp. 30–60. *JSTOR*, [www.jstor.org/stable/10.7864/j.ctt21kk0p0.10](http://www.jstor.org/stable/10.7864/j.ctt21kk0p0.10). Accessed 2 Sept. 2021
8. Glassman A, Chalkidou K, Giedion U, et al. Priority setting institutions in health. *Glob Heart*. 2012; 7:13–34.
9. Glassman, A., Giedion, U., Sakuma, Y., & Smith, P. C. (2016). Defining a health benefits package: what are the necessary processes. *Health Systems & Reform*, 2(1), 39-50.
10. Glassman, U. Giedion, and P. C. Smith, The Health Benefits Package: Bringing Universal Health Coverage from Rhetoric to Reality, in *what's in, What's out? Designing Benefits for Universal Health Coverage*, A. Glassman, U. Giedion, and P. C. Smith, Eds. Washington DC: Center for Global Development, 2017.
11. GoU (2015c) 'Quality Improvement Framework and Strategic Plan (2015/16-2019/20),' Ministry of Health: Kampala.
12. GoU (2016a) 'Annual health sector performance report,' Ministry of Health: Kampala.
13. GoU (2016b) 'Health financing strategy,' Ministry of Health: Kampala
14. Government of the Republik of Malawi, Health Sector Strategic Plan II 2017-2022, Lilongwe, 2017.
15. Hawkins, N., Heggie, R., & Wu, O. (2017). Reliable Sources: Generating, Selecting, and Applying Evidence to Inform the Health Benefits Package. In Glassman A., Giedion U., & Smith P. (Eds.), *What's In, What's Out: Designing Benefits for Universal Health Coverage* (pp. 235-246). Washington DC: Brookings Institution Press. Retrieved September 2, 2021, from <http://www.jstor.org/stable/10.7864/j.ctt21kk0p0.22>

16. Hayati R, Bastani P, Kabir MJ, Kavosi Z, Sobhani G. Scoping literature review on the basic health benefit package and its determinant criteria. *Global Health*. 2018;14(1):1–7
17. Health Finance & Governance Project. July 2015. *Essential Package of Health Services Country Snapshots*: Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
18. Hediger V et al. Health system financing: Tips for emerging markets. McKinsey white paper. April 2018.
19. Kadowa, I. (2017). *A case study of the Uganda National Minimum Healthcare Package*, EQUINET discussion paper 110, Ministry of Health, EQUINET, Uganda.
20. Kwesiga, B., Aliti, T., Nabukhonzo, P. et al. What has been the progress in addressing financial risk in Uganda? Analysis of catastrophe and impoverishment due to health payments. *BMC Health Serv Res* 20, 741 (2020). <https://doi.org/10.1186/s12913-020-05500-2>
21. Loewenson R, Mamdani M, Todd G, Kadowa I, Nswilla A, Kisanga O, Luwabelwa M, Banda P, Palale M, Magagula S (2018) ‘The role of an essential health benefit in health systems in east and southern Africa: Learning from regional research’, EQUINET discussion paper 113, TARSC and IHI, EQUINET, Harare
22. Love-Koh, J., Walker, S. M., Kataika, E., Sibandze, S., Arnold, M., Ochalek, J. M., ... & Sculpher, M. J. (2019). Economic analysis for health benefits package design.
23. Luwabelwa. M., Banda P, Palale, M . A case study of the role of an Essential Health Benefit in the delivery of integrated health services in Zambia. Lusaka: Zambia Ministry of Health, EQUINET; 2017, Zambia Ministry of Health, EQUINET, Lusaka, *EQUINET Discussion. Paper 111*, 2017.
24. Mallender J,A. Health System Benefit Package Design & Provider Payment Mechanisms Consultancy to WHO Sudan for NHIF October 2020. 2021;(October 2020).
25. Matsiko C, W (2010) ‘Positive practice environments in Uganda: Enhancing health worker and health system performance,’ Global Health Workforce Alliance, PPE Secretariat, International Council of Nurses: Geneva
26. Maynard A. and Bloor K, 1998, “Our certain fate: rationing in health care” Office of Health Economics London
27. McIntyre, D.M., Shared Responsibilities for Health: A Coherent Global Framework for Health Financing, in Final Report of the Centre on Global Health Security Working Group on Health Financing. 2014, Chatham House: London, UK.
28. McPake, B et al., “Informal Economic Activities of Public Health Workers in Uganda: Implications for Quality and Accessibility of Care.” *Social Science and Medicine*. 49, no. (1999): 849-865.
29. Ministry of Finance Planning and Economic Development 2021, The performance of Economy report- June 2021
30. Ministry of Health, 2020, Annual Health sector Performance Report 2019/20
31. Ministry of Health, Health Sector Development Plan (Draft) 2021-2025, Kampala (Uganda) Ministry of Health; 2021
32. Ministry of Health, National HIV/AIDs Strategic Plan 2021-2025, Kampala (Uganda) Ministry of Health; 2021
33. Ministry of Health, National TB/Leprosy Strategic Plan 2021-2025, Kampala (Uganda) Ministry of Health; 2021
34. Ministry of Health, National TB/Leprosy Strategic Plan 2021-2025, Kampala (Uganda)



35. Ministry of Health, The Uganda Malaria Reduction Strategic Plan, 2014-2020, Kampala (Uganda) Ministry of Health; 2021.
36. Ministry of Health. Annual Health Sector Performance Report Financial Year 2019/20. Kampala (Uganda): Ministry of Health; 2020
37. Ministry of Health. Annual Health Sector Performance Report Financial Year 2017/18. Kampala (Uganda): Ministry of Health; 2018.
38. Ministry of Health. Health Financing Strategy 2015–2025. Kampala: Ministry of Health, Uganda; 2016.
39. Ministry of Health. Health Sector Strategic Plan III 2010/11-2014/1’, 2014. Kampala (Uganda): Ministry of Health; 2018
40. Moat, K. A., & Abelson, J. (2011). Analysing the influence of institutions on health policy development in Uganda: a case study of the decision to abolish user fees. *African health sciences*, 11(4), 578–586.
41. Nabukeera M (2016) Challenges and Barriers to the Health Service Delivery System
42. Nabyonga J, O., and Zikusooka C. Health financing reform in Uganda: How equitable is the proposed National Health Insurance scheme? *International Journal for Equity in Health*. (23) 2010.
43. National Planning Authority. National Development Plan (NDP III) 2020/21-2024/25. Kampala. 2020
44. National Planning Authority. National Development Plan II 2015-2020. Kampala. 2015
45. National Planning Authority. Vision 2040. Kampala. 2013
46. Nazerali H, Oteba MO. 2005. Escalating medicines prices and the Uganda Minimum Health Care Package: For Health or for Profit? Paper presented at the International Health Economics Association (IHEA 2005) Conference, Barcelona, Spain, July 10-13, 2005. Unpublished document.
47. Ochalek, J., Revill, P., Manthalu, G., McGuire, F., Nkhoma, D., Rollinger, A., ... & Claxton, K. (2018). Supporting the development of a health benefits package in Malawi. *BMJ global health*, 3(2), e000607.
48. OECD (2010). Value for money in health spending. Paris: Organization for Economic Co-operation and Development; 2010.
49. Ottersen T et al. A new proposal for priority setting in Norway: Open and fair. *Health Policy*. 2016; 120:246–251.
50. PricewaterhouseCoopers Limited, 2019, Uganda Economic Outlook – 2019
51. Report on assessment of proposed Health Sector Reforms and their implications for Universal Health Coverage in Uganda. Makerere University School of Public Health (2016).
52. Smith P,C., Kalipso C. Should countries set an explicit health benefit package? The case of English National Health Service. *Value in Health*. 2017;20(1):60–66.
53. Ssempala R., Francis K., Boniface O., Ssenkooba, F., Bagonza J., Tashobya, C, K. (2019) Health Sector Budgetary Allocations and their Implications on Health Service Delivery and UHC in Uganda.
54. Ssenkooba, F. (2004). Uganda’s minimum health care package: rationing within the minimum?
55. Ssenyonjo, A., Namakula, J., Kasyaba, R. et al. Government resource contributions to the private-not-for-profit sector in Uganda: evolution, adaptations and implications for universal health coverage. *Int J Equity Health* 17, 130 (2018).  
<https://doi.org/10.1186/s12939-018-0843-8>
56. The World Bank. Universal Health Coverage Study Series (UNICO). 2017  
<http://www. World bank. org/ en/ topic/ health/ publication/>

57. Ubel P. *Pricing Life: Why It's Time for Health Care Rationing*. MIT Press.  
2001. Uganda (2016) OSR Journal of Nursing and Health Science (IOSR-JNHS) e-  
ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 5, Issue 2 Ver. V (Mar. - Apr. 2016),  
PP 30-38
58. Uganda (2016) OSR Journal of Nursing and Health Science (IOSR-JNHS) e-ISSN:  
2320–1959.p- ISSN: 2320–1940 Volume 5, Issue 2 Ver. V (Mar. - Apr. 2016), PP 30-  
38
59. Uganda Bureau of statistics 2021, The Uganda national House hold Survey 2019/20
60. Uganda National Health Accounts (NHA), 2018
61. WHO; World Health Report. Health Systems Financing: The Path to Universal Health  
Coverage. World Health Rep. 2010; 1-128
62. World Health Organization. The world health report 2013: research for universal  
coverage. Geneva: World Health Organization; 2013.
63. World Health Organization. The world health report 2013: research for universal  
coverage. Geneva: World Health Organization; 2013.
64. Zikusooka C,M., Kyomuhang R., Orem J,N and Tumwine M (2009) ‘Is health care  
financing in Uganda equitable?’ African Health Sciences 9(2):52-58.

## ANNEX ONE: ADVISORY COMMITTEE MEMBERS

No.	Name	Title	Organization
1	Dr. Charles Olaro	Director Health Services - Curative Services	MoH
2	Dr. Sarah Byakika	Commissioner Planning, Financing and Policy	MoH
3	Dr. Jackson Amone	Commissioner Clinical Service	MoH
4	Dr. Jesca Nsungwa – Sabiiti	Commissioner Reproductive Health	MoH
5	Dr. Patrick Tusiime	Commissioner National Disease Control	MoH
6	Dr. Suzan Nabadda	Commissioner UNHLS	MoH
7	Dr. Richard Kabanda	Acting Commissioner Health Promotion and Education	MoH
8	Mr. Chris Mugarura	Assistant Commissioner Policy and Planning	MoH
9	Mr. Kabagambe Richard	Assistant Commissioner Budget and Finance	MoH
10	Mr. Aliyi Walimbwa	Principal Health Planner	MoH
11	Dr. Lydia Nabiryo	Principal Social Development Officer, Human Rights	MoGLSD
12	Dr. Katumba Sentongo Gubala	Registrar	UMDPC
13	Dr. Nakku Juliet	Executive Director	Butabika MNRH
14	Dr. Onyachi Nathan	Hospital Director	Masaka RRH
15	Dr. Sam Okware	Executive Director	UNHRO
16	Dr. Daniel Okello	Director Public Health	KCCA
17	Dr. Ivan Kamyia	District Health Officer/ Chair of DHOs	Kiruhura District
18	Dr. Patrick Twesigye	M&E Officer	NPA
19	Dr. Vicent Bagambe	Director Planning	UAC
20	Dr. Mwoga Joseph	National Professional Officer	WHO
21	Ms. Christabel Abewe	Health Financing Officer	WHO
22	Dr. Garoma Kena	Senior Health Systems Specialist	USAID
23	Mr. Thomas Maina	Chief of Party	USAID UHSS Activity
24	Mr. Chimwemwe Musukwa	Health Specialist	UNICEF
25	Ms. Grace Kiwanuka	Chief Executive Officer	UHCF
26	Dr. Peter Kawanguzi	President	UPMPA
27	Dr. Tonny Tumwesigye	Executive Director	UPMB

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