THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

# GUIDELINES TO THE LOCAL GOVERNMENT PLANNING PROCESS

## HEALTH SECTOR SUPPLEMENT

2016

# GUIDELINES TO THE LOCAL GOVERNMENT PLANNING PROCESS

## HEALTH SECTOR SUPPLEMENT

# TABLE OF CONTENTS

# ACRONYMS

| | |
|---|---|
| AC/B & F | Assistant Commissioner Budget & Finance |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ANC | Ante Natal Clinic |
| BFP | Budget Framework Paper |
| CAO | Chief Administrative Officer |
| C/HSC | Commissioner Health Service Commission |
| CHS/P | Commissioner Health Services Planning |
| CSO | Civil Society Organization |
| DBTA | District Based Technical Assistance |
| DDP | District Development Plans |
| DHC | District Health Committees |
| DHMT | District Health Management Team |
| DHO | District Health Officer |
| DHPT | District Health Planning Team |
| DHT | Health Sub District |
| DHPs | Development Health Partners |
| DPHS | Director Planning Health Services |
| DSC | District Service Commission |
| EMoC | Emergency Obstetrics Care |
| FBO | Faith Based Organization |
| HCII | Health Centre Level II |
| HCIII | Health Centre Level III |
| HCIV | Health Centre Level IV |
| HIV | Human Immuno-deficiency Virus |
| HMB | Hospital Management Boards |
| HMIS | Health Management Information System |
| HOD | Head of Department |
| HPC | Health professional Council(s) |
| HRDD | Human Resource Development Division |
| HRH TWG | Human Resource Technical Working Group |
| HRH | Human Resources for Health |
| HRHIS | Human Resources Information System |
| HRM | Human Resource Management |
| HRWG | Human Resource Working Group |
| HSBWG | Health Sector Budget Working Group |
| HSC | Health Service Commission |
| HSDT | Health Sub District Teams |
| HSSIP | Health Sector Strategic and Investment Plan |
| HSC | Health Service Commission |

| | |
|---|---|
| HU | Health Unit |
| HUMC | Health Unit Management Committee |
| HW | Health Worker |
| IP | Implementing Partners |
| IPPS | Integrated Personnel and Payroll System |
| IST | In-service Training |
| JRM | Joint Review Mission |
| M&E | Monitoring and Evaluation |
| MFPED | Ministry of Finance Planning and Economic Development |
| MOES | Ministry of Education and Sports |
| MOGLSD | Ministry of Gender Labor and Social Development |
| MOH | Ministry of Health |
| MOLG | Ministry of Local Government |
| MOPS | Ministry of Public Service |
| MPS | Ministerial Policy Statement |
| MTEF | Medium Term Expenditure Framework |
| NGO | Non-Governmental Organisation |
| NHA | National Health Accounts |
| NRH | National Referral Hospital |
| OPD | Out Patient Department |
| OPM | Office of the Prime Minister |
| PMTCT | Prevention of Mother to Child Transmission of HIV |
| PNFP | Private Not for Profit |
| PPO | Principal Personnel Officer |
| PS | Permanent Secretary |
| PSC | Public Service Commission |
| QAD | Quality Assurance Department |
| RRH | Regional Referral Hospital |
| RRHS | Regional Referral Hospitals |
| SWOT | Strength Weaknesses Opportunities Threat |
| TB | Tuberculosis |
| UBOS | Uganda Bureau of Statistics |
| UBTS | Uganda Blood Transfusion |
| UCMB | Uganda Catholic Medical Bureau |
| UPMB | Uganda Protestant Medical Bureau |
| USAID | United States Agency for International Development |
| VHT | Village Health Team |
| WHO | World Health Organization |

# FOREWORD

The health of our population is central to the socio- economic development of Uganda. Uptake of primary health care services, while improving, is still at an unacceptable level due to various planning and budgeting challenges at the decentralized level. In view of these challenges and policy reforms in the Health sector and in line with the new planning framework provided by the NDP II and HSDP, it is imperative that the Ministry of Health guide Local Government health planning to be properly integrated within the decentralization framework and link its processes to the new national planning policies, planning frameworks and reforms including being guided by the NDP frame work, HSDP and the NHP II.

In response, the Ministry of Health has developed the 2016 supplement to the National Planning Authority Local Government Planning Guidelines 2014 to specifically guide health policy formulation, planning, budgeting, implementation and monitoring of health sector performance within the Local Governments.

The main aim of the guidelines is to enhance decentralized health services delivery, improve efficiency and effectiveness in delivery of primary health services and promote healthy living.

I wish to acknowledge the team that developed the guidelines and appreciate the Strengthening Human Resources for Health Activity implemented by IntraHealth International and funded by USAID, and UNICEF for the support offered in finalization and printing of the guidelines.

I call upon Local Governments and all stakeholders to make effective use of the guidelines in their planning and budgeting processes and during implementation and monitoring of the annual work plans in the Health Sector.

Dr. Asuman Lukwago

**Permanent Secretary/Ministry of Health**

**June 2016**

# Section 1

# Introduction

The republic of Uganda is an East African state currently under multiparty dispensation. Service delivery is decentralized to local governments as per the 1997 local Government Act. The Central government, however, retains the role of setting standards and providing guidelines to local governments. The country has a population of 34.9 MILLION is currently divided into 116 districts.

In the last 10 years, the health sector has undergone a number of reforms in the areas of governance, budgeting, service delivery and monitoring. These reforms are evidence of an institutionalized response to a changing landscape in national policy, economic status, demography, life styles and disease burden in Uganda. While there has been improved geographical access to services, demand-side bottlenecks have remained a major challenge affecting utilization of services.

The health sector must develop plans that link the needs of the population to the available resources within the evolving landscape in order to respond to the aforementioned changes. A clear and robust planning framework with well-defined objectives that aim at making the best use of the available resources is therefore of essence.

In 2007 the health sector developed planning guidelines in response to the decentralization of the health system which added decision-making points in the system. The guidelines addressed planning needs of the various levels of the district health system within the context of the overall local government planning process. Between 2007 and 2014, more reforms in the policy context, strategic planning, budgeting and reporting were ushered in. Inter alia, the reforms are enshrined in the Vision 2040, the National Development Plan, the Health Sector Strategic Plan II, Output Oriented Budgeting, and Integrated Financial Management System. These reforms had not been catered for in the Planning Guidelines developed in 2007. In addition, new health technologies continually emerge which, necessitates changes in planning processes. Revisions to the planning guidelines were necessary to make them responsive to the new reforms and changes.

The revised Planning Guidelines herein are geared to improving the performance of the health sector by enhancing coordination of the planning process through:

1. Introducing the district planning team concept
2. Improving and harmonizing tools and budgeting calendars
3. Partner mapping, performance & Situation analysis review
4. Harmonizing work plans and reporting, and improving governance and accountability across the local governments (LGs).

These guidelines are therefore intended to guide LG health staff, and those in the private sector, in the development of their annual work plans within the decentralization framework.

# Section 2

# Overview of the Health Service Delivery System

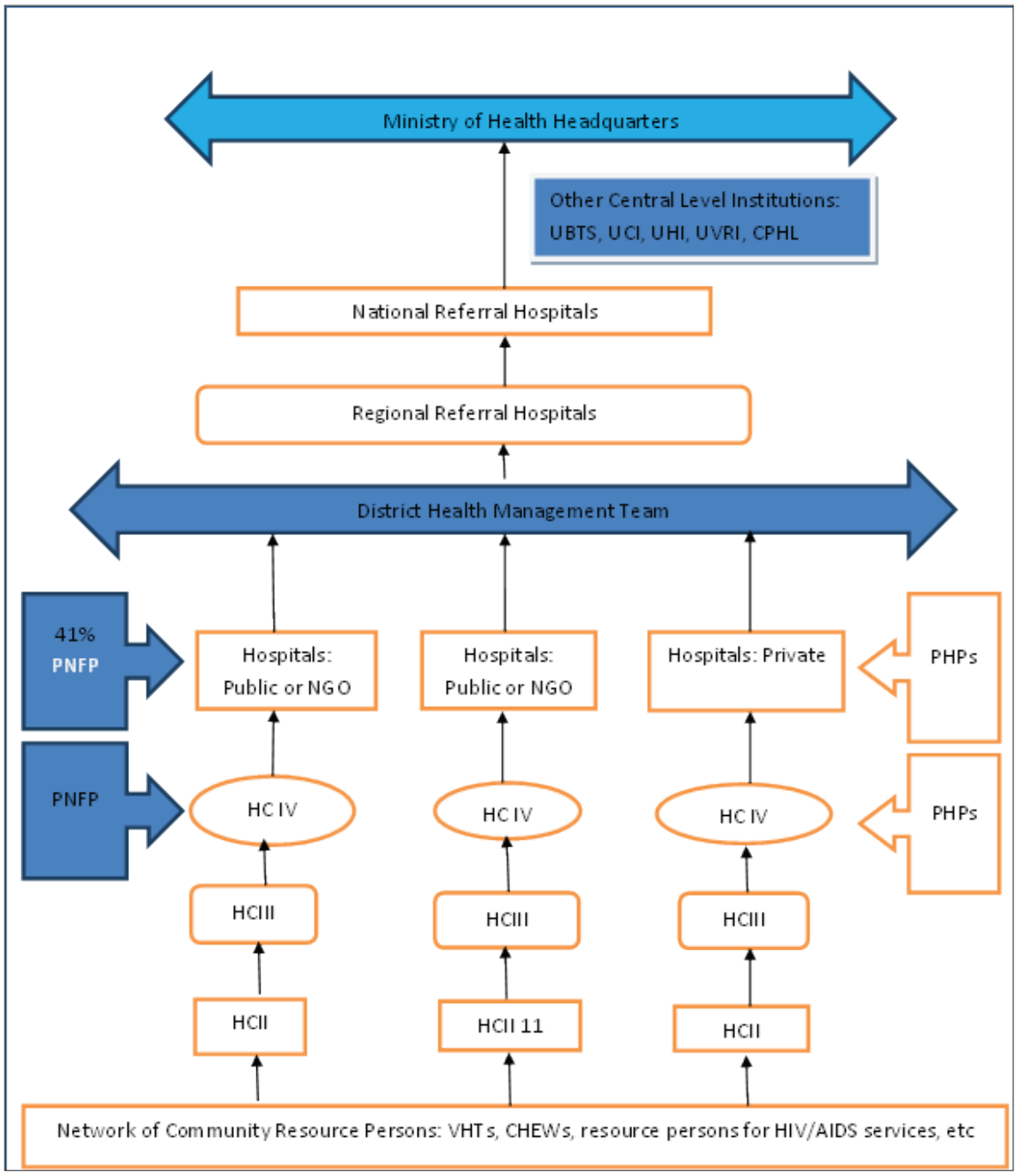
The National Health Service delivery system in Uganda is comprised of all the institutions, structures and actors involved in health service provision, categorize by public and private ownership. The public health system has two levels - central and local. The central level includes the Ministry of Health (MOH) and other central institutions in addition to the National Referral Hospitals (NRHs) and Regional Referral Hospitals (RRHs). The private system contains Private not for profit (PNFP) facilities, private for-profit (PFP) and civil society organizations (CSOs).

At the national level, the MOH is responsible for planning, policy development, setting standards, quality control, research, resource mobilization and managing central level services and control of epidemics. The functions are carried out in collaboration with other central level institutions such as Health Service Commission (HSC), Uganda Blood Transfusion Service (UBTS) and National Medical Stores (NMS).

Health facilities in Uganda have three levels of care: primary, secondary and tertiary. The primary level are composed of the Village Health Teams (VHTs), Health Centre IIs, Health Centre IIIs, Health Centre IVs and General Hospitals. The secondary levels are the Regional referral Hospital and other PNFP hospitals with large bed capacities. The Tertiary level is for the National Referral Hospital and other super-specialized Hospitals. The MOH directly supervises the Regional and National Referral Hospitals who have self-accounting and semi- autonomous status accordingly.

Figure 2 below displays the structure of the Uganda's health system. Detailes of the roles, responsibilities and mandates of each level of service delivery are secribed in section .

## Figure 2.1 Structure of Uganda's Health System



# Section 3

# Alignment of the Planning Guidelines with the Existing Policy Frameworks

## 3.1 Overview of the Health Sector Development Plan

The Ministry of Health has drafted a five-year Health Sector Development Plan (HSDP 2015/16-2019/20), in line with the National Development Plan II. The goal of the Health Sector Development Plan (HSDP) is to achieve Universal Health Care by June 2020. As such the HSDP aims to expand access to the Uganda National Minimum Healthcare Package (UNMHCP) to all Ugandans. Accordingly, Essential Healthcare Packages (ESPs) for different levels of care in Uganda have been revised. The HSDP proposes expansion in the scope of ESPs at all levels of care; with a number of essential services being rolled out to lower levels of care. For example, EMTCT services will be scaled up to some (high volume) HCIIs. The ESP for HCIIIs will now include assessment of CD4 count; while the proposed package for HCIVs includes abdominal ultrasound examinations and a mortuary. The HSDP introduces the concept of a 60-bed community hospital (between HCIV and General Hospitals), the functional structure for which is not yet determined. There is strong emphasis on health promotion, underlined by the introduction of "Alert Villages" and "model homes". Further, the vision is for general hospitals to offer specialized services, and for referral hospitals to offer super-specialised services.

In order to achieve this, the HSDP underlines the significance of increased, evidenced-based, strategic investments in the health sector. Of particular focus are health governance and partnerships, service delivery systems, disease prevention and control, health information, health financing, health products and technologies, health workforce, health infrastructure, and social determinants of Health.

Details of the proposed revision of the basic health care are displayed on the next page.

## *PROPOSED REVISED PACKAGE OF BASIC HEALTH SERVICES FOR UGANDA, 2014*

| Facility | Services | Population | Beds | Staffing | Equipment |
|---|---|---|---|---|---|
| HC I (community) | ▪ Mobilization to improve people's the health condition<br>▪ Data collection<br>▪ Health promotion<br>▪ Hygiene and sanitation<br>▪ Nutrition & Child growth Monitoring<br>▪ "Alert village"<br>▪ "Model home" | 1,000 | Nil | Community Health Workers (volunteers) | |
| HC II | ▪ Immunization (both fixed and mobile)<br>▪ Antenatal care<br>▪ Health education, sanitation and disease prevention<br>▪ Screening for health risks/diseases<br>▪ Family planning (methods such as orals/depo)<br>▪ Basic first aid<br>▪ Monitoring service delivery<br>▪ General OPD services<br>▪ Emergency deliveries<br>▪ Plus all functions of the HC I for the target population<br>▪ Functions of HC 1 above | 5,000 | 2:<br>▪ Emergency delivery | See approved staff List | NACME list |
| HC III | ▪ Minor surgery (non-operating room)<br>▪ Maternity services<br>▪ inpatient services<br>▪ Sanitation<br>▪ Treatment of common diseases and illnesses<br>▪ Static immunization point<br>▪ Minor dental treatment (mobile)<br>▪ SRH services (including long-term family planning methods)<br>▪ Basic laboratory services<br>▪ Plus all functions of the HC II for the target population where it exists. | 20,000 | 14:<br>▪ 4 Maternity<br>▪ 4 children<br>▪ 4 Female<br>▪ 2 Male | See approved staff List | NACME list |

| Facility | Services | Population | Beds | Staffing | Equipment |
|---|---|---|---|---|---|
| HC IV | ▪ Supervision of HC IIIs and HC IIs.<br>▪ Centralised data collection, analysis of health trends and disease surveillance<br>▪ Simple surgery including caesarean sections and lifesaving surgical operations<br>▪ Blood transfusion<br>▪ Ultra sound examinations for abdominal conditions especially obstetric cases<br>▪ Standby ambulance<br>▪ Mortuary<br>▪ Plus all functions of the health centre III for the target population where it exists. | 100,000 | 24:<br>▪ 8 Maternity<br>▪ 6 Children<br>▪ 6 Female<br>▪ 4 Male | See approved staff List | NACME list |
| Community Hospital | ▪ Plain X-ray examinations (BRS)<br>▪ Family medicine<br>▪ Elective surgery<br>▪ Plus all the functions of the HC IV of the target population where it exists. | 250,000 | 60:<br>▪ 15 Maternity<br>▪ 15 Children<br>▪ 15 Male<br>▪ 15 Female | See approved staff List | NACME list |
| General Hospital | ▪ Plain X-ray Examinations (BRS & Mobile)<br>▪ All general medical and surgical conditions[1]<br>▪ Specialist services<br>▪ Plus all functions of a community hospital | 500,000 | 100:<br>▪ 25 Obs & Gyn<br>▪ 25 Paediatrics<br>▪ 25 Medicine<br>▪ 25 Surgery | See approved staff List | NACME list |

[1] World Health Organization, **the Hospital in Rural and Urban Districts**, WHO TRS 819, Geneva, 1992.

### 3.2 Uganda Public Health Service Protocols

In order to enhance preventive measures to health care delivery (Prevention is better than Cure), Uganda has highlighted 7 tips for a healthy life style in the Uganda Public Health Service Protocols 2015 as indicated below.

- Eat Healthy Food and Exercise Regularly
- Immunize Children and others at Risk from VPDs
- Observe Proper Personal Hygiene and Sanitation
- Fight Malaria, TB and other Common Infections
- Avoid Drug and Alcohol abuse to prevent diseases and accidents
- Practice Responsible Sexual behavior and life styles
- Attend regular Check Ups

These tips must be emphasized at all time during community engagement on health issues at the decentralized planning processes.

### 3.3 Resource Allocation in the Health Sector

The Ministry of Health is responsible for allocation of resources (Central Government Grants) between Local Government. Currently the allocation formula for PHC recurrent non-wage is based on the following factors:

(i) A fixed amount to each District/Municipal councils to cater for the cost implications of a higher local government.

(ii) A fixed amount for hard to reach local governments and those implementing special government programs.

(iii) A variable amount allocated depending on the estimated number of infant deaths in each local government.

(iv) Each local government's allocation should be equal to or higher than the previous financial years.

The PHC wage is allocated taking into account the staff in post and the planned recruitment. District hospitals and PNFP grants are allocated basing on the level and number of facilities in the District. However, plans are underway to review the allocation formula, consolidate the grants, and introduce performance/results-based financing/allocations. When concluded the principles will be communicated to the local governments.

### 3.4 Primary Health Care Conditional Grants

The Ministry of Health issues PHC conditional grant guidelines each financial year. The PHC grants guidelines set out the framework for utilizing PHC grant releases to DLGs. The guidelines set out the allowable and dis-allowable expenses and budget ceilings for DLGs and health facilities within the districts. PHC grants are linked directly to the district annual work plans and budgets, as approved by the district council if not objected to by MOH. District and Municipal plans should be submitted to MOH for review by the end of November of every year. District plans should be inclusive of health facility plans and budgets, which should be consistent with the PHC grants guidelines.

PHC conditional grants are released on a quarterly basis in accordance with timely submission of Performance Form B reports to MOFPED and MOH. Allocation of PHC grants to organizational units within the district, namely DHO, HSD, HC IV, HC III, and HC II is be guided by the MOH from time to time.

The budget for medicines was transferred to Vote 116 under NMS with effect from FY2010/11; such that procurement and distribution of medicines and medical supplies is now managed directly by NMS. Activities of the PNFP health institutions should be integrated into the district BFP and the Annual work plan and budget for the LG.

*PHC non-wage recurrent (NWR) budget*

The following items may be planned for under the PHC NWR budget:

- Employee cost (other than wage)
- Administrative expenses
- Food supply
- Medical and office equipment supply
- Operation and maintenance
- Utilities
- Cleaning services
- Material supplies and manufactured goods
- Training costs
- Payment of interns
- Outreaches
- Monitoring, supervision and reporting
- Property costs

*Health infrastructure*

The strategy for the HSDP on health infrastructure development is to consolidate the existing facilities for enhanced effectiveness in service delivery; and to upgrade and establish new facilities only in underserved areas, thereby expanding accessibility to services. Hence for the next 3 years, the PHC development grant and/or the District Discretional Equalization Grant (DDEG) will be directed towards equipping, renovating and rehabilitating existing health facilities. Particular focus will be on improving staff accommodation, maternity infrastructure, water and sanitation facilities, and ambulance services. However, LGs should plan and budget for the cost of demarcation of boundaries of land facilities and the cost of acquisition of land titles.

### 3.5 Resource Allocation within Local Governments

Resource allocation to facilities within local governments has been based on the service of-

fered and the level of care as well as the global resources envelope for the respective local government. At HSD level currently the proposed allocating should be as follows:

- 23.7% for monitoring and supervision
- 25.62% for constituency taskforce/HSD meetings and assemblies
- 31.23% for special outreach programs
- 19.45% for disease preventions and health promotion activities

However, the GoU is moving towards introducing performance/results based financing where allocation of funds to facilities will be depend on verified service outputs and quality produced at the facility.

### 3.5.1 The Performance-Based Financing (PBF) Framework

The HSDP and the Health Financing Strategy (HFS) 2015/16-2024/25 propose the adoption of Performance-based financing (PBF) as one of the mechanism for funding public health services in Uganda. PBF is a mechanism for paying for health services, or a method paying providers of in a health facility, based on attainment of agreed performance targets. Performance targets often combine elements of both quantity and quality of a package of care, agreed upon *a priori*. Existing literature shows that pay for performance has the potential to change incentives provided for health workers in a manner that promotes the delivery of quality health services.

Unlike input-based planning, funding under PBF schemes are usually linked to comprehensive, systematic, evidence based work plans, which are oriented towards achieving specific targets (outputs and quality). In addition, it is characterized by extensive verification of performance of indicators. Therefore, PBF funding mechanism requires a shift in the planning paradigm.

The Health Financing Strategy (HFS) 2015/16-2024/25 aims to promote PBF as a mode of output-based provider payment; and to roll it out systematically and progressively to cover the whole country by the end of the HFS. This will be accompanied by capacity building for providers and MOH in planning and implementing PBF, in order to support the transition towards PBF as the preferred output-based provider payment mechanism.

The main Principles of PBF implementation in Uganda include separation of the functions and responsibilities for regulation, purchasing, fund holding, verification and service provision. These are described further below.

1. Autonomous management of services by health facilities. In line with decentralisation policy, the PBF philosophy envisages that facilities have increased autonomy with regard to spending of public funds, hiring and firing and purchasing of drugs and supplies.

2. Promoting Public-Private partnerships with Public, Private not for Profit (PNFP) and Private Health Practitioners (PHP).

3. Transparency in the use of PBF funds.

4. Provision of PBF funds as an additional source of funds to the health facilities and other entities.

5. Simplicity: the processes in the PBF program will be kept simple so as to allow easy adaptation and uptake of the new procedures.

### 3.6 Accountability for Local Government Grants

The grants to local governments should be managed in accordance with local government Act and local government finance and accounting regulations. The CAO/TC will be the accounting officers. Local governments are however advised to make timely accountability and to be cognizant of any changes issued through calendars from the central government.

### 3.7 Health leadership and governance

The second National Health Policy provides for the establishment of a Health Unit Management Committees (HUMC) or Hospital Board to provide stewardship in operations of health centers (II – IV) and hospitals. HUMCs and hospital boards are critical in overseeing the development, approval, implementation, monitoring and evaluation of health facility plans. They are responsible for ensuring that plans are aligned with the aspirations of the HSDP. They therefore must be conversant with the goal of the HSDP, in particular the service delivery packages for the different levels of care and the requisite needs. Specifically, a functional HUMC or hospital board is expected to ensure community empowerment and engagement in health facility management, characterized by supportive relation between the community and the facility. In addition, they are expected to exact accountability in general administration, and management of financial and other resources of the health facility. Furthermore, HUMC and hospital boards have a responsibility to see to it that the communities have access to health services in the health facility, and that the services are of acceptable quality. Their specific day-to-day roles and functions include:

- Monitoring the general administration of the health facility
- Providing strategic vision, direction of the health facility in line with the HSDP framework
- Supervising the management of the health facility finances in accordance with the Government financial regulations
- Ensuring that annual work plans and budgets are drawn reflecting priority needs, approve budgets and monitor performance
- Presenting health facility annual performance reports
- Approving health facility audit reports
- Recommending reallocation of funds in line with PFMA 2015
- Monitoring procurement and utilization of services and goods
- Ensuring that essential health facility requirements are in place
- Liaising with the accounting officer and Minister responsible for health on pertinent issues regarding attention of higher authorities
- Fostering improved communication between the facility and the community; and encouraging community participation in community related health facility activities
- Assisting the health facility in resource mobilization
- Promoting CPD among the staff and monitor/evaluate staff performance
- Performing any other function as directed by the appointing authority

### 3.8 Community Extension Workers Strategies

In 2001, the Ministry of Health introduced a Village Health Teams (VHT) strategy, aimed at enhancing accessibility and affordability of health services to rural and poor communities, and to empowering communities to participate in improving their own health. In 2015, an

assessment of the status and functionality of VHTs strategy revealed a number of gaps and challenges in implementation of the VHT strategy, particularly regarding member composition, training, retention, motivation, coordination, supervision, partnership and political commitment. It was concluded that the VHT strategy is unsustainable over a long period of time because it is hinged on volunteerism.

Lessons from other countries indicate that, for it to be effective, the provision of community health services often requires full-time engagement which therefore cannot be cost free. Models using Community Health Extension Workers (CHEWs) are thought to present a more viable strategy to the VHT strategy. Unlike VHTs, CHEWs will consist of full-time, trained, equipped and paid health workers. Evidence from countries similar to Uganda indicate that effective use of community health extension workers can lead to improved health outcomes and the services provided by them are more appropriate to the health needs of populations and less expensive than those which are facility based[1].

Accordingly, the MOH has designed a Community Health Extension Workers (CHEW) strategy for Uganda, aimed at addressing the weakness of the current VHT approach. The CHEW strategy is in line with HSSIP and is meant to provide a framework for strategic partnerships for increased investments for community health program.

Effective implementation of the CHEW strategy entails ensuring inclusion of specific activities and the corresponding budget in yearly action plans at different levels and relevant tools and guidelines.

### 3.9 District Health Management Team (DHMT) – Extended

The extended DHMT is the sector's technical decision managing body at the District level it is chaired by the DHO.

#### 3.9.1 Composition of the DHMT -E

The extended DHMT shall be comprised of the following members: The DHT (DHO, ADHO-MCH, ADHO-Environmental Health, SHI, SHE, Biostastician, Programme Focal Officers), ACAO-Health, District Health Information Officer, HSD in charges, Representatives of RRHs and General Hospitals, PNFP Representative,, Principal  Planner, a representative of the Private Health Providers, CSO Representative and a representative of IPs (Implementing Partners).

#### 3.9.2 Roles/Responsibilities of DHMT-E

- The committee will be responsible for the following:
- Prepare a District Health Sector Strategic plan
- Coordinate planning for health services
- Prepare annual plans
- Co-ordinate all stakeholders, including development partners at all levels in the district

1 Ministry of Health, Community Health Extension Workers Strategy in Uganda (2015-2020)

- Oversee operational research and any sector specific studies in the district
- Monitor plan implementation
- Mobilise resources for the district health programmes
- Promote staff welfare
- Monitor and evaluate staff performance

### 3.10 Constituency/County Management Health Team

In order to strengthen the planning and management of health services at the constituency or HCIV, it is deemed necessary to have in place a constituency or county management health team.

#### 3.10.1 The Roles of the Constituency/County Management Health Team

The Constituency/County Management Health Team will comprise of the Head of a HSD, in charges of HCIVs, the Health Inspector, and representative of HUMCs (not the health unit I/C) The Team will be chaired by the HSD in charge.

The committee will be responsible for the following:

- Preparing a County Health Sector Strategic plan
- Coordinating planning for health services
- Preparing annual plans.
- Co-ordinate all stakeholders including development partners at all levels of the county.
- Overseeing the operational research/sector specific studies in the county
- Monitor implementation of the plans
- Mobilise resources for the county health programmes
- Promote staff welfare
- Monitoring and evaluate staff performance

#### 3.10.2 Role of sub-county Management Health Team

The committee will be responsible for the following:

- Preparing the Sub-County Health Sector Strategic plan
- Coordinating planning for health services
- Preparing annual plans.
- Co-ordinate all stakeholders including development partners at all levels of the sub-county.
- Overseeing the operational research/sector specific studies in the sub-county

- Monitor implementation of the plans
- Mobilize resources for the Sub-county health programs
- Promote staff welfare
- Monitoring and evaluate staff performance

The District, County, and Sub-county Health management teams should co-opt members from other departments in order to facilitate and enable inter-sectoral coordination and collaborations.

## 3.11 Criteria for Establishing or Upgrading New Health Facilities

### 3.11.1 Establishing new health facilities

New facilities shall be established in either of the following circumstances:

- A community of about 5,000 people is not in reach of a health unit within 5 km walking distance. A Health Centre II would then be established.
- Access to available health units for recognisable community is constrained by geographical features such as mountains, water, and conflict or otherwise. Appropriate level of facility to be determined - specific assessment on a case by case basis. Factors to consider include population, distance to different levels and feasibility of attracting staff to work in the area.

### 3.11.2 Upgrading health facilities

Upgrade of health facilities should be planned with evidence of resources for all inputs for the facility to function. This includes availability of the following:

- *Infrastructure*
    - Have all medical buildings and equipment for Current Level
    - Have at least 50% of basic staff houses for current level
    - Have a clear plan for acquiring additional infrastructure for the higher level
    - Standard buildings designs and related requirements for Health Facilities should be gotten from the Ministry of Health
- *Staffing*
    - Should be > 65% of Staffing Norm of current level
    - A clear plan for acquiring additional staff for the upgraded level

## *Criteria for establishment and upgrading of health facilities*

| | Activity | By Whom |
|---|---|---|
| 1 | Identification of need and initiation of the process for establishment of a new facility or upgrading of existing. | Community, District Health Team, Lower Level Local Governments, Non-Government Organisations or other Development Partner |
| 2 | Documenting the justification for the need with necessary statistics and data | Community, District Health Team, Lower Level Local Governments, Non-Government Organisations or other Development Partner |
| 3 | Submit the request / proposal for the development to the District Health Officer for review by the District Health Team. | Community, District Health Team, Lower Level Local Governments, Non-Government Organisations or other Development Partner |
| 4 | If the proposal is approved by the District Health Team, submit to the District Council for review and / or approval with due consideration of the resources for effective utilisation of the development | District Health Officer |

# Section 4 Structure of the District Health Plan

This section presents a standard structure for planning at all levels of health service delivery at the district level.[2] This includes HCIIs, HCIIIs, HCIVs, and general hospitals. The work plans for HCIIs, HCIIIs, and HCIVs are consolidated to form a health sub- district plan. Consolidated plans from different HSDs will form a district health plan. The information which is needed to populating the plans is outlined below.

### 4.1 Outline of Plan

The District Plan shall have the following main sections and sub-sections;

i) Background information

a. Geographical location

b. Demographics

ii) Situation analysis

a. health status including socio-economic indicators based on the community / household surveys.

b. Performance against the key sector performance indicators (HSDP)

c. Health Infrastructure

d. Human Resources for Health

e. Partner support

f. Inter-sectoral collaboration

iii) Goal, objectives, strategies and interventions (Developing Interventions; How will we get there?)

iv) Implementation and coordination framework

v) Roles and responsibilities

vi) Budget

vii) M&E of the plan

[2] This can also be used for planning at regional and national hospitals

### 4.2 Background information

This section provided the district/municipal/HSD or facility background information in relation to the geographical location, organisation or administrative unit in an organised manner and assists in interpreting important features of the respective unit.

A health map highlighting key geographical areas such as rivers, roads, lakes and location of other major facilities should be inserted in the section. Respective maps can be picked from the District Planning Unit or Uganda Bureau of Statistics.

*(Attach a map of the district/Areas with location of facilities, if available).*

The parameters in the table below should be used to assess the demographic status.

**Table 1: Demographic data**

| Demographic Variables | Number | Proportion (%) |
|---|---|---|
| a) Total Population | A | 100% |
| b) Children below 18 years | 55.1% x [A] | 55.1% |
| c) Adolescents and youth (young people) (10 – 24 years) | 34.8% x [A] | 34.8% |
| d) Orphans (for children below 18 years) | 8,04% x [A] | 8.04% |
| e) Infants below one year | 4.3% X [A] | 4.3% |
| f) Children below 5 years | 17.7% x [A] | 17.7% |
| g) Women of reproductive age (15 – 49 years) | 20.2% x [A] | 20.2% |
| h) Expected number of pregnancies | 5% x [A] | 5% |

Any special circumstance affecting the district, administrative unit or catchment area such as; refugees, landslides, epidemics, etc should be described.

### 4.3 Situation Analysis: Where are we now?

The section should provide a glimpse of the demographics, infrastructure, human resources, partner support, health status, socio-economic indicators, inter-sectoral collaboration, gender and equity status, as well as a summary of the strengths and weaknesses in the area. Use as much as possible existing data, particularly from HMIS, HRIS and Community-based Management Information System. Other information can be got from survey and research reports, statistical reports, and annual reports. Disaggregate analysis by gender and geographical areas and whenever applicable assess how equitable the sector services are. Table 2 below provides a summary of some key indicators for describing the health status of the district or local government area.

**Table 2: Indicators of the Health Statusin the District or Local Government Area**

| Indicator | National Baseline | Baseline Region | Current (Region) | Target 2019/20 |
|---|---|---|---|---|
| Maternal Mortality Ratio (per 100,000) | 438 (UDHS2011) | | | 320 |
| Neonatal Mortality Rate (per 1,000) | 26 (UDHS2011) | | | 16 |
| Infant Mortality rate (per 1,000) | 54 (UDHS2011) | | | 44 |
| Under five mortality rate (per 1,000) | 90 (UDHS2011) | | | 51 |
| Total Fertility Rate | 6.2 (UDHS 2011) | | | 5.1 |

| Indicator | National Baseline | Baseline Region | Current (Region) | Target 2019/20 |
|---|---|---|---|---|
| Adolescent Pregnancy Rate | 24%<br>(UDHS 2011) | | | 14% |
| Contraceptive Prevalence Rate | 30%<br>(UDHS 2011) | | | 50% |
| Children below 5 years who are stunted | 33%<br>(UDHS 2011) | | | 29% |
| Children below 5 years who are under weight | 14%<br>(UDHS 2011) | | | 10% |

Institutions should use parameters which are relevant to their levels for situation analysis and performance review. For example, in reviewing the infrastructure status, a total number of health facilities both public and private in the district may be vital to the DHO but this may not apply to the analysis at HCII level. At the HC II the number of service delivery facilities e.g. staff houses and status of OPD is more relevant in reviewing infrastructure status.

### 4.3.1 Performance against HSDP Indicators

Analyze the performance during the previous FY and the provisional outturn for the current FY of both the budget and the performance indicators. The targets set in the previous and the current plans become the benchmarks for assessment. The table below indicates areas for HSSIP performance assessment. The areas are arranged according to indicator category ranging from input indicators to impact indicators. It is important to make a critical analysis of achievements, the constraints & reasons for the shortfalls. This can be indicated in the column forcomments.

## Table 3: Key Sector performance Indicators

| Specific Objective | Key Result Area | Indicator | Previous FY | | Current FY | | HSDP Target 2019/20 | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | Target/ Output | Achieved | Target | Achieved to December | | |
| To increase financial risk protection of households against impoverishment due to health expenditure | Health financing | PHC including PHC NGO Grant | | | | | | |
| | | NWR | | | | | | |
| | | Devt | | | | | | |
| | | Donor | | | | | | |
| | | Other | | | | | | |
| | | Private Sector Finances | | | | | | |
| To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services. | **HEALTH & RELATED SERVICES OUTCOME TARGETS** | | | | | | | |
| | Communicable disease prevention & control | ART Coverage | | | | | 80% | |
| | | HIV+ women receiving ARVs for PMTCT during pregnancy & delivery | | | | | 95% | |
| | | TB Case Detection Rate (all forms) | | | | | 95% | |
| | | Intermittent Presumptive Treatment (IPT) 3 or more doses coverage for pregnant women | | | | | 93% | |
| | | In patient malaria deaths per 100,000 persons per year | | | | | 5 | |
| | | Malaria cases per 1,000 persons per year | | | | | 198 | |
| | | Under-five Vitamin A second dose coverage | | | | | 66% | |
| | | DPT3Hib3Heb3 coverage | | | | | 97% | |
| | | Measles coverage under 1 year | | | | | 95% | |
| | Essential clinical and rehabilitative care | Bed occupancy rate (Hospitals & HC IVs) | | | | | 90 | |
| | | | | | | | 75 | |
| | | Average length of stay (Hospitals & HC IVs) | | | | | 3 | |
| | | | | | | | 3 | |
| | | Couple years of protection | | | | | 4.7 M | |
| | | ANC 4+ coverage | | | | | 45% | |
| | | Health Facility deliveries | | | | | 64% | |
| | | HC IVs offering CEmOC Services | | | | | 50% | |
| | **HEALTH SYSTEMS OUTPUT TARGETS** | | | | | | | |
| | Health Infrastructure | New OPD utilization rate | | | | | 1.5 | |
| | | Hospital (inpatient) admissions per 100 population | | | | | 10 | |
| | | Population living within 5km of a health facility | | | | | 85% | |
| | Medicines and health supplies | Availability of a basket of commodities in the previous quarter (% of facilities that had over 95%) | | | | | 100% | |
| | Improving quality of care | Facility based fresh still births (per 1,000 deliveries) | | | | | 11 | |
| | | Maternal deaths among 100,000 health facility deliveries | | | | | 115 | |
| | | Maternal death reviews conducted | | | | | 65% | |
| | | Under five deaths among 1,000 under 5 admissions | | | | | 16.1 | |
| | | ART Retention rate | | | | | 84% | |
| | | TB Treatment Success Rate | | | | | 90% | |
| | Responsiveness | Client satisfaction index | | | | | 79% | |
| | Human Resources | Approved posts in public facilities filled with qualified personnel | | | | | 80% | |
| | | Number of health workers (doctors, midwives, nurses) per 1,000 population | | | | | 1:23,500 | |
| | | | | | | | 1:9,500 | |
| | | | | | | | 1:17,000 | |
| To address the key determinants of health through strengthening inter-sectoral collaboration and partnerships. | Health promotion & environmental health | Latrine coverage | | | | | 82% | |
| | | Villages/ wards with a functional VHT, by district | | | | | 85% | |

### 4.3.2 Disease Burden, Cause of Mortality, and HMIS data reporting status

The top 10 diseases and their contribution to mortality in the particular catchment area should be listed. The information should be extracted from the HMIS database.

**Table 4: Top Ten Causes of morbidity for all age groups during previous FY**

| No. | Disease | Female | Male | Number | (%) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | Others | | | | |

**Table 5: Top Ten Causes of morbidity for under fives during previous FY**

| No. | Disease | Female | Male | Number | (%) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | Others | | | | |

**Table 6: Top Ten Causes of morbidity for adults during previous FY**

| No. | Disease | Female | Male | Number | (%) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | Others | | | | |

### Table 7: Top Ten Causes of mortality for all age groups during previous FY

| No. | Disease | Female | Male | Number | (%) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | Others | | | | |

### Table 8: Top Ten Causes of mortality for under fives during previous FY

| No. | Disease | Female | Male | Number | (%) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | Others | | | | |

### Table 9: Top Ten Causes of mortalityfor adults during previous FY

| No. | Disease | Female | Male | Number | (%) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | Others | | | | |

**Table 10: Causes of Maternal Mortality during previous FY**

| No. | Condition | Number | (%) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | Others | | |

### 4.3.3 Health infrastructure Status

A good knowledge of the existing health infrastructure by level and functionality is key in planning for health services.At the district level, all public and private facilities in the district should be listed and defined by facility level (GH, HCIV, HCIII, HCII) and ownership (Public, PNFP, PHP). The functionality of the health infrastructure should also be stated as follows: *fully functional, partially functional or not functional.*

**Table 11: Health Facility Infrastructure Status**

| HSD | S/C | Parish | Health facility Name | Level | Ownership | Functionality | Comment |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

The number of vehicles available should be summarized by level of service delivery, indicating their functional status as follows.

**Table 12: Transport**

| Facility Level | Type of Vehicle (s) | Vehicle condition (Good or Poor) |
|---|---|---|
| District | | |
| Hospital | | |
| HC IVs | | |
| HC IIIs | | |
| HC IIs | | |
| **Total** | | |
| | | |

At the district level, it is useful to indicate the total number of health facilities (both public and private). At health facility level, the health infrastructure status shall be based on the Health Unit Physical Inventory (HMIS Form 101). The DHO shall summarize the information submitted by the individual health facilities regarding the status of health infrastructure into one form shown in Table 14 below.

**Table 13: Health Infrastructure of the Health Facility**

| Type of Building | | Available (Tick) | | Year of construction | Year of last rehabilitation | General Condition | Comments |
|---|---|---|---|---|---|---|---|
| | | Ye | No | | | | |
| 1. OPD | | | | | | | |
| 2. Maternity<br>Bed Capacity for maternity | Bed capacity for delivery | | | | | | |
| | | | | | | | |
| 3.General wards (indicate number of beds) | Medical ____beds | | | | | | |
| | Surgical ____beds | | | | | | |
| | Paediatrics ___beds | | | | | | |
| | Obs/Gyn ____ beds | | | | | | |
| | TB _____ beds | | | | | | |
| 4. Operating theatre | | | | | | | |
| 5. Laboratory | | | | | | | |
| 6. X-ray unit | | | | | | | |
| 7. Dental unit | | | | | | | |
| 8. Blood Bank | | | | | | | |
| 9. Pharmacy | | | | | | | |
| 10. Store | | | | | | | |
| 11. Mortuary | | | | | | | |
| 12. Staff houses with: (specify number) | Two bed roomed house | | | | | | |
| | Three bed roomed house | | | | | | |
| | | | | | | | |
| 13. Incinerator | | | | | | | |
| 14. Others (specify) | | | | | | | |

### 4.3.4 Human Resource Situation

Human resource is a key factor in health service delivery in districts. While preparing a work

plan, it is important that their positions, numbers and skills mix are well documented and defined and that gaps are properly identified by different levels. The table below should be used in capturing relevant information for planning purposes at the district level. The staffing situation should be assessed for both the public and private not for profit sector.

**Table 14: Public Sector District Staffing by Health Facility Level[3]**

| Level | No. of Units | No. of Posts | Filled | Vacant | Annual Budget (In post) | Annual Budget (vacant posts) | % Filled |
|---|---|---|---|---|---|---|---|
| DHO's Office | | | | | | | |
| General Hospital | | | | | | | |
| HC IV | | | | | | | |
| HC III | | | | | | | |
| HC II | | | | | | | |
| Municipal Council | | | | | | | |
| Big Town Council | | | | | | | |
| Small Town Council (Town Boards) | | | | | | | |
| District Total | | | | | | | |

**Table 15: PNFP sector District staffing by health facility level[4]**

| District & Facility level | No. of Units | No. of Posts | Filled | Vacant | % Filled | % Vacant |
|---|---|---|---|---|---|---|
| General Hospital | | | | | | |
| HCIV | | | | | | |
| HCIII | | | | | | |
| HCII | | | | | | |

## Capacity Building

The funds for capacity building should be used for Continuous Professional Development (CPD) (institutional In-Service Training/CPD, seminars, workshops, induction of newly recruited health workers/ those preparing for retirements, short courses in priority health care of the district). The districts should have training plans outlining the training priority areas.

**Table 16: Monitoring Staff on training**

| Position | No. of staff | Courses attended | Duration | Institution |
|---|---|---|---|---|
| DHO | | | | |
| ADHO | | | | |
| Doctors | | | | |
| Registered Nurses / Midwives | | | | |
| Enrolled Nurses | | | | |
| Enrolled Midwives | | | | |
| Clinical Officers | | | | |
| Pharmacy Technicians | | | | |
| Laboratory Technicians | | | | |
| Others (specify) | | | | |

[4] Please refer to the annex 3 for the staffing norms

### 4.3.5 Partner Mapping

For effective allocative efficiency it is imperative that all the support to the districts or institution is documented by source, amount, and area of support. A distinction should be made between those partners that are giving funds and those that giving support in-kind. As much as possible, the support in-kind should be monetized. The partners whose support is projected to end should be stated for purposes of identifying potential sources of filling the gap where necessary or sustainability strategies for the interventions.

***Table 7: Partner Mapping***

| Name of Project/ Partner | Intervention Area | Duration of project | Start date | Coverage (Health Sub district) | Target group/ Estimated population | Implementation mode (tick all applicable) | | | Estimated annual budget |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Direct Funding | Technical Assistance | In kind | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

### 4.3.6 Inter-sectoral Collaboration

Health status is determined by a number of factors, some of which lie outside the health sector. It is imperative that an analysis is done on the key determinants of health contributed to by other sectors. An example of these is the safe water coverage and education which contribute significantly to cluster 01 of the HSSIP-Health Promotion, Disease Prevention and Community Health Initiatives. An assessment of the determinants is therefore necessary for purposes of arriving at the health sector contribution to the respective interventions to be included in the work plan or inform the resource allocation in other sectors.

### 4.3.7 Socio-economic Profile

Any factors, features or activities affecting the social or economic status of the district, administrative unit or catchment area should be described.

### 4.3.8 Special Circumstances

Any special circumstance affecting the district, administrative unit or catchment area such as; refugees, landslides, epidemics, etc. should be described.

### 4.3.9 Strength Weaknesses Opportunities and Threats (SWOT) Analysis

From the above analysis of the aforementioned inputs and factors, a SWOT analysis table

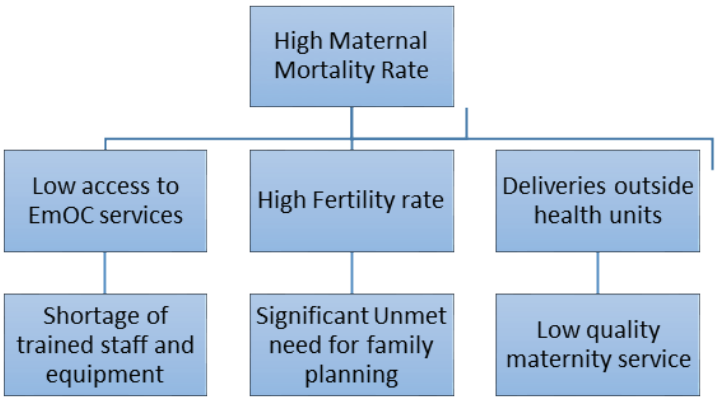
should be developed. This analysis should help to inform the next stages of the planning cycle: ***Where do We Want to Go*** and ***How Will We Get There.*** The strengths and opportunities can be used in setting the objectives and harnessing available resources while the threats and weaknesses can help in identifying areas to be improved and anticipate factors that could affect the attainment of the objectives and targets.

### *Table 10: SWOT analysis framework*

| **Positive** | | **Negative** | |
|---|---|---|---|
| **Internal** | | | |
| Strengths | What are we doing well? | Weaknesses | What we are doing poorly? |
| | What relevant resources do we have? | | What can we improve? |
| | What are our advantages? | | What should we avoid? |
| **External** | | | |
| Opportunities | Where are the favorable opportunities? | Threats | What obstacles do we face? |
| | What are the positive trends? | | Could any of our weaknesses threaten our plans? |
| | Where can we do the difference? | | What are our stakeholders doing? |

## 4.2 Problem Analysis: Where do we want to go and how?

The situation analysis and the performance review should be followed by a problem identification process. A problem can be defined as a deviation between the actual situation and population's goals with regard to sustainable satisfaction of the population's needs. In other words, problems are undesired conditions of life for the population or undesired conditions hampering healthcare delivery. The problems are usually nourished by problem causing factors or constraints. The problems and constraints should then be put into context in a problem tree. Starting with the main or starter problem illustrate the structured relationships between causes and effects in a diagram format. When formulating problems make sure they suit the definition of undesirable conditions of life or being, for example absence of a health unit (a pre conceived solution in this case) is not a problem in itself but it may be a constraint leading to the problem of low survival for newborn babies. An example of a problem tree is provided in the figure below.




After identifying the problems, it is important that they are ranked in order of importance. When doing the ranking it is important to take into consideration the national priorities as reflected in the policies, HSSIP, Joint Review Mission, District Development Plan and respective programmes. The problems should always be linked to their causes as illustrated in the problem tree. Prioritization of problems is essential in making decisions on how to allocate limited resources to solve the health problems.

The following criteria can be used for ranking problems:

- Magnitude - proportion of population affected by the problem.
- Severity/Danger - how serious is the problem? Does it threaten life?
- Responsiveness to intervention - can the problem be solved by the possible interventions?
- Cost effectives - is solving the problem worth the cost involved?
- Political acceptance and expedience - is the problem and possible solution acceptable to higher authorities? Will it be accepted by the District Council or Parliament?

Just as there are constraints in a system there are problem solving potentials (unused or under used possibilities to overcome constraints) in the same system. For example, in an area with a high unmet need for family planning there may be private health practitioners in the area who could assist with distribution of family planning supplies at a very low cost. The potential solutions can be derived from the SWOT analysis. All potentials in the area should be identified and by linking potentials to the constraints they can solve, strategies for solving the problem can be designed.

### 4.3.10 The Principles of Bottlenecks Analysis

The MOH has adopted the use of scorecards/dashboards to link district planning to the DHIS2. This will enable use of information generated by the DHIS2 for setting priorities in the planning process. The DHIS2 will be customized to create score card/ dashboards that can provide real time performance reports which will be used to set sector priorities. For example, a scorecard will be created for maternal and child health - the RMNCAH Scorecard. The RMNCAH scorecard will be color coded and used as one of the tools to review performance on a quarterly basis.  An example of the RMNCAH score card which shows real time data is shown below:

**Real time data**

The RMNCAH score card dash board provides snapshot on how districts. It triggers the BNA and CA processes which improve planning, budgeting and response.

MOH - Uganda Scorecard for September 2015

| Org Unit | Reporting Rate | C-Section Rate | Institutional U5 Mortality | Institutional Maternal Mortality | Institutional Newborn Mortality | % Of Babies With Birth Asphyxia | % Of Mothers Initiating | % Of Sick Neonates Presenting | % Babies Receiving P N C Checks |
|---|---|---|---|---|---|---|---|---|---|
| Abim District | 100.0 | 0.0 | 116.9▲ | 0.0 | 8.1▲ | 0.81 | 0.0 | 0.0 | 69.0 |
| Adjumani District | 100.0▲ | 9.1 | 27.1▲ | 0.0▼ | 1.7 | 1.2 | 0.0 | 32.0▲ | 73.9▲ |
| Agago District | 100.0 | 3.8 | 0.0▼ | 0.0 | 0.0 | 2.0 | 0.0 | 80.0▲ | 23.1 |
| Alebtong District | 72.2 | 1.8 | 0.0 | 0.0 | 0.0 | 2.6 | 0.9 | | 46.3▼ |
| Amolatar District | 100.0 | 3.5 | 0.0 | 0.0 | 0.0 | 0.98 | 0.0 | 100.0▲ | 60.7▼ |
| Amudat District | 100.0 | 2.9 | 0.0 | 0.0 | 0.0 | 1.2 | 0.0 | 100.0 | 70.3▲ |
| Amuria District | 100.0 | 0.97 | 0.0 | 0.0 | 0.0 | 3.3 | 0.0 | 62.5▼ | 58.0▼ |
| Amuru District | 100.0▲ | 0.0 | 0.0 | 272.5▲ | 0.0 | 0.82 | 8.1▲ | 42.9▼ | 38.1 |
| Apac District | 97.1▲ | 5.2 | 0.0▼ | 0.0 | 0.0 | 7.5 | 0.0 | 45.0 | 70.0▲ |
| Arua District | 94.5▼ | 9.2 | 0.94 | 47.1▼ | 0.0 | 0.75 | 0.0 | 27.6▼ | 18.1 |
| Budaka District | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.36 | 0.0 | 50.0▼ | 22.7▼ |
| Bududa District | 100.0 | 2.5 | 22.2▲ | 370.4▲ | 0.0 | 0.74 | 0.0 | 46.2▲ | 97.0▲ |
| Bugiri District | 98.0 | 8.4 | 0.0▼ | 603.1▲ | 0.0 | 5.9 | 0.0 | 0.0▼ | 75.2▲ |
| Buhweju District | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | | 89.4▼ |

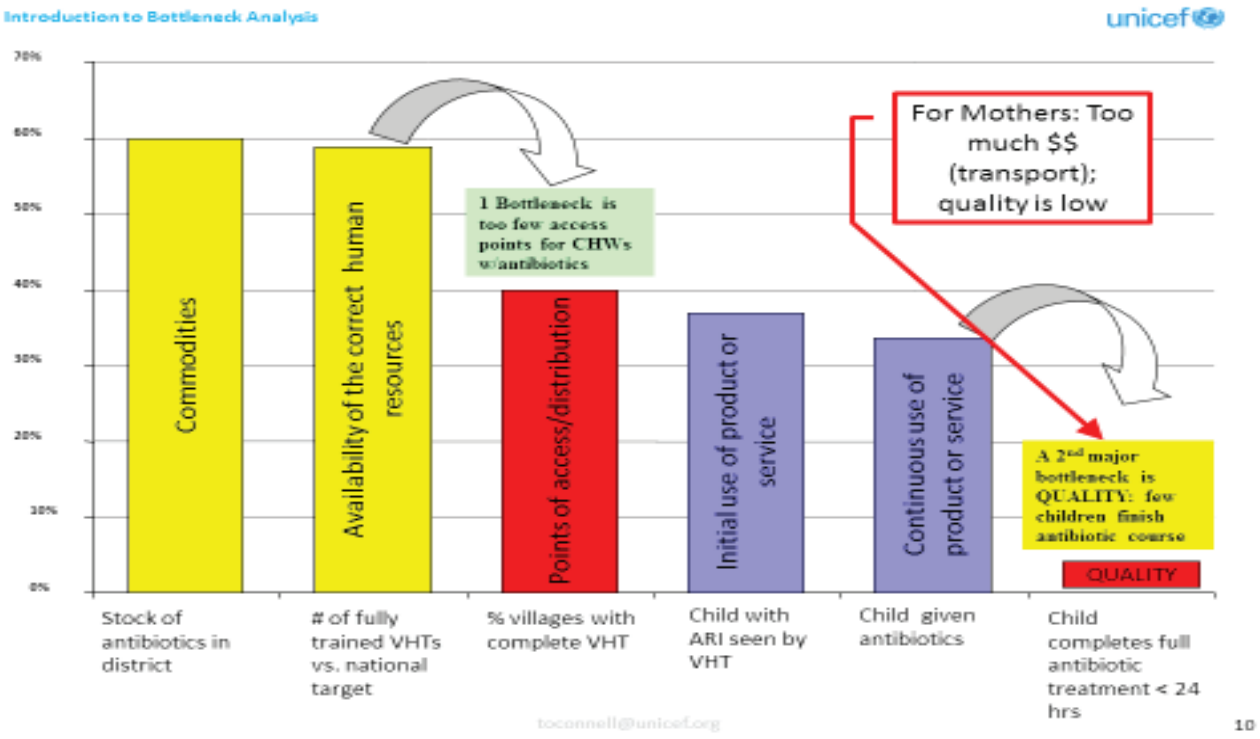
All indicators in the RMNCAH score card which are performing sub optimally i.e. with a red color will be analyzed further using the TANAHASHI model of bottleneck analysis. The bottleneck analysis is a graphical display of six health systems factors which interact to influence the effective coverage of key RMNCAH indicators and it organizes these indicators in a logical manner. The indicators built in the Tanahashi model include three supply-side factors and three demand side factors namely:

**Supply side factors**

- Availability of essential commodities
- Availability of human resources appropriately trained to provide the interventions under review
- The proportion of the target population who have access to the intervention (who are within 5 KMs radius of the facility or a worker offering the intervention)

**Demand side factors**

- Initial utilization of an intervention by the target population
- Continued utilization,
- The level of equality coverage (the proportion of the target population who receive the intervention as per relevant guidelines)




Two bottlenecks can be identified in the graph above:

- **Geographical coverage** -only 48% of the villages are VHTs trained to administer antibiotics for pneumonia.
- **Quality coverage** - less than 5% of children access the antibiotics within 24 hours

Consequently the following interventions can be prioritized

- Surveillance for acute respiratory tract infections.
- Ensure that budgets are allocated for conducting the surveys and surveillance. (Where resource gaps are observed, this needs to be described).
- The indicator framework should show which indicators are reported on using data from these survey.

When doing the ranking, in addition to bottlenecks analysis it is important to take into consideration the national priorities as reflected in the policies, HSDP, Joint Review Mission, District Development Plan, and respective programmes. The problems should always be linked to their causes as illustrated in the problem tree. While bottlenecks analysis provides an excellent technical model for setting priorities ethical issues should also be taken into consideration allocating resources. These will include issues such as prioritization of problems is essential in making decisions on how to allocate limited resources to solve the health problems.

- Magnitude - proportion of population affected by the problem.
- Severity/Danger - how serious is the problem. Does it threaten life?
- Responsiveness to intervention - Can the problem be easily solved by the possible interventions?
- Cost effectives - is solving the problem worth the cost involved?
- Policy framework - is there an enabling policy for the intervention? Is it socially acceptable? Will it be accepted by the District Council or Parliament?

Just as there are constraints in a system, there are problem solving potentials (unused or under used possibilities to overcome constraints) in the same system. For example, in an area with a high unmet need for family planning there may be private health practitioners who could assist with distribution of family planning supplies at a very low cost. The potential solutions can be derived from the SWOT analysis. All potentials in the area should be identified and by linking potentials to the constraints they can solve, strategies for solving the problem can be designed.

### 4.3.11 Setting Objectives and Targets: Where do we want to go & what do we want to do?

### 4.4 What to Do (Setting Objectives)

As defined by Rufaroetal (2004)[5], an objective is "the intended result of a successful activity or programme within given inputs and process. Objectives will be formulated to address the identified problems and their immediate causes. Objectives should be Specific, Measurable, attainable, Realistic and Time bound. (SMART)." The objectives could be facilitated by turning the statements in the problem tree into positive as illustrated below:

Objectives can be short or long term. An example of a short term objective that could be derived from the above figure would be to recruit 10 trained staff or provide 4,160 antenatal visits. The long term objective can be reducing maternal mortality from 430/100,000 to 380/100,000.

5 Planning and Implementation of District Health Services-World Health Organisation

### 4.4.1 Setting Targets

After setting objectives it is important that the number and quality of activities to attain the objectives should be determined. This should be done within available resources.

*Example*

If the objective is to reduce the maternal mortality rate by scaling up the antenatal visits then a target of the women to be reached should be determined appropriately bearing in mind the available staff and resources. Assuming that there are 2000 pregnant women in the catchment area with each needing an average of 4 contacts per woman. These number of contacts needed will be (2000*4) i.e. 8,000 contacts per year. If however the available staff from past trends can make 6,200 contacts in a year then 78% of the women can be covered within the available resources. The realistic target should then be set at 78% of the women to be covered within the available resources in the year.

### 4.4.2 Developing Interventions: *How will we get there?*

Interventions are alternative measures to address the health priority needs. Interventions are developed by identifying, listing and deciding alternative approaches to addressing identified and prioritized health problems. This phase in the planning cycle is done concurrently with determining the resource requirements and preparing action plans. The problems/challenges, their causes, identified priority actions and objectives can be summarized in the tables below.

***Table 12: District/Institutional Health Priorities For ------Fy -----***

| Challenges | Major Causes/Why these challenges | Priority Actions |
|---|---|---|
| **1** | | |
| 2 | | |
| 3 | | |

*(From LG Data, DDP, BFP, HSSIP, and JRM)*

***Table 13: HRH Action Plan***

**General objective:**_____

| | Identified HRH challenge (List in order of priority) | Strategy / intervention | Output | Activi-ties | Target | Action by |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |

***Table 14: Health Infrastructure Action Plan***

**General objective:**_____

| | Identified Infrastructure challenge ( List in order of priority) | Strategy /intervention | Activities | Target | Action by |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |

### *Table 15: Medicines and Health Supplies Action Plan*

**General objective:**_____

| | Identified medicines and health supplies challenge (List in order of priority) | Strategy/intervention | Activities | Target | Action by |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |

From the action plan a consolidated intervention matrix can be developed as below

### *Table 16: Example Intervention Matrix with Objectives and Targets*

| Long Term Objective | Aim | Short Term Objective | Programme Intervention | Planned Targets | Activities |
|---|---|---|---|---|---|
| Reduction of Maternal Mortality | Improve the quality of maternity service | Safe Deliveries in Health units | Provide 4,160 antenatal visits | 4,160 antenatal visits a year | Meetings<br><br>Out Reach Visits |
| | Improve the quality of maternity service | Better access to EmOC services | Recruiting staff trained in Emoc | 10 | -Training Needs Assessment-<br><br>-Identifying Training Institution.<br><br>-Get sponsorship |

## 4.2.3 Determining Resource Requirements; *What do we Need to Get There?*

The resources required to implement the activities should be determined by translating the activities into the inputs such as human labour, materials, space, time and information. The value of the inputs should be determined as far as possible by using the standard unit costs. In the absence of unit cost than the average market prices of the inputs can be used. The table below gives an example of how the resource requirements can be arrived at.

### *Table 17: Determining Resource Requirements - Example*

| | **Inputs** | | | | | **Outputs** | |
|---|---|---|---|---|---|---|---|
| **Intervention** | **Personnel** | **Infrastructure** | **Equipment** | **Transport** | **Fees** | | **Total cost of output** |
| Training Nurses in Emoc | 10 Nurses<br><br>2 Doctors | Class room or Institution hired/engaged | Books-50,000<br><br>Charts<br><br>Disposable syringes | Shs 200,000 per student | 500,000 per semester per student | 2 Doctors and 10 Nurses Trained | |
| | | | | | | | |

The planned activities, the outputs, the inputs the respective indicators and the time frame can then be consolidated into one matrix-that is reflected below.

### *Table 17: Template for the District Health Plan*

| CODE | OUTPUT DESCRIPTION | ACTIVITIES TO DELIVER OUTPUTS[2] (QUANTITY AND LOCATION) | PLANNED OUTPUT | QUARTERLY BUDGET | | | | CUMULATIVE BUDGET | OUTPUT IDICATOR | OUTCOME INDICATOR | RESPONSIBILITY | ASSUMPTIONS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | TARGET | Q1 | Q2 | Q3 | Q4 | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

### 4.2.4 Ambulance / Referral Service

An ambulance/referral service is an emergency medical service that responds to the acutely ill and injured or responds to any other emergency medical condition before the victim arrives at a health facility. It involves emergency measures that will save life and prevent further jeopardy to the individual at the spot of injury/catastrophe and transportation to hospital by well trained and motivated individuals.

Emergencies in Uganda have exerted a large societal and economic toll. The economic burden of emergencies is great – both in terms of the direct costs of medical care and the indirect economic costs of premature death and disability. A majority of the victims die during the pre-hospital stage and comparative studies in high and low income countries have shown that 50% of trauma deaths occur during this stage.

A well streamlined Ambulance/Referral service system is a key determinant for efficient health service delivery. This is because outcomes of hospital management of emergencies are dependent on the service and thus the condition of the patient on arrival at emergency department. It is a vital necessity urgently needed to compliment the Emergency Department/Accidents and Emergency Units (A&E) / Out Patient Departments (OPD) efforts to save lives and prevent disability.

It is important to strengthen ambulance referral systems at all levels of health service intervention. Currently the ambulance/referral service is decentralized at facility level with allocation of a vehicle and driver. Without well- defined funding for ambulance/ referral services, emergency health service delivery is hindered. Funding will cater for both wage and Non-wage recurrent costs. Hence the need for specific inclusion of ambulance/ referral services under Primary Health Care services.

Ambulance/referral services are comprised of a continuum of care from the community capacity to respond to emergencies; establishment a pre-hospital ambulance service to respond to emergencies occurring out of hospital; strengthening of OPD / A&E units; and strengthening monitoring and evaluation systems for the ambulance referral services.

***Table 18: Status of District ambulance/referral service Performance***

| District Facility | Number of Ambulance Vehicles | Staffing for ambulances | Number of referrals | |
|---|---|---|---|---|
| | | | Pre-hospital / Community pickups | Inter-facility Referrals |
| **General Hospital** | | | | |
| **HCIV** | | | | |
| **HCIII** | | | | |
| | | | | |

# Section 5 Implementation and coordination framework

The Constitution and the Local Governments Act 1997 (with Amendment Act 2001) defines the legal mandate of the District/Municipal councils. In the health sector, the District/Municipal councils are responsible for Medical and Health services. This includes general hospitals and all health centres in the respective catchment areas. Services under this mandate include maternity and child welfare services, control of communicable diseases (especially Malaria, HIV/AIDS, TB & Leprosy, NCDs, NTDs etc.), vector control, environmental sanitation, health education, quality monitoring of water supplies, supervision and monitoring within the local government, implementation/enforcement of the various health acts, and rural ambulance services. The activities to fulfill these responsibilities are carried out at the Local Government Department level, the Health Sub-District (HSD) level, Lower Level Health Facilities level and the Community level.

## 5.1 Responsibilities of the MoH

At the national level, the MoH Directorate of Planning is responsible for

- Developing of national health policies and strategic plans.
- Developing planning guidelines for the health sector.
- Coordinating all planning activities in the health sector.
- Compiling the comprehensive annual work plans for the sector.
- Budgeting and budget monitoring
- Health Information Management.
- Identifying, formulating and appraising development projects.
- Coordinating Public Private Partnerships for Health
- Coordinating inter-sectoral collaboration.
- Coordinating Development Partner Support and Global Health Initiatives in the sector.
- Workplan performance monitoring and evaluation.

These functions are carried out in collaboration with other MoH Departments, central level institutions and stakeholders, including Health Development Partners, Medical Bureaus and CSO representatives.

## 5.2 Responsibilities of National and Regional Referral hospitals

National and Referral hospitals provide complex curative care. Regional referral hospitals act

as first referral level for complex curative care, while national referral hospitals act as secondary referral or last level curative care facilities. Both NRH and RRH provide emergency care for the severely injured or the critically ill. They constitute an essential source of information and power (research) and support the Primary Health Care Strategy as a referral and support mechanism of the National Health System. In addition to this, National Referral Hospitals are centers for the transfer of knowledge, skills training, and supervision.

### 5.3 Mandates of Local Governments

The roles of the Local Governments in Health can be summarized as follows:

- Mobilize and allocate resources
- Plan and budget for the services they are responsible for including compiling the Local Government Budget Framework Papers
- Approve District Development Plans (DDP) and Annual Work plans and Budgets
- Monitor the overall performance of the district/municipal health care delivery system
- Human resources for health development management (recruitment, deployment, in-service- training, career development, payroll management, etc.)
- Control of epidemics
- Advocacy for health
- Health Systems Research.
- Other functions delegated by central government

District and municipal health officers should provide timely inputs into the district development plans and local government budget framework paper (BFP) to ensure coordination with other sectors at the district level. This is because the activities contained within the DDP and annualized in the BFP constitute information that is required to make decisions that link-up inputs with intended results or outcomes. The annualized activities and the respective outputs captured in the Local Government Output Budgeting Tool (LGBT) constitute the authorized expenditures for the Local Governments for the respective year and the BFP.

#### 5.3.1 Mandates of the District Health Team/Municipal Health Office

This is the technical arm of the District/Municipal council in the management of the council's health system. The core functions of the office include:

1) Policy implementation
    - Integration of the National Health Policies into the District Health System
    - Provision of leadership in the development of District/municipal Health Plans and Programmes
    - Building the capacity of the HSD teams in the planning process.
    - Resource mobilization, allocation and overall management.
2) Human Resource Development Management

- Human resource planning and In-Service Training
- Planning and Implementing Continuing Professional Development.
- Personnel management functions

3) Quality Assurance / Support Supervision
   - Dissemination of national standards, guidelines and other policy documents and ensuring their implementation
   - Provision of technical support to the HSDs/HC
4) Integration and Coordination of Health Services
   - Fostering inter-sectoral collaboration for health
   - Supervision and Monitoring of health services
   - Efficient and cost effective utilization of the available resources including development partner investments.
   - Coordinating all key stakeholders in service delivery in the district
5) Disease and Epidemic Control / Disaster Preparedness
6) Monitoring and Evaluation of District Health Services
   - Collecting the relevant data
   - Utilization of Health Data and information to assess performance against targets
   - Assessment of various programs and interventions
   - Report on outputs and expenditures by the 10th day of each month
7) Advocacy for Health Services
   - Raising awareness of health sector needs among decision makers, consumers and health workers.
8) Health Systems Research
   - Provision of leadership in Health Sector Operations Research and build capacity for HSDs and lower levels to undertake research

### 5.3.2 Responsibilities of District Health Management Team (DHMT)

The DHMT shall comprise of the following members: The ACAO-Health, DHT (DHO, ADHO-MCH, ADHO-Environmental Health, SHI, SHE, Biostastician, Programme Focal Officers), District Health Information Officer, HSD in charges, representatives of RRHs or General Hospitals, PNFP Representative, Principal Planner, a representative of the Private Health Providers, CSO Representative and a representative of IPs (Implementing Partners)

The DHMT will be responsible for the following:

- Reviewing and approving the District Health Sector Strategic plans and annual

workplans and budget for presentation to the DTP and Health Committee.

- Monitor implementation of the work plans.
- Mobilize resources for the district health programs.

### 5.3.3 Heath sub-district (HSD)

This is a functional zone of the District Health System responsible for implementing the delivery of the Minimum Health Care Package. It has a defined area of responsibility comprised of several Sub-Counties/Divisions and the health services therein. An existing hospital or a health centre upgraded to HCIV serves as the HSD Referral Facility, which is responsible for planning, implementation, monitoring and supervision of all basic health services.

The objectives of the HSD health care system are:

- To ensure equity in access and utilization of health services
- To deliver socio – culturally acceptable services
- To provide continuous and integrated services
- To use a comprehensive / holistic approach to service delivery and
- To sensitize communities to take up responsibility for their own health (*Health literacy)* and involve them in the management and organization of health services.[1]

In practical terms, this means that the HSD referral facility will provide:

- Basic clinical and preventive health services in its area of responsibility including CEmOC.
- Basic Referral Clinical Services for the delivery of the Minimum Health Care Package in the HSD
- Provision of technical support and capacity development for the Lower Level Health Facilities in the HSD
- Monitoring and evaluation of health services

**Key functions carried out by the HSD**

**1) Planning and Management Capacity Development**

- Assist the teams at Health Centre II and III in micro – planning for the individual Health Units with full involvement of the communities, including defining areas of responsibility and setting targets.

**2) Develop the Referral Facility plan**

- Collate the sub county health plans and the Referral Facility plan into one HSD work plan.
- Work with the sub-counties in the integration of micro–plans into sub-county plans.
- Ensure copies of the Health Unit plans must be attached to Sub-county plans as an Appendix.
- The VHTs, HUMCs, Sub-county Health Committees and the HSD Management Teams should be actively involved in the development of their respective components of the HSD plans.

- In Municipal Councils the Medical Officer of Health shall in addition to management of the HSD perform the functions of the District Health Office, but the referral facility for the HSD shall remain the General or Regional Referral Hospital located in the Municipal council. General Hospitals in Municipal Councils shall be managed by their respective Municipal Councils.

**3) Supervision and Quality Assurance**

- Regular (monthly) integrated support supervision of all activities and management functions of lower level units with emphasis on adherence to national standards
- Focused supervision targeting specific identified resource management problems
- Participation in HUMC meetings for dialogue and specific feedback to community representatives

**4) Human Resource Management**

- On-the-job training as part of Support Supervision
- Facilitate Continuing Professional Development and distance learning
- Management of the Annual In-Service Training requirement to narrow the individual knowledge and skills gaps.

**5) Logistic Support**

- Provision of supplies including vaccines including vaccine carriers, equipment, HMIS stationery and other reporting forms
- Provision of standard package of IEC material for HC II and III
- Provision of containers and Media for specimen transportation
- Conduct disease surveillance and submit cumulative M&E reports to the DHO

**6) Monitoring and Evaluation (M&E)**

- Assist the health centre teams to interpret their data in relationship to output indicators and measure them against their own targets and those of the HSD and District.
- Relate inputs to outputs in order to determine efficiency and identify weak performers among the Health Centers and Sub-counties and propose remedial measures.

**7) Case Management**

- Ensure the availability of Ambulance Services
- Ensure proper case management
- Ensure appropriate referral to higher levels
- Ensure the availability emergency services including CeMOC

**8) Operations Research**

- Undertake Operations Research in their work places
- Use existing data e.g. HMIS for research and planning
- Use research based evidence for better planning and overall improvements in service delivery

### 5.3.4 The Roles of Lower Level Health Facilities

The network of health facilities in each Sub-county/Division is comprised of a number of Health Centre IIs (each serving one or more parishes/wards) and HC IIIs (which act as the immediate referral facility for the HC IIs in the Sub-county). In addition, there are HC I, which are not facility-based, and correspond with community based health care. The roles of the lower level health facilities are outlined below.

**Community / HC I**

The primary challenge within the health system is the ability to extend basic health care services to the entire population especially in rural areas where access is limited. This gap is being filled, partially, by different forms of Community Health Workers—the most notable being the Village Health Teams (VHTs). VHTs were established by the MOH in Uganda to empower communities to take part in the decisions that affect their health, to mobilize communities for health programs, and to strengthen the delivery of health services at the household level. The overall function of the VHT within these districts is to promote health at the individual, family and community levels through a set of core tasks and activities. Routine tasks of the VHTs include maintaining village maps and registers, visiting village members, helping to save lives, linking the village with the health facility, mobilizing the village and holding monthly team meetings.

Thus, the VHTs (and other forms of CHWs) are an essential part of the continuum of care from the community to health facility and referral level, and for counter referrals. Provision of technical support to the VHTs is the responsibility of the Health Centre IIs, or nearest health facility. All this support should be provided in the context of the Harmonized Participatory Planning Guidelines for Parishes and Wards, issued by the Ministry of Local Government. Comprehensive VHT guidelines and their roles have been developed and should be used during planning and implementation of services.

**Health Centre II**

This health service level serves as the interface to the community at parish level. This arrangement fulfils the principle of "close to client" and enables close collaboration between the health service providers and the community structures like the VHTs, HUMCs, Women Councils, Youth Councils and Councils for Disabled Persons. It is expected that, a well-functioning HC II will take care of 75% of the health problems for the catchment community.

**Health Centre III**

A HC III serves the functions of the basic peripheral unit in the parish where it is located while at the same time performing the supervisory function for all the HC IIs in the Sub-county. Similarly, a HSD Referral Facility serves the functions of the basic peripheral unit in the parish where it is located and also serves the function of a HC III, over and above the functions elaborated above. Municipal councils with Public/NGO hospitals need not have HC IVs and HC IIIs.

The lowest planning unit of the district/municipal health system is the HC II. These guidelines should be used to prepare annual work plans for both Public and PNFP facilities as well as Private Health Provider facilities where feasible.

### 5.3.5 Health Facility Management Boards/Committees

The management of health facilities is overseen by health facility management boards/committees. The establishment of health facility boards or committees is intended to strengthen the community engagement and empowerment on health facility management. In particular, it is aimed at ensuring transparency in financial management and general management of the health facility resources. Ultimately, having a functioning health facility board/committee is expected to ensure quality care and to lead to increased access to health services in the health facility by the community.

The main functions of these boards and committees include policy and planning; monitoring and evaluation; reporting; leadership and governance; and general advisory roles. Their specific tasks/roles entail:

- Monitor the general administration of the health facility
- Provide strategic vision, direction of the health facility in line with the HSDP framework
- Supervise the management of the health facility finances in accordance with the Government financial regulations
- Ensure that annual work plans and budgets are drawn reflecting priority needs, approve budgets and monitor performance
- Present health facility annual performance reports
- Discuss and approve health facility audit reports
- Recommend the reallocation of funds in line with PFMA 2015
- Monitor the procurement and utilization of all services and goods
- Ensure availability of all essential health facility requirements are in place
- Liaise with the accounting officer and Minister responsible for health on pertinent issues regarding attention of higher authorities
- Ensure and foster improved communication thereby encouraging community participation in community related health facility activities
- Assist the health facility in resource mobilization
- Promote CPD among the staff and monitor/evaluate staff performance
- Perform any other advisory function as directed by the appointing authority.

N.B. Details on composition and formation of boards and committees and other Terms of reference are contained in the health facility management guidelines of 2012.

### 5.3.6 Roles of other key stakeholders

Key stakeholders health service delivery should be involved in the planning process. They include Health Development Partners or Implementing Partners; the PNFPs (Medical Bureaus), Private Providers and Civil Society Organisations (CSOs). Their roles include the following

### a) Roles of Health Development Partners/Implementing Partners

- Participating in joint planning and budgeting
- Supporting and participating in supervision, performance review, monitoring and evaluation of interventions in the districts.
- Providing demand driven technical assistance and inputs into implementation of the different district priorities.
- Complementing financing of the district priorities.

### b) Roles PNFP (Medical Bureaus and/Private Health Providers

- Participating in joint planning and budgeting
- Providing complementary health services, in underserved areas with large indigent populations in line with the sector standards and guidelines
- Participating in supervision, performance review, monitoring and evaluation of interventions in the districts.
- Promote CPD among the staff and monitor/evaluate staff performance
- Reporting on service delivery

### c) Roles of CSOs

- Advocacy
- Supporting implementation of non-facility based health service priorities in line with the sector standards and guidelines
- Providing a link between health services and households in articulating health issues of importance
- Participating in joint sector monitoring
- Reporting on service delivery

# Section 6

# Mainstreaming Human Rights, Gender and Climate Change in Planning

Human rights, gender inequity, disability, climate change and human health are inter-related and must be considered in planning, budgeting, monitoring and evaluation.

## 6.1 Human rights and Gender

The ultimate goal under gender mainstreaming is to achieve equity in resource allocation and service delivery. The main objectives in gender and health strategic planning include:

- To create an enabling environment for achieving health equity among gender groups
- To increase availability of quality gender sensitive health services
- To ensure full supply of essential medicines, supplies and equipment at all gender health service delivery points
- To conduct advocacy and communication for behavior change aimed at eliminating gender bias and disparities that negatively impact public health and development

In developing plans and designs interventions, there must be considerations on issues of human rights and gender issues. The principles of universal access, equity, participation, respect to privacy, quality of services by the clients are key in designing and implementation. Thus during the planning process, all key stakeholders both government and none government, CSOs among others need to be involved. During resource allocation priority should be given to interventions that address the needs of groups of the society are that most affected or disadvantaged.

Sections of the population that are considered disadvantaged may be nationally defined by policy such as pregnant women, children, elderly etc. Additional groups based on the local situations can be identified through a situation analysis with particular attention to top causes of morbidity and mortality by sex, age, location/geographical location as well as income status, quintiles.

The other key issues to plan for are capacity building in HH/Gender mainstreaming, complaints and redress mechanisms for both staff and clients. Information and mechanisms that bring to the attention of all parties concerned, the implications of violating the right to health (by health workers and clients) should be provided.

**Here under are simplified checklist indicators and checklist for ensuring human rights and gender responsive plans**

- Focus on both clients and service providers
- Family friendly policies including a sexual harassment-free environment, flexible work

hours, day care services at work place etc.

- Client focus: point of complaints and redress within the facilities, suggestion boxes, open days to share with community information about services available, active health management committees, quality assurance committees, focal points of HHR/Gender, hotlines, messages on the right to health, plan for clients' charter and patient charter message messages etc.

## 6.2 Climate change and human health

Climate change is among the greatest health risks of the 21st century. Rising temperatures and more extreme weather events like heavy rains, drought, wind storms, heat and cold waves cost lives, directly increase transmission and spread of diseases, and undermine the environment determinants of health including clean air, water, sufficient food and secure shelter.

The impacts of climate change on population health in Uganda are already being experienced and have been characterized by heavy rains floods, landslides, population displacement, associated with disease outbreaks and destruction of health infrastructure. Reducing emissions of greenhouse gases through better medical waste management, efficient transport systems, food and energy-use choices can result in improved health, particularly through reduced air pollution.

It is therefore critical that climate change is mainstreamed in all health planning, budgeting, implementation, monitoring and evaluation.

**Goal**

Reduce morbidity and mortality due to climate related diseases and events

**Specific objectives**

1. Ensure health plans are climate-proof i.e. effectively prepared to respond to climate change impacts.
2. Conduct climate change vulnerability and impact assessment to inform decision-making.
3. Identify opportunities and entry points for integration of climate change mitigation and adaptation (CCMA) measures
4. Identify, analyze and integrate options of CCMA into health service delivery.

## 5.3 Disability

Disability and poverty are interlinked and each can be a consequence of the other. Over 20% of the Ugandan population has one form of impairment or the other (UDHS 2011). These include physical, visual, hearing, mental, learning disabilities. The population of older persons has also increased to 6% of the population, most of them vulnerable to disabling conditions.

Despite the above burden, rehabilitative health care services remain limited to the population. Assistive devices are not easily accessible to PWDs, yet they are the main intervention to mitigate disability.

Although disability and rehabilitative health care are well captured in the HSDP, their visibilities continuously diminish as we go to the lower levels of health service delivery.

**Goal**

Provision of accessible, quality and comprehensive rehabilitative health care services that uses multisectoral linkages and is integrated into the national health system.

Guidance on interventions is available in the National disability policy 2006, Strategic plan for prevention of blindness, deafness, injury prevention and control.

# Section 7

# Monitoring and Evaluation (M&E) for the Local Government Health Workplan

These guidelines provide an M&E framework for local government health sector planning in line with the NDP II (2015/16-2019/20) M&E framework, the National Monitoring and Evaluation Policy 2013, and the National Health Sector Development M and E plan.

**Illustration of a conceptual framework for M&E**

| | **INDICATOR** | **DEFINITION** How is it calculated? | **BASELINE** What is the current value? | **TARGET** What is the target value? | **DATA SOURCE** How will it be measured? | **FREQUENCY** How often will it be measured? | **RESPONSIBLE** Who will measure it? | **REPORTING** Where will it be reported? |
|---|---|---|---|---|---|---|---|---|
| **Goal** | | | | | | | | |
| **Outcomes** | | | | | | | | |
| **Outputs** | | | | | | | | |

The M&E implementation plan shows how the above conceptual framework will be implemented. This plan should also be linked to the national M&E plan.

## 7.1 Indicator Definitions and Measurement

The M&E plan includes indicators for which data is routinely collected and should be based on the National HMIS. For each indicator included in this indicator framework, the following information should be provided:

a) Indicator standard definition from MOH, Resource Centre and Quality Assurance Department
b) National baseline values and source
c) et targets and frequency of review
d) Data collection methods and sources for the indicators (For example HMIS program monitoring, sentinel surveillance, population-based surveys, facility-based surveys, mortality audits, community or VHT registers, etc.)
e) Frequency of data collection (daily, weekly, monthly, quarterly and annually)
f) Responsible unit for data collection and reporting

The indicators included in the local government performance frame work should be aligned to the indicator framework contained in the M&E plan of the HSSDP, and the review of the indicators should follow a participatory process and involves key stakeholder.

## 7.2 Data Management

This section outlines how data is managed at local government level, including; data collection, storage, processing, analysis and reporting.

### 7.2.1 Data Collection

This section in the M&E plan describes existing systems and plans to collect data for measuring input, process, output, outcome and impact. The section includes a mapping of relevant data flows and descriptions along the following areas:

a) Frequency of data collection in real time weekly, monthly, quarterly, bi-annually and annually depending on the sources and need.

b) Frequency of reporting from service delivery points (including public, private not for profit, and private health facilities and at community level) and other intermediate levels to the highest local government level;

c) Data collection and reporting tools (for capturing and reporting data from public and private health facilities and community level) - prescribed in the HMIS.

d) Information and report flow and feedback mechanisms, including a schematic map of report flow from public and private health facilities, and the community level to the highest local government level, and national level.

### 7.2.2 Data storage

The section describes the infrastructure and facilities available for data management and storage including equipment, any software or electronic systems being used or planned.

### 7.2.3 Data Review, Evaluation, and Surveys

Data reviews, evaluations and surveys are important for determining overall performance, cost-effectiveness and impact. This section of the M&E plan describes existing practices, gaps and plans or schedules for conducting data reviews, evaluations and surveys.

**Data reviews and evaluations:**

g) Describe the schedules/plans and timelines for conducting data reviews. Specify the frequency of reviews at each level of the local government health system.
h) Describe the key evaluative questions to be answered, and the proposed methodologies to be employed for scheduled data reviews and evaluations.
i) Differentiate between external independent evaluations/reviews by MOH and Partners, and routine/specific internal evaluations led by the local government.
j) Ensure that a budget is allocated for conducting data reviews and evaluations (where resource gaps are observed, this needs to be described).

Districts, HSD and Sub-counties are encouraged to plan for quarterly review meeting.

These meeting should always among when they issue review performance program score cards from DHIS and make recommendation to improve performance during the financial year.

### 7.2.4 National Health Accounts

National Health Accounts (NHA) is a useful tool for understanding and informing responses to these health sector policy concerns. Resource tracking through institutionalization of NHAs is a global agenda in health financing. Prior to NHA studies, there were a number of attempts by partners and key stakeholders to estimate health expenditure through studies,

surveys and public expenditure reviews, however these were only an aggregate total estimate generated without a standard approach.

National health accounts (NHA) constitute a systematic, comprehensive, and consistent monitoring of and tracking of resource flows and amounts into a country's health system. It is a tool specifically designed to inform the health policy process, including policy design and implementation, policy dialogue, and the monitoring and evaluation of health care interventions. NHA provides the evidence to help policy-makers and other stakeholders to make better and evidence based decisions in their efforts to improve health system performance. In view of NHA institutionalization Local Governments are expected to annually report on their various health financing, sources, financing agents, health providers in the local government, health functions delivered and the beneficiary population, plus the factors of health provision. This shall annually be done through filling and submitting in September of every year an NHA information sheet provided as an annex to this guideline

**Surveys and surveillance:**

- Describe the surveys and surveillance to be conducted.
- Describe schedules of the surveys and surveillance planned.
- Ensure that budgets are allocated for conducting the surveys and surveillance. (Where resource gaps are observed, this needs to be described).
- The indicator framework should show which indicators are reported on using data from these surveys.

### 7.2.5 Operational Research:

a) Describe the operations/implementation research to be conducted during the timeline covered by the M&E plan.
b) Show which indicators are reported on using data from operational research

### 7.3 Data Quality Assurance Mechanisms

This section includes practices and mechanisms required for ensuring data quality. While there may be an overlap with other sections, it should include the following;

- Data quality assurance mechanisms for ensuring the quality of data during data collection, transfer, compilation, analysis and storage. This should how late, missing and incomplete data is accounted for
- Human resources and technical capacity needs for data management and for ensuring data quality
- Plans for assessing consistency of primary data during data entry and analysis
- Data Quality Assessments
- Utilization of tools and guidelines / checklists for data quality assurance/assessments and for supervision
- Support supervision of local government facilities and partners for M&E and data quality (reliability, accuracy, completeness, timeliness and integrity)

### 7.4 M&E Coordination

Under this section the local government M&E Plan should capture:

- M&E coordination mechanisms (including management structures and roles)
- Linkages with MOH and OPM
- M&E partnerships in the local government
- M&E assessments/reviews, meetings
- Alignment and harmonization on indicators, information/report flows, reporting timelines, etc.

### 7.5 Capacity Building

Describe the human resource capacity in the local government for information management, identify the gaps, and plans to improve human resource capacity (in data collection, processing, analysis, and disseminations.

### 7.6 M&E Costed Work Plan

The M&E costed plan should feed into the national costed M&E plan. The relevant costs, consistent with activities in the M&E plan. All sources of funding should be reflected in the M&E work plan. The costed M&E work plan should be considered a living document: regularly monitored and reviewed and updated.

### 7.7 M&E Budget

This budget can be divided into categories, including estimated contributions from both the central government, local government and partners, as well as any outstanding gaps in funding.

Category I: M&E Stewardship, governance and coordination

- Development of M&E Plan (including development of indicators and work plan)
- Training materials and guidelines
- Training (public and private stakeholders in the local government)
- Coordination and Management
- Information dissemination and communication to technical staff and local government policy makers

Category II: Routine data collection and reporting

- Strengthening the routine health information system (to regularly capture health information from both public and private sector)
- Strengthening data quality procedures for routine information systems
- Strengthening vital registration systems
- Developing or strengthening disease surveillance systems
- Recruiting and training staff for routine information systems

- Enhancing staff skills in data analysis, synthesis, use, publication and dissemination of reports

Category III: Evaluation, surveys, surveillance

- Implementation of population and facility surveys
- Undertaking implementation research program evaluation and reviews
- Conducting health system research and epidemiological studies
- Recruiting and training staff for episodic data collection systems (surveys, research, evaluations, etc.)
- Strengthening data quality procedures for episodic data collection systems

### 7.8 Information Dissemination and Use

Once data is collected, consolidated and analyzed, it will be used to inform decision-making and increase the efficiency and effectiveness of the local government health plans. The results of the analysis should be disseminated to all relevant stakeholders and shared with implementers through a systematic feedback mechanism. The plan should describe how data will be shared with local government stakeholders, MOH, OPM and Partners (periodic reports, meetings, etc.).

Section 8

# Planning Budget and Calendar for Local Government Institutions

### *Table 18: Planning and Budget Calendar for Local Government Institutions*

| Timing | Activity/event | Responsibility Centre | Output |
|---|---|---|---|
| 15th September | 1st Budget Call Circular with GOU priorities and MTEF is issued | MFPED | MTEF |
| Late September | Local Governments Budget Committee agrees the rules, conditions & flexibility of the coming planning & budgetary process | LGBC | Agreement about the overall planning &budgetary framework before start of budget process |
| Early October | Joint Review Mission | Hon. MoH | Aide Memoir |
| Mid October | Health Sector Planning Committee drafts Health Sector Plan for the Year | Health Sector Planning Committee | Draft Health Sector Plan |
| Mid October | MOH Carries out Regional Planning Meetings | MoH | Final Health Sector Plans |
| Late October | Holding of Regional Local Government Budget Framework Paper Workshops | MFPED | Recurrent and development grants ceilings communicated to LGs alongside changes to sector policies and guidelines |
| Early November | Executive Committee meets to determine inter-sectoral priorities as identified in previous DDP and to fix inter sectoral allocation % | District Executive Committee | Intersectoral priorities identified for potential budget reallocations & flexibility |
| Early November | Budget Desk prepares Local Government Budget Call and circulates it to Heads of Department and Lower Local Governments | Local Government Budget Desk, Executive Committee | Draft activity & time schedule for the entire budget process, and indicative budget allocations for LLGs &HoDs, etc. |
| Mid November | Health Sector Planning Committee adjusts the Health Sector Plan to curve out activities to be implemented within the available resources detailing out the activities that cannot be funded within the available resources | Health Sector Plan | Health Sector Plan |
| Late November | District/Municipal Health Officer prepare input to budget framework paper, based on the outputs in the sector work plan | District/Municipal Health Officers & HSD for lower local government | Draft inputs to budget framework paper to be presented to sector (social services) committees and development plans to be Considered by LLG councils. |

| Timing | Activity/event | Responsibility Centre | Output |
|---|---|---|---|
| 1st week December | Budget desk compiles/prepare draft budget framework paper, and the planning unit the development plan. The District Technical Planning Committee reviews them. | Budget Desk | Draft budget framework paper and development plan ready to be presented to Executive Committee |
| Beginning of 2nd Week December | A meeting of the Executive Committee, Chairpersons of Sector Committees, HoDs is held to examine draft budget framework paper, and prioritize sector expenditures and programmes. | Executive Committee, Chairpersons of Sector Committees, HoDs | Draft budget framework paper and development plan ready for Budget Conference |
| End of 2nd Week of December | Holding of Budget Conference | Full council, NGOs,<br><br>Civil Society. | Budget input (i.e. priorities, re-allocations & preliminary budget estimates) ready for incorporation in draft budget by the Budget Desk |
| Mid December | Budget Desk incorporates input from budget conference in budget framework paper and draft budget.<br><br>Executive Committee approves budget framework paper and draft budget | Budget Desk<br><br>Executive Committee | Final budget framework paper and draft budget ready to be presented to Finance- or Executive Committee Draft budget ready for submission to MFPED |
| 20th December | MFPED Consolidates National BFP and submits to Cabinet | MFPED | National BFP |
| 10th January | 2nd BCC with Revised MTEF | MFPED | OBT with Revised MTEF |
| Mid-January | Budget Desk incorporates grant ceilings & comments received from MoH&MoFPED in annual work plan & draft budget | Budget Desk | Final draft budget and work plan ready to be presented to sector committees |
| Late January | Sector committees review final annual work plan & budget | Sector Committees | Final input from sector committees to annual work plan & budget |
| Early February | Finance- or Executive Committee examines final draft budget | Finance- or Executive Committee | Final draft budget (including annual work plan) ready to be read by council |
| Mid-February | Draft Budget Estimates are entered into and generated off the OBT and submitted to MFPED | Budget Estimates | Budget Desk |
| 1st March | Draft Budget Estimates are produced off the OBT and submitted to Parliament | Budget Estimates | MFPED |
| Before 1st of April | Reading and approval of budget | Full council | Approved budget to be signed by chairperson and submitted to MoFPED/MoLG/LGFC & Auditor General |
| 1st April | Reading of the National Budget Speech | Hon. MFPED | National Budget Speech |
| 31st May | Budget Estimates approved by Parliament | Parliament | Approved Budget Estimates |
| 1st July | Budget Execution | All Votes | Outputs |

# Annexes

## Annex 1: Staff list template-districts

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DIRECTORATE OF HEALTH SERVICE** | | | | | | | | | | | | | | | | |
| | DISTRICT HEALTH OF-FICER | 1 | | | | | | | | | | | | | | |
| | ASSISTANT DHO ENVIRON' HEALTH | 1 | | | | | | | | | | | | | | |
| | ASSISTANT DHO MCH NURSING | 1 | | | | | | | | | | | | | | |
| | SENIOR ENVRON' OFFICER | 1 | | | | | | | | | | | | | | |
| | SENIOR HEALTH EDUCATOR | 1 | | | | | | | | | | | | | | |
| | BIOSTATISTICIAN | 1 | | | | | | | | | | | | | | |
| | STENOGRAPHER SECRETARY | 1 | | | | | | | | | | | | | | |
| | COLD CHAIN TECHINICIAN | 1 | | | | | | | | | | | | | | |
| | STORES ASSISTANT | 1 | | | | | | | | | | | | | | |
| | OFFICE ATTENDANT | 1 | | | | | | | | | | | | | | |
| | DRIVER | 1 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **11** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **General HOSPITAL (If Applicable)** | | | | | | | | | | | | | | | |
| | **MEDICAL OFFICERS** | | | | | | | | | | | | | | | |
| | PRINCIPAL MEDICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | SENIOR MEDICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | MEDICAL OFFICER SG (COMMUNITY) | 1 | | | | | | | | | | | | | | |
| | MEDICAL OFFICER SG OBS & GYN | 1 | | | | | | | | | | | | | | |
| | MEDICAL OFFICER SG SURGERY | 1 | | | | | | | | | | | | | | |

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MEDICAL OFFICER SG PAEDIATRICS | 1 | | | | | | | | | | | | | | |
| | MEDICAL OFFICER SG INTERNAL MEDICINE | 1 | | | | | | | | | | | | | | |
| | MEDICAL OFFICER | 4 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **11** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **DENTAL OFFICERS** | | | | | | | | | | | | | | | |
| | DENTAL SURGEON | 1 | | | | | | | | | | | | | | |
| | PUBLIC DENTAL OFFICER | 2 | | | | | | | | | | | | | | |
| | DENTAL ASSISTANT | 1 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **4** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **PHARMACIST** | | | | | | | | | | | | | | | |
| | PHARMACIST | 1 | | | | | | | | | | | | | | |
| | DISPENSER | 2 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **3** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **NURSING** | | | | | | | | | | | | | | | |
| | PRINCIPAL NURSING OFFICER (MATRON) | 1 | | | | | | | | | | | | | | |
| | SENIOR NURSING OF-FICER | 5 | | | | | | | | | | | | | | |
| | NURSING OFFICER NURSING | 17 | | | | | | | | | | | | | | |
| | NURSING OFFICER (PSYCIATRIC) | 1 | | | | | | | | | | | | | | |
| | NURSING OFFICER (MIDWIFERY) | 3 | | | | | | | | | | | | | | |
| | PUBLIC HEALTH NURSE | 1 | | | | | | | | | | | | | | |
| | ENROLLED PSYCHIATRIC NURSE | 2 | | | | | | | | | | | | | | |
| | ENROLLED NURSE | 46 | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | 25 | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | 15 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **116** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **ALLIED HEALTH PRO-FESSIONALS** | | | | | | | | | | | | | | | |
| | SENIOR CLINICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | HEALTH EDUCATOR | 1 | | | | | | | | | | | | | | |
| | SENIOR LABORATORY TECHNOLOGIS | 1 | | | | | | | | | | | | | | |
| | PSYCHIATRIC CLINICL OFFICER | 1 | | | | | | | | | | | | | | |
| | OPTHALMIC CLINICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | CLINICAL OFFICER | 5 | | | | | | | | | | | | | | |
| | HEALTH INSPECTOR | 1 | | | | | | | | | | | | | | |
| | ASS ENTOMOLICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | RADIOGRAPHER | 2 | | | | | | | | | | | | | | |
| | PHYSIOTHERAPIST | 1 | | | | | | | | | | | | | | |
| | OCCUPATIONAL THERAPIST | 1 | | | | | | | | | | | | | | |
| | ORTHOPAEDIC OFFICER | 2 | | | | | | | | | | | | | | |
| | ASSISTANT HEALTH EDUCATOR | 1 | | | | | | | | | | | | | | |
| | ANAESTHETIC OFFICER | 3 | | | | | | | | | | | | | | |
| | LABORATORY TECHNOLOGIST | 1 | | | | | | | | | | | | | | |
| | LABORATORY TECHNICIAN | 2 | | | | | | | | | | | | | | |
| | LABORATORY ASSISTANT | 1 | | | | | | | | | | | | | | |
| | ANAESTHETIC ATTENDANT | 2 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **28** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **ADMINISTRATIVE STAFF** | | | | | | | | | | | | | | | |
| | SENIOR HOSPITAL ADMINISTRATOR | 1 | | | | | | | | | | | | | | |
| | HOSPITAL ADMINISTRATOR | 1 | | | | | | | | | | | | | | |
| | PERSONEL OFFICER | 1 | | | | | | | | | | | | | | |

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MEDICAL SOCIAL WORKER | 1 | | | | | | | | | | | | | | |
| | NUTRITIONIST | 1 | | | | | | | | | | | | | | |
| | SUPPLIES OFFICER | 1 | | | | | | | | | | | | | | |
| | SENIOR ACCOUNTS ASSISTANT | 1 | | | | | | | | | | | | | | |
| | STENOGRAPHER | 1 | | | | | | | | | | | | | | |
| | OFFICE TYPIST | 1 | | | | | | | | | | | | | | |
| | STORES ASSISTANT | 2 | | | | | | | | | | | | | | |
| | RECORDS ASSISTANT | 2 | | | | | | | | | | | | | | |
| | ACCOUNT ASSISTANT | 2 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **15** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **SUPPORT STAFF** | | | | | | | | | | | | | | | |
| | DARK ROOM ATTENDANT | 1 | | | | | | | | | | | | | | |
| | MORTUARY ATTENDANT | 2 | | | | | | | | | | | | | | |
| | DRIVER | 2 | | | | | | | | | | | | | | |
| | COOK | 3 | | | | | | | | | | | | | | |
| | WATCHMAN | 2 | | | | | | | | | | | | | | |
| | ARTISANS MATE | 3 | | | | | | | | | | | | | | |
| | **SUB TOTAL** | **13** | | | | | | | | | | | | | | |
| | **TOTAL GENERAL HOSPITAL** | **190** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **H/C IV (If there are more than one HC IV, please create rows and list staff per HC IV separately)** | | | | | | | | | | | | | | | |
| | SENIOR MEDICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | MEDICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | SENIOR NURSING OF-FIC | 1 | | | | | | | | | | | | | | |
| | PIBLIC HEALTH NURSE | 1 | | | | | | | | | | | | | | |
| | CLINICAL OFFICER | | | | | | | | | | | | | | | |
| | CLINICAL OFFICER | 2 | | | | | | | | | | | | | | |

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | OPTHALMIC CLINICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | HEALTH INSPECTOR | | | | | | | | | | | | | | | |
| | HEALTH INSPECTOR | 2 | | | | | | | | | | | | | | |
| | DISPENSER | 1 | | | | | | | | | | | | | | |
| | PUBLIC HEALTH DENTAL OFFICER | 1 | | | | | | | | | | | | | | |
| | LABORATORY TECHINICIAN | 1 | | | | | | | | | | | | | | |
| | ASSISTANT ENTOMOLOGICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | NURSING OFFICER NURSING | 1 | | | | | | | | | | | | | | |
| | NURSING OFFICER (MIDWIFERY) | 1 | | | | | | | | | | | | | | |
| | NURSING OFFICER (PHSYCHIATRY) | 1 | | | | | | | | | | | | | | |
| | ASSTANT HEALTH EDUCATOR | 1 | | | | | | | | | | | | | | |
| | ANAESTHETIC OFFICER | 1 | | | | | | | | | | | | | | |
| | THEATRE ASSISTANT | | | | | | | | | | | | | | | |
| | THEATRE ASSISTANT | 2 | | | | | | | | | | | | | | |
| | ANAESTHETIC ASSISTANT | | | | | | | | | | | | | | | |
| | ANAESTHETIC ASSISTANT | 2 | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | 3 | | | | | | | | | | | | | | |
| | ENROLLED PSYCHATRIC NURSE | 1 | | | | | | | | | | | | | | |
| | ENROLLED NURSE | | | | | | | | | | | | | | | |
| | ENROLLED NURSE | | | | | | | | | | | | | | | |
| | ENROLLED NURSE | 3 | | | | | | | | | | | | | | |
| | COLD CHAIN ASSISTANT | 1 | | | | | | | | | | | | | | |
| | OFFICE TYPIST | 1 | | | | | | | | | | | | | | |
| | LABORATORY ASSISTANT | 1 | | | | | | | | | | | | | | |

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | STORES ASSISTANT | 1 | | | | | | | | | | | | | | |
| | ACCOUNTS ASSISTANT | 1 | | | | | | | | | | | | | | |
| | HEALTH ASSISTANT | 1 | | | | | | | | | | | | | | |
| | HEALTH INFORMATION ASSISTANT | 1 | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | 5 | | | | | | | | | | | | | | |
| | WATCHMAN | | | | | | | | | | | | | | | |
| | WATCHMAN | | | | | | | | | | | | | | | |
| | WATCHMAN | 3 | | | | | | | | | | | | | | |
| | PORTER | | | | | | | | | | | | | | | |
| | PORTER | | | | | | | | | | | | | | | |
| | PORTER | 3 | | | | | | | | | | | | | | |
| | DRIVER | 1 | | | | | | | | | | | | | | |
| | **Sub total** | **48** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **HC III; (If there are more than one HC III, please create rows and list staff per HC IV separately)** | | | | | | | | | | | | | | | |
| | SENIOR CLINICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | CLINICAL OFFICER | 1 | | | | | | | | | | | | | | |
| | NURSING OFFICER (NURSING) | 1 | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | 2 | | | | | | | | | | | | | | |
| | ENROLLED NURSE | | | | | | | | | | | | | | | |
| | ENROLLED NURSE | | | | | | | | | | | | | | | |
| | ENROLLED NURSE | 3 | | | | | | | | | | | | | | |
| | HEALTH ASSISTANT | 1 | | | | | | | | | | | | | | |
| | INFORMATION ASSISTANT | 1 | | | | | | | | | | | | | | |

| S/n | Title/Facility | Appr No | Filled | Vacant | S/Scale | Name | Sex | DoB | Comp.NO | Basic Pay | Incremental Date | 1st at app | L/app | status | Qualification | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | 3 | | | | | | | | | | | | | | |
| | LABORATORY ASSISTANT | 1 | | | | | | | | | | | | | | |
| | LABORATORY TECHNICIAN | 1 | | | | | | | | | | | | | | |
| | WATCHMAN | | | | | | | | | | | | | | | |
| | WATCHMAN | 2 | | | | | | | | | | | | | | |
| | PORTER | | | | | | | | | | | | | | | |
| | PORTER | 2 | | | | | | | | | | | | | | |
| | **Sub total** | **19** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **HC II; (If there are more than one HC II, please create rows and list staff per HC IV separately)** | | | | | | | | | | | | | | | |
| | ENROLLED NURSE | 1 | | | | | | | | | | | | | | |
| | ENROLLED MIDWIFE | 1 | | | | | | | | | | | | | | |
| | HEALTH ASSISTANT | 1 | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | | | | | | | | | | | | | | | |
| | NURSING ASSISTANT | 2 | | | | | | | | | | | | | | |
| | WATCHMAN | | | | | | | | | | | | | | | |
| | WATCHMAN | 2 | | | | | | | | | | | | | | |
| | PORTER | | | | | | | | | | | | | | | |
| | PORTER | 2 | | | | | | | | | | | | | | |
| | **Sub total** | **9** | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | **G/Total** | **277** | | | | | | | | | | | | | | |

## *Annex 2: Criteria for Access of Public Subsidies by NGOs and Private Service Providers*

**N.B. Criteria for recipients are updated and validated annually.**

1. If a PNFP (NGO or CBO), it should be registered and certified as not-for-profit by the NGO Board (not-for-profit body with full and open accountability for the use of public funds and the quality and effectiveness of the services, and their constitutional document includes rules to this effect.)
2. Should be registered/accredited by an all embracing and credible national body
3. Registration though an Umbrella Organization with a national outlook and acceptable by Government
4. Geographical Location (Serving rural, disadvantaged and hard-to-reach populations or being the only service provider in the area)
5. Must agree to be supervised and audited by public governance bodies (LGs, MOLG, MOH, MOFPED, OAG). This agreement is documented in an MOU with Ministry of Health and/or LG signed by both parties.
6. Must demonstrate evidence of reduction or elimination of service consumption costs for consumers (provide evidence that subsidy is passed to consumers)
7. Evidence of participation in community health activities
8. If it is a private-for profit facility, it must have a designated public wing where free/ subsidized care is given to community or private providers delivering community health services
9. MOU/Explicit Contract with the LG, MOH and the respective umbrella body registration body to purchase a package of services from the provider
10. Evidence that provider is delivering the Uganda National Minimum Healthcare Package
11. Agreement to share input and output data with LGs and MOH, including financial data
12. Agreement to stick to PNFP/ PHP implementation guidelines developed by MOH
13. Approval and registration by the district health office and the LG Council
14. Licensed by Local Councils for non-facility based PNFPs
15. Evidence of HMIS reporting to MOH and umbrella organizations
16. Income by source and expenditure data: Requirement to provide financial reports to Government oversight organs (MOH, MOFPED, Auditor General, IGG), with income and expenditure by source clearly indicated.
17. PHPs/PFPs must be licensed by the respective statutory professional council
18. PHPs must submit HMIS returns to the MOH and the respective district health office, explicitly reporting on the free services they provide in form of outputs using the standard Government HMIS reporting formats
19. Evidence of involvement of communities in the governance processes of the subsidy recipients

20. Must have reported utilization data (to MOH) for at least two years

## *Annex 3: National Health Facility Availability Standards*

| Type of facility | Health Facility Population Ratio standard |
|---|---|
| 1. National Referral Hospital | 1: 10,000,000 |
| 2. Regional Referral Hospital | 1: 3,000,000 or 1per region |
| 3. General Hospital | 1: 500,000 or 1 per District |
| 4. Health Centre IV | 1: 100,000 or 1 per county |
| 5. Health Centre III | 1: 20,000 or 1 per sub-county |
| 6. Health Centre II | 1: 5,000 or 1 per parish |
| 7. Health Centre I/ VHT | 1: 1,000 or 1 per village |


USAID
FROM THE AMERICAN PEOPLE

IntraHealth
INTERNATIONAL
Because Health Workers Save Lives.

Strengthening Human Resources for Health