



THE REPUBLIC OF UGANDA

**MINISTRY OF HEALTH**

**GUIDELINES TO THE  
LOCAL GOVERNMENT PLANNING  
PROCESS**

**HEALTH SECTOR SUPPLEMENT**

**JULY 2019**





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## ACRONYMS

ANC	Ante Natal Care
BFP	Budget Framework Paper
CAO	Chief Administrative Officer
CPD	Continuous Professional Development
CSO	Civil Society Organization
DDP	District Development Plans
DHMT	District Health Management Team
DHO	District Health Officer
DHT	District Health Team
DSC	District Service Commission
EmONC	Emergency Obstetric and Neonatal Care
FBO	Faith Based Organization
HC	Health Centre
HDP	Health Development Partner
HMB	Hospital Management Board
HMIS	Health Management Information System
HOD	Head of Department
HPC	Health professional Council
HRHIS	Human Resources Information System
HRM	Human Resource Management
HSD	Health Sub District
HSDP	Health Sector Development Plan
HSDT	Health Sub District Team
HSC	Health Service Commission
HUMC	Health Unit Management Committee
HW	Health Worker
IP	Implementing Partner
IPPS	Integrated Personnel and Payroll System
IST	In-service Training
LG	Local Government
MDA	Ministries Department and Agencies
M&E	Monitoring and Evaluation
MoFPED	Ministry of Finance Planning and Economic Development
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender Labour and Social Development

MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MPS	Ministerial Policy Statement
NHP	National Health Policy
MTEF	Medium Term Expenditure Framework
NDP	National Development Plan
NGO	Non-Governmental Organisation
OPD	Out Patient Department
PHC	Primary Health Care
PNFP	Private Not for Profit
PPO	Principal Personnel Officer
RRH	Regional Referral Hospital
RMNCAH	Reproductive Maternal Child Health Services
SWOT	Strength Weaknesses Opportunities Threat
UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UNMHCP	Uganda National Minimum Health Care Package
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
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 under the National Development Plan II and Health Sector Development Plan, it is imperative that the Ministry of Health guides Local Government health planning to be properly integrated within the decentralization framework.

The Ministry of Health has revised the 2016 Health Sector Supplement Guidelines to the Local Government Planning Process to specifically guide annual 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 Care services and promote healthy living.

I wish to acknowledge the Ministry of Health Planning, Financing and Policy Department that led the process of revising the guidelines, all the District Health Team representatives that participated in the review process and UNICEF for the technical and financial 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. Diana Atwine**

**PERMANENT SECRETARY**

## ■ 1.0 INTRODUCTION

The Republic of Uganda is an East African state currently under multiparty dispensation. Service delivery is decentralized to Local Governments (LG) as per the 1997 Local Government Act. The Central government, however, retains the role of setting standards and providing guidelines to the LGs.

In the last 20 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. These guidelines are therefore intended to guide LG health managers including those in the private sector in the development of their annual workplans within the decentralization framework.

The Planning Guidelines herein are geared at improving governance and accountability of the health sector by enhancing coordination of the planning process through:

- Introducing the district comprehensive health workplan and budget concept. Interventions and activities supported by Health Development Partners and CSOs should also be reflected in the District Annual Plan.
- Improving and harmonizing planning tools and budgeting calendars.
- Partner mapping and resource alignment with the sector priorities.
- Identification of performance bottlenecks, key interventions, indicators and setting performance targets.

The use of scorecards/dashboards for real-time monitoring of program performance has also been adopted by the health sector. The Health Management Information System (HMIS) using the District Health Information System (DHIS-2) software has been customized to provide performance scorecards/dashboards for specific programs instantaneously. These guidelines also provide a framework for linking scorecard's monitoring results with the planning process as well as the identification of sector bottlenecks to guide priority setting within the decentralization framework.



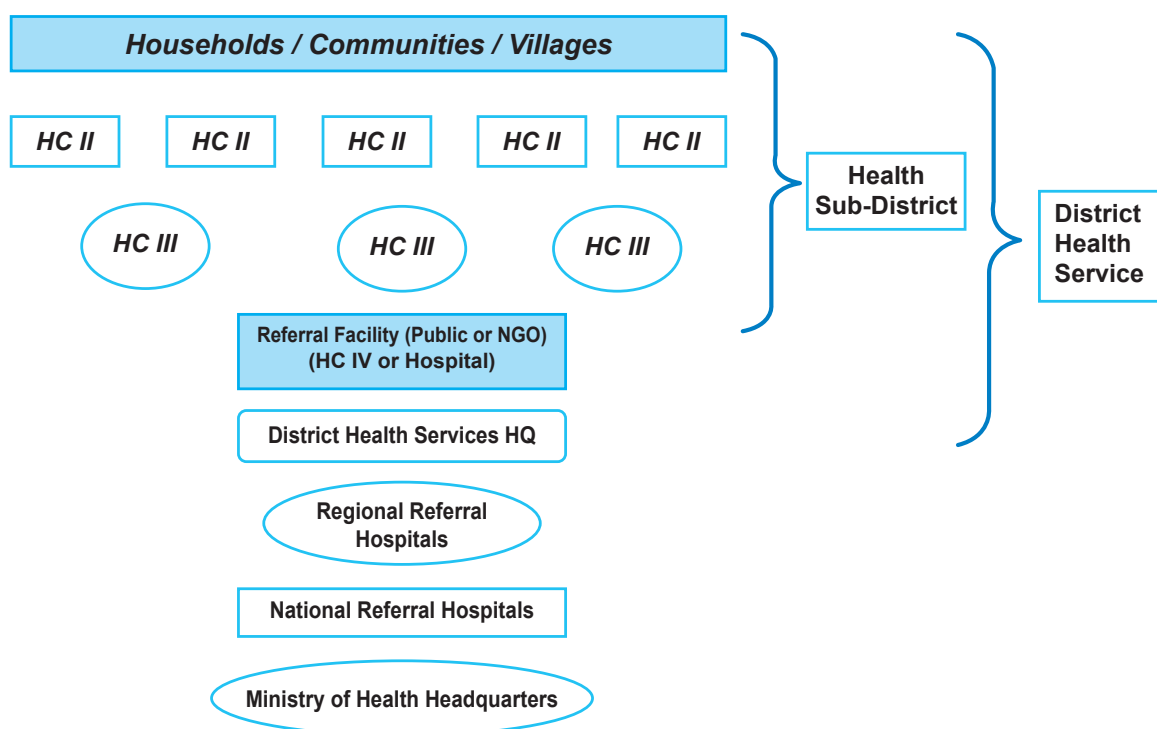
## 2.0 OVERVIEW OF THE HEALTH SERVICE DELIVERY STRUCTURE

The National Health Service delivery structure in Uganda is comprised of all the institutions, structures and actors involved in health service provision, categorized by public and private ownership. The public health sector 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 sector 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 National Drug Authority, Health Service Commission (HSC), the Professional Councils (PCs) and other related Ministries Departments and Agencies (MDAs).

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 (HC) IIs, HC IIIs, HC IVs and General Hospitals (GHs). The secondary level are the Regional referral Hospitals (RRHs). The Tertiary level is for the National Referral Hospitals and other super-specialized Hospitals.

**Figure 1: The National Health Service Delivery Structure**



## ■ 3.0 THE NATIONAL HEALTH PLANNING FRAMEWORK

The MoH is implementing a five-year Health Sector Development Plan (HSDP 2015/16-2019/20), in line with the National Development Plan (NDP) II. The goal of the HSDP is to accelerate movement to Universal Health Coverage (UHC) by 2030. As such the HSDP aims to expand access to the Uganda National Minimum Healthcare Package (UNMHCP) to all Ugandans.

The HSDP provides overall strategic direction for the stakeholders in health, together with outlining their expected roles and responsibilities in attaining this strategic agenda. It in addition lays down the implementation framework within which the stakeholders contribute towards improving the health of the population. Furthermore, HSDP lays down clear coordination mechanisms for the various stakeholders.

The HSDP provides orientation to:

- Business / investment plans for health services programs, system inputs (human resources, medicines, health infrastructure and others), parastatals and district multi-year plans by providing them with sector targets and priority interventions.
- Sector budgeting process by providing the key investments that require financing and their related outcomes, and so influencing the operational planning process.

Under the country planning framework (Figure 2), all MDAs and LGs are required to develop joint comprehensive annual workplans as a basis for resource mobilization and national development.

### 3.1 The Planning Process

A good planning process requires that all stakeholders participate, people involved are knowledgeable about planning, there is exploration of new ideas, institutions take advantage of opportunities at hand, and necessary resources are available.

#### 3.1.1 Steps in Planning

The planning process is a sequence of steps that should be followed in coming up with a plan. These include;

- Organizing and delegating roles
- Information gathering including consultations
- Analyzing data
- Writing the plan
- Plan approval
- Dissemination of the plan

Planning in the LGs is aligned to the overall Government of Uganda process which begins in September and ends in May when the budget is approved by Parliament (Annex 2). Following the annual sector Joint Review Mission, the Health Sector Planning Committee shall identify the sector priorities for the coming year and carry out regional planning meetings to communicate these priorities to the LGs.

The districts shall begin their planning process and align their priorities to the overall sector priorities and resources available in the Medium Term Expenditure Framework (MTEF).

### **3.1.2 Organizing and Delegating Roles**

The DHO shall be responsible for organizing the DHMT and communicate the sector priorities and delegating responsibilities for the annual work plan development process.

## 4.0 STRUCTURE OF THE DISTRICT HEALTH PLAN

This section presents a standard structure for planning at all levels of health service delivery in the district.<sup>1</sup> These include the District Health Office, HSD, HC II, III, HC IVs, and general hospitals. The work plans for HC IIs HC IIIs and HC IVs will therefore be consolidated to form HSD plans. Consolidated plans from different HSDs will form a District Health Plan.

### 4.1 Outline of Plan

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

- Background information including the geographical location and demographics
- Situation analysis including the health status including socio-economic indicators based on the community / household surveys and performance against the key sector performance indicators, health Infrastructure, Human Resources for Health, partner support and inter-sectoral collaboration
- Goal, objectives, strategies and interventions (Developing Interventions; How will we get there?)
- Implementation and coordination framework

### 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 Table 1 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%

<sup>1</sup> This can also be used for planning at regional and national hospitals

## 4.2.1 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.

## 4.2.2 Special Circumstances

Any special circumstance affecting the district, administrative unit or catchment area such as; refugees, landslides, epidemics, floating populations 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 and Human Resource Information System (HRIS). 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 provides a summary of health status impact indicators at national and regional level and the targets for the national strategy.

**Table 2: Indicators of the health status**

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
Adolescent Pregnancy Rate	24% (UDHS 2011)			14%
Contraceptive Prevalence Rate	30% (UDHS 2011)			50%
Children below 5 years who are stunted	33% (UDHS 2011)			29%
Children below 5 years who are under weight	14% (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 HC II 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 Key Sector Performance Indicators

Analyse 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 setting targets for planning period. Table 3 indicates key sector performance indicators for the HSDP 2015/16 - 2019/20 for benchmarking however, the MoH will provide the key sector performance indicators and annualised targets in the M&E Plans for the 5 year strategic plans for reference.

During the planning process, In-charges and managers will use information registered in the Database for the current and previous years. Using that information for planning and monitoring purpose will make planners understand the importance of collecting and compiling quality data on prevailing diseases and service delivery as well as the budget performance.

It is important to make a critical analysis of achievements, the constraints & reasons for the shortfalls. This can be indicated in the column for comments.

**Table 3: Key sector performance indicators for the HSDP**

Specific Objective	Key Result Area	Indicator	Previous FY		Current FY		HSDP (National) Target for the year	Comments
			Target/ Output	Achieved	Target	Achieved up to December		
To increase financial risk protection of households against impoverishment due to health expenditure	Health financing	PHC including PHC NGO Grant						
		NWR						
		Dev't						
		Donor						
		Other						
	Private Sector Finances							
<b>HEALTH &amp; RELATED SERVICES OUTCOME TARGETS</b>								
To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.	Communicable disease prevention & control	ART Coverage						
		HIV+ women receiving ARVs for PMTCT during pregnancy & delivery						
		TB Case Detection Rate (all forms)						
		Intermittent Presumptive Treatment (IPT) 3 or more doses coverage for pregnant women						
		In patient malaria deaths per 100,000 persons per year						
		Malaria cases per 1,000 persons per year						
		Under-five Vitamin A second dose coverage						
		DPT3Hib3Heb3 coverage						
		Measles coverage under 1 year						
		Bed occupancy rate (Hospitals & HC IVs)						
		Average length of stay (Hospitals & HC IVs)						
		Couple years of protection						
		ANC 4+ coverage						
		Health Facility deliveries						
		HC IVs offering CEmOC Services						
	Essential clinical and rehabilitative care							

Specific Objective	Key Result Area	Indicator	Previous FY		Current FY		HSDP (National) Target for the year	Comments
			Target/ Output	Achieved	Target	Achieved up to December		
	<b>HEALTH SYSTEMS OUTPUT TARGETS</b>							
	Health Infrastructure	New OPD utilization rate						
		Hospital (inpatient) admissions per 100 population						
		Population living within 5km of a health facility						
	Medicines and health supplies	Availability of a basket of commodities in the previous quarter (% of facilities that had over 95%)						
	Improving quality of care	Facility based fresh still births (per 1,000 deliveries)						
		Maternal deaths among 100,000 health facility deliveries						
		Maternal death reviews conducted						
		Under five deaths among 1,000 under 5 admissions						
		ART Retention rate						
		TB Treatment Success Rate						
	Responsiveness	Client satisfaction index						
	Human Resources	Approved posts in public facilities filled with qualified personnel						
		Number of health workers (doctors, midwives, nurses) per 1,000 population						
		Latrine coverage						
	Health promotion & environmental health	Villages/ wards with a functional VHT, by district						
To address the key determinants of health through strengthening inter-sectoral collaboration & partnerships.								



The LGs should use data generated from service delivery for evidence-based planning and resource allocation. Therefore, data from the HMIS database should be analysed and presented as highlighted in this section.

**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				
	<b>Total</b>				

**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				
	<b>Total</b>				

**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				
	<b>Total</b>				

**Table 7: Top ten causes of mortality for all age groups during previous FY**

No.	Cause of death	Female	Male	Number	(%)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.	Others				
	<b>Total</b>				

**Table 8: Top ten causes of mortality for under-fives during previous FY**

No.	Cause of death	Female	Male	Number	(%)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.	Others				
	<b>Total</b>				

**Table 9: Top ten causes of mortality for adults during previous FY**

No.	Cause of death	Female	Male	Number	(%)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.	Others				
	<b>Total</b>				

**Table 10: Causes of maternal mortality during previous FY**

No.	Cause of death	Number	(%)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.	Others		
	<b>Total</b>		

### 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, HC IV, HC III, HC II) 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	Comment

**4.3.4. Transport Equipment**

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

**Table 12: Transport equipment**

Facility Level	Type of Transport				Condition (Good or Poor)
	General purpose vehicle	Ambulance	Motorcycle	Bicycle	
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 13.

**Table 13: Health infrastructure of the health facility**

No.	Type of Building Yes	Available (Tick)		General Condition	Comments
		No			
	OPD				
	Maternity				
	Bed Capacity for ma- ternity  (indicate number of beds)	Delivery beds			
		Pre / Postnatal beds			

No.	Type of Building Yes		Available (Tick)		General Condition	Comments
			No			
	General wards (indicate number of beds)	Medical_____beds				
		Surgical_____beds				
		Paediatrics beds				
		Obs/Gyn_____beds				
		TB_____beds				
	Operating theatre					
	Laboratory					
	X-ray unit					
	Dental unit					
	Blood Bank					
	Pharmacy					
	Store					
	Mortuary					
	Staff houses with: (specify number)					
	Incinerator					
	Others (specify)					

**Note:** Provide more details about year of construction and rehabilitation status in the appendix

#### 4.3.5. 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 staffing by health facility level**

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							
City Council Divisions							
Town Council (Town Boards)							
<b>Total</b>							

**Table 15: PNFP sector staffing by health facility level**

Facility level	No. of Units	No. of Posts	Filled	Vacant	% Filled	% Vacant
General Hospital						
HC IV						
HC III						
HC II						
Total						

#### 4.3.6. Capacity Building

The funds for capacity building should be used for Continuous Professional Development (CPD) (institutional In-Service Training/CME, 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	Trainings attended	Duration	Institution holding training
DHO				
ADHO				
Biostatisticians				
Doctors				
Clinical Officers				
Dental Surgeon				
Public Health Dental Officer				
Pharmacist				
Pharmacy Technicians				
Anaesthetic Officer				
Anaesthetic Assistant				
Theatre Assistant				
Nursing Officers				
Public Health Nurse				
Enrolled Nurses				
Enrolled Midwives				
Laboratory Technicians				
Laboratory Assistant				
Health Educator				
Assistant Health Educator				
Health Inspectors				
Health Assistants				
Cold Chain Technician				
Dental Assistant				
Others (specify)				

### 4.3.7. 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 17: Partner mapping**

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

### 4.3.8 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-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.

### 4.3.9. 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? 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 18: SWOT analysis framework**

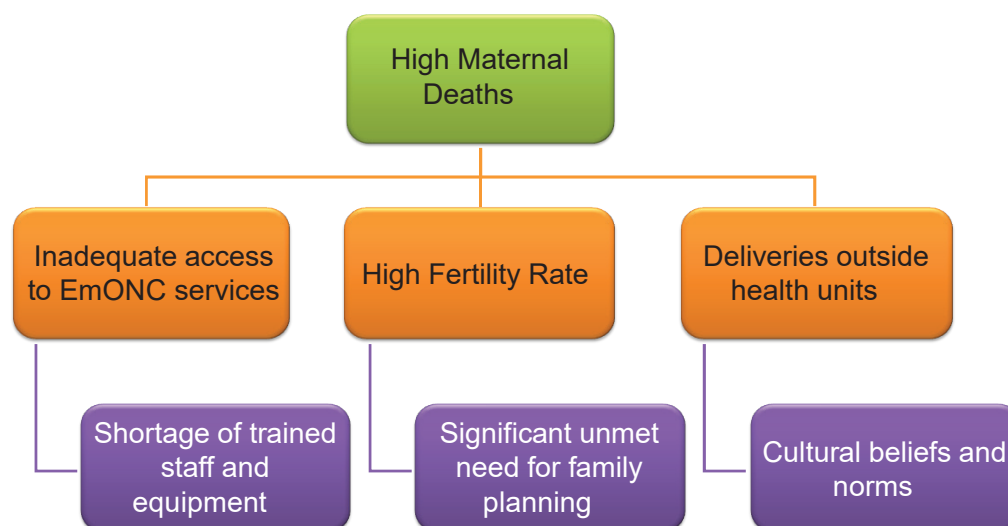
Positive		Negative	
<b>Internal</b>			
Strengths	What are we doing well?	Weaknesses	What we are doing poorly?
	What relevant resources do we have?		What can we improve?
	What are our advantages?		What should we avoid?
<b>External</b>			
Opportunities	Where are the favourable opportunities?	Threats	What 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?



## ■ 5.0 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 new-born babies. An example of a problem tree is provided in the Figure 2.

**Figure 2: Example of a problem tree**



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, 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. 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 effectiveness - 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.

### 5.1.1 The Principles of Bottleneck Analysis

The bottleneck analysis is a graphical display of six health systems factors which interact to influence the effective coverage of key program 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:

a. **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)

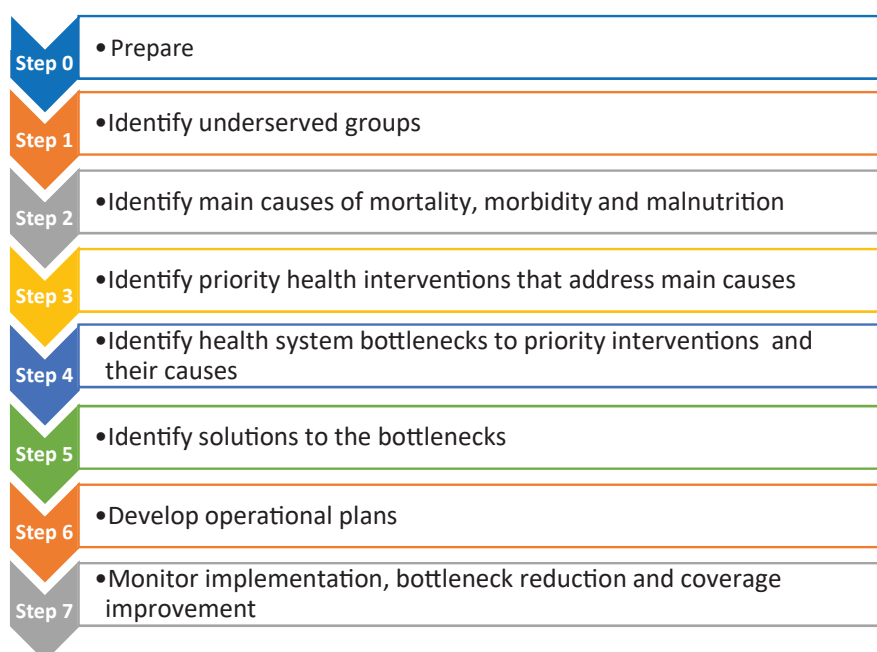
b. **Demand side factors**

- 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)

### 5.1.2 The BNA Steps

The BNA process entails the following the seven steps for improved evidence-based planning using a bottleneck analysis methodology. See figure 3.

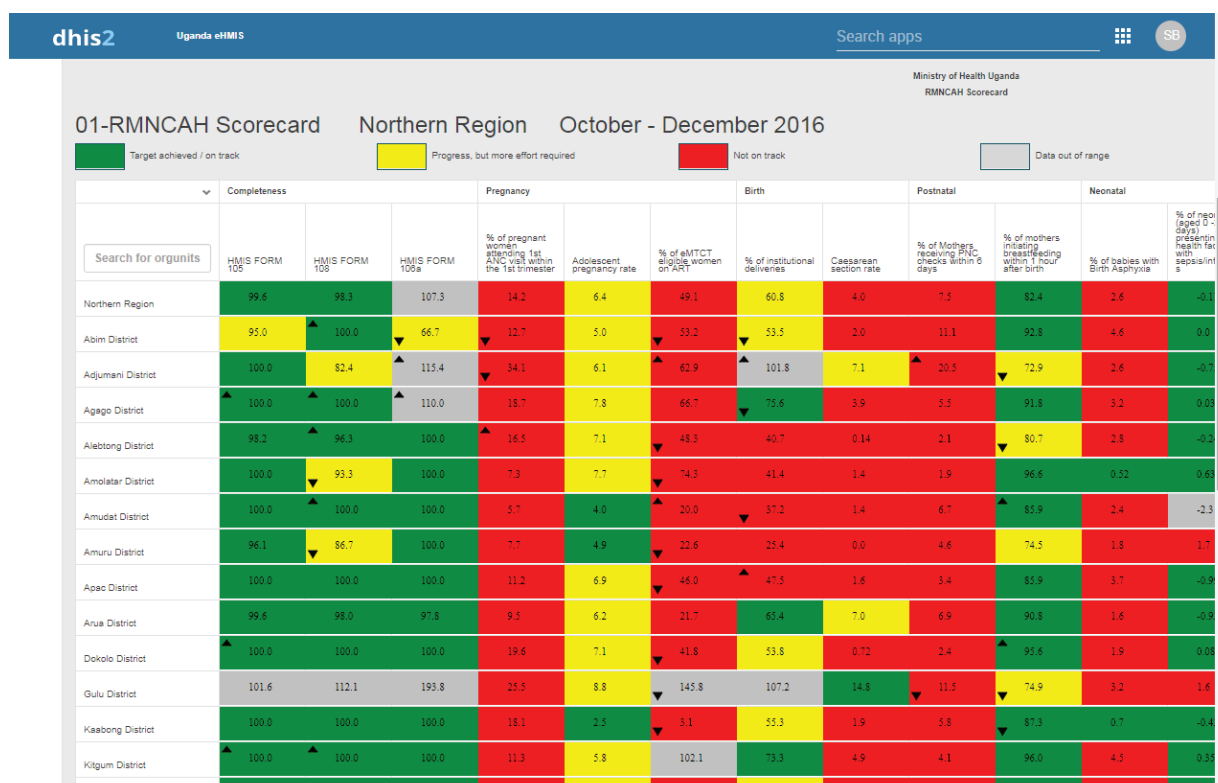
**Figure 3: Seven steps using a bottleneck analysis methodology**



### 5.1.3 Use of Scorecards / Dashboards

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 colour 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:

**Figure 4: Example of a score card**



All indicators in the RMNCAH score card which are performing sub-optimally i.e. with a red colour will be analysed further using the TANAHASHI model of bottleneck analysis.

1. Theoretically, if an intervention is delivered at its optimal level, all bars in the score card should reach 100 percent. This would indicate that supplies, human resources, and delivery points are available for the whole target population and that everyone in the target population who needs an intervention is receiving it with timeliness and adequate quality. When the bars do not reach 100%, and particularly when there is a big difference between bars on the chart, there is a bottleneck or weakness in the health system that is important to understand.

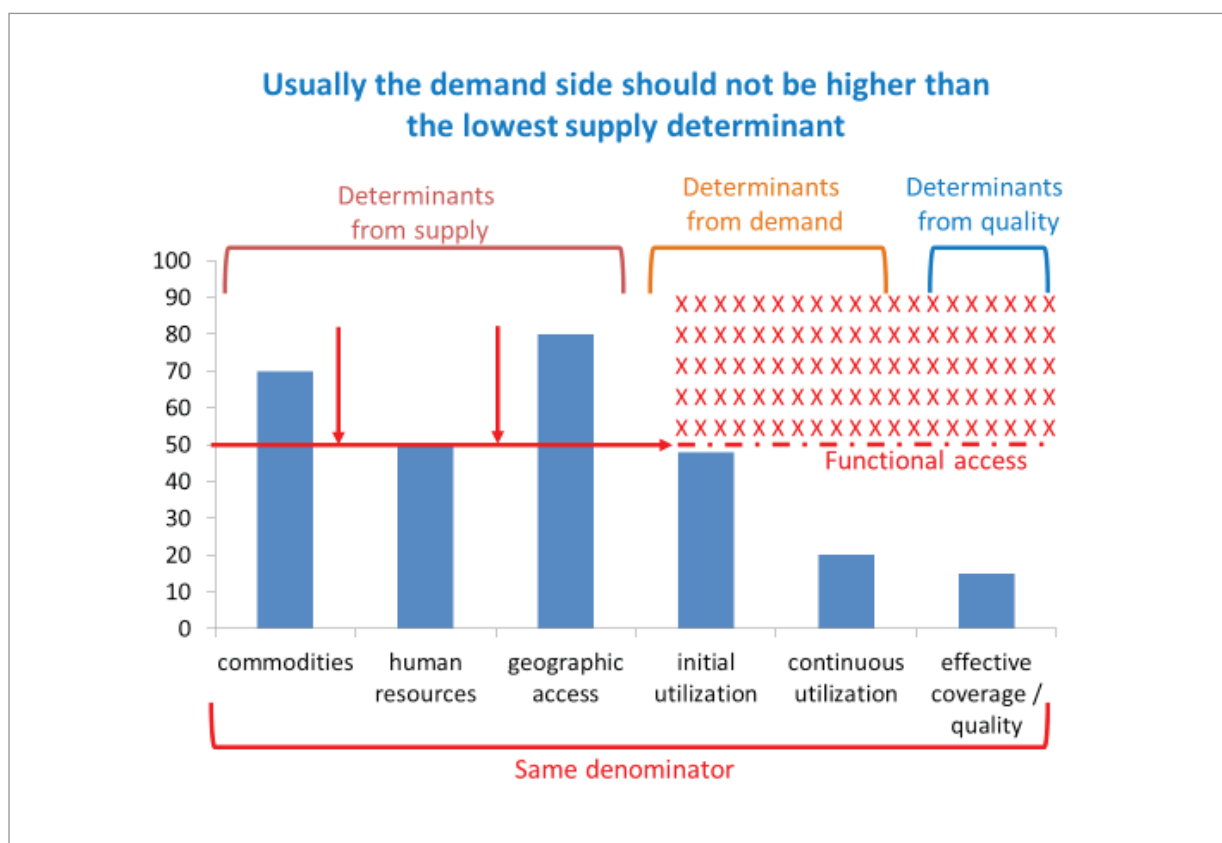
2. First look at the supply-side determinants

Supply-side determinants define the percentage of the population that can access the intervention with a reasonable level of effort. Since the population cannot use a service that is not made available, in theory the demand/quality determinants should not be higher than the lowest of the supply-side determinants. This “ceiling” from the supply side above which utilization cannot go is called “functional access.” (Figure 6) Functional access would be entirely true if each determinant of coverage had the

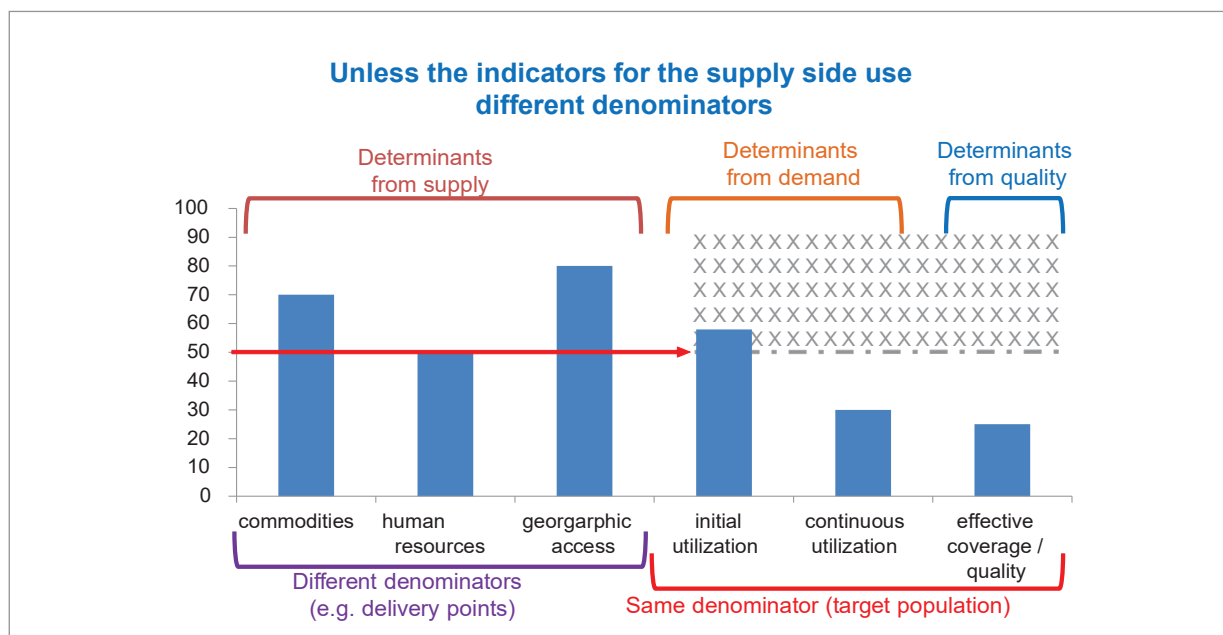
same denominator. However, this is often not the case. We typically measure indicators for supply determinants with health facilities as the denominator, while indicators for demand and quality determinants use the population as the denominator.

For example, 12 of 16 health facilities have sufficiently trained human resources to deliver midwifery services and 97 of 100 expected pregnant women attended at least one ANC visit. By using different denominators for supply and demand determinants, a situation where the ceiling for functional access does not hold may occur (See figure 5). Nonetheless, it can be used as a rule of thumb.

**Figure 5: Depiction of functional access using same denominator**

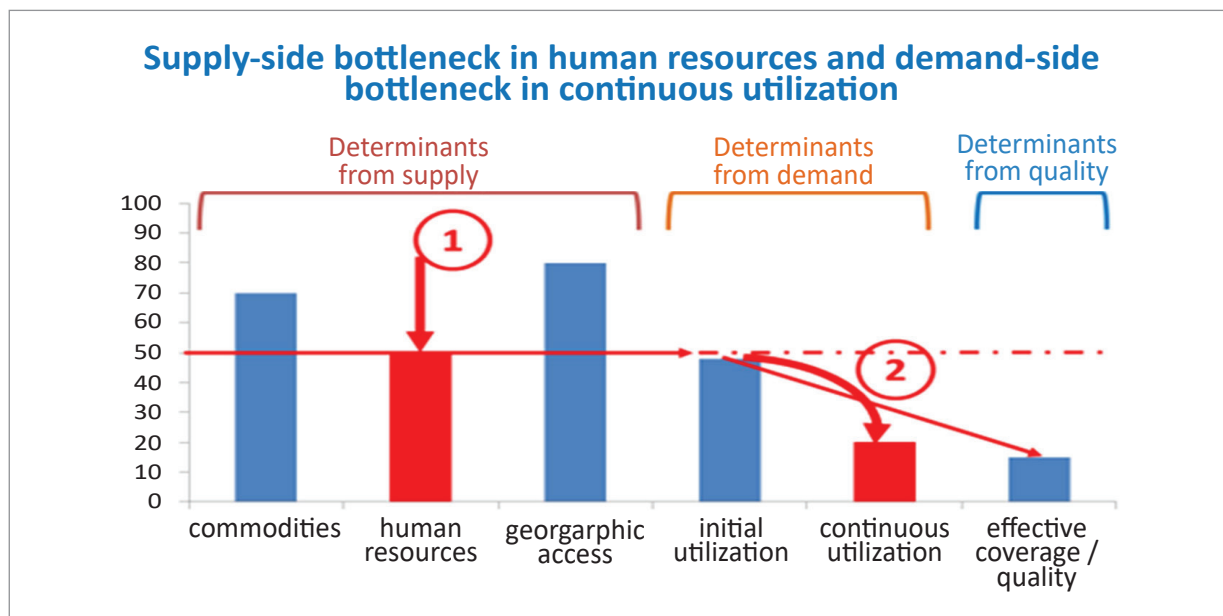


**Figure 6: Depiction of functional access using same denominator**



- To identify the bottleneck among the supply determinants, look at the supply-side determinants and see where the lowest bar occurs. In Figure 7, the most important supply-side bottleneck is human resources: 70% of facilities have adequate commodities, and 80% of the population can access those facilities with a reasonable effort, but the facilities have only 50% of the staff they require to function well (see Figure 7 and red bar with the number 1).

**Figure 7: Supply side bottleneck related to human resource**



- Next analyse the demand/quality determinants. Remember, it is impossible for people to use a service if they cannot access it (supply); it is also impossible for people to repeatedly use (continuous utilization) a service those who use it once (initial utilization). It is also not feasible for more people to participate in the recommended number of service contacts that are also of high quality than those who continuously use services of any level of quality. Thus, the indicators for the demand determinants are closely related in a logical “cascade.” Initial utilization is always

higher than continuous utilization, and quality coverage is always the lowest bar on the graph. NOTE: If this is not apparent in your bottleneck chart, there is an error in your data or indicator definitions.

Now, look at the cascade and determine where the biggest drop(s) occur(s). In Figure 7, the biggest demand-side bottleneck is between initial utilization and continuous utilization, i.e. 50% of women attend one antenatal visit but only 20% (less than half) return for the recommended 4+ visits (see figure 7 and red bar with the number 2).

5. Consider whether other interventions in the same intervention package share similar bottlenecks. In principle, you selected tracer interventions that are representative of several interventions in the same package, but there may be exceptions to this rule. For example, maybe your tracer intervention for community-based child health services is treatment of diarrhoea with ORS and zinc. Community health workers are also treating malaria and pneumonia and screening for malnutrition. A district-wide stock out of rapid diagnostic tests for malaria may have resulted in a temporary cessation of community-based screening for malaria that will not be captured through an ORS-zinc tracer intervention. Be sure to discuss and record these bottlenecks to other interventions in the same package that may not have been captured by the tracer.
6. Prioritize bottlenecks: In most cases, there will be several bottlenecks affecting a single tracer intervention. It is unlikely that you will be able to solve all the bottlenecks in a one year timeframe. You should decide which bottlenecks are the top priorities. To prioritize, begin by scoring the bottlenecks as mild, moderate or severe. Consider the proportional “drop” from one coverage determinant to the next in addition to the absolute level. In principle, prioritize the most severe bottlenecks. Also consider which bottleneck(s) may be contributing to other bottlenecks. For example, a moderate bottleneck in human resources might be contributing to severe bottlenecks in demand because of long waiting times at facilities or compromised operating hours. Finally, consider bottlenecks that are common to multiple interventions. One bottleneck could affect multiple interventions and is worth prioritizing.

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 surveys.

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.

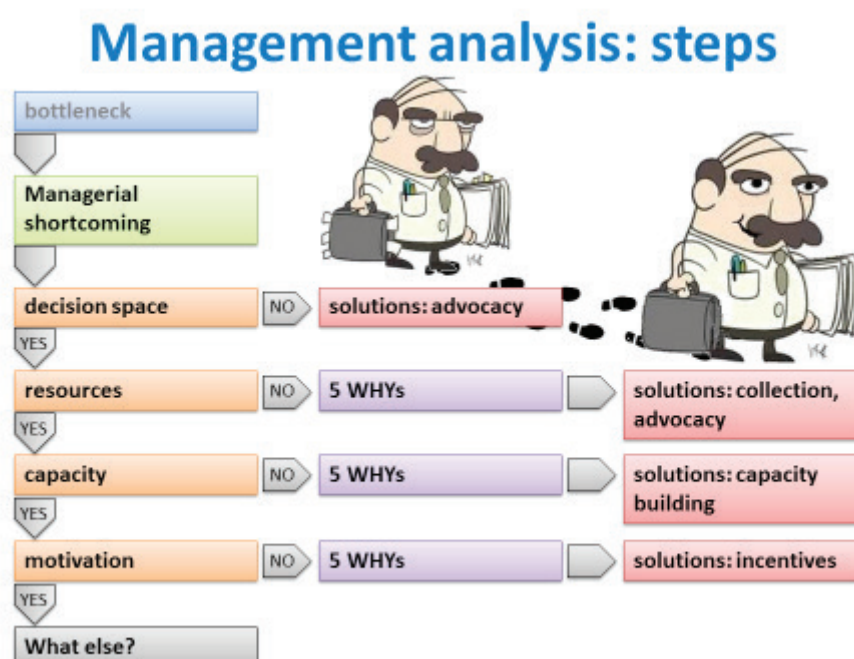
- Magnitude - proportion of population affected by the problem.
- Severity/Danger - how serious is the problem. Does it threaten life?
- Responsiveness to intervention - Can the problem be easily solved by the possible interventions?

- Cost effectiveness - 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?

The BNA should be followed by a Casual Analysis. For each of the identified bottleneck the DHMT should conduct an in-depth analysis (Demand & managerial aspects) to determine the underlying causes (constraints) of the bottleneck.

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.

**Figure 8: Flow chart for managerial analysis after identification of bottlenecks**



**NB: See more details in the BNA Manual**

## 5.2 What to Do (Setting Objectives)

As defined by Rufaroetal (2004), 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.



## 5.2.1 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 ANC 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  $(2000 \times 4)$  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.

## 5.2.2 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 19: District/institutional health priorities for FY.....**

Challenges	Major Causes/Why these challenges	Priority Actions

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

**Table 20: HRH action plan**

General objective: \_\_\_\_\_

Identified HRH challenge (List in order of priority)	Specific Objectives	Strategy / intervention	Output	Activities	Target	Action by



**Table 21: Health infrastructure action plan**

General objective: \_\_\_\_\_

No.	Identified Infra- structure challenge (List in order of priority)	Specific Objectives	Strategy / intervention	Activities	Target	Action by

**Table 22: Medicines and health supplies action plan**

General objective: \_\_\_\_\_

No.	Identified medicines and health supplies challenge (List in order of priority)	Specific Objectives	Strategy / intervention	Activities	Target	Action by

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

**Table 23: 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 ANC visits a year	Meetings Out Reach Visits
	Improve the quality of maternity service	Better access to EmONC services	Recruiting staff trained in EmONC	10	<ul style="list-style-type: none"> <li>• Training Needs</li> <li>• Assessment-</li> <li>• Identifying Training Institution.</li> <li>• Get sponsorship</li> </ul>

### 5.2.3 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 24: Determining resource requirements - example**

Intervention	Inputs					Outputs	Total cost
	Personnel	Infrastructure	Equipment	Transport	Fees		
Training in EmNOC	5 Trainers	Venue hire	Stationery 50,000	Shs 200,000 per student	500,000 per semester	2 Doctors and 5 nurses trained	

Several interventions/solutions may be identified but the resource envelop available to the DHMT may be inadequate to address all. The solutions should be ranked using the matrix shown in table 25 below. The solutions are given scores and interventions with the best score are selected as the top priorities.

**Table 25: Matrix for selecting priority intervention**

Identified Solutions	Evidence	Feasibility (Policy, Capacity)		Affordability (Resource Availability, Cost effectiveness)		Acceptability		Equity/Gender/Human Rights/Climate change focus:				Score	Recommendations
	<i>Is there Evidence of Its Effectiveness?</i>	<i>Approved Supportive Policy</i>	<i>Does the LG have capacity to implement it?</i>	<i>Is the solution cost effective?</i>	<i>Is finding Available</i>	<i>Is it acceptable to the stakeholders?</i>	<i>Is it acceptable to the community?</i>	<i>Does it benefit the poor more?</i>	<i>Does it address gender disparities?</i>	<i>Is it a human Right Issue?</i>	<i>Does it address Climate change challenges?</i>		
<b>Solution 1</b>	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		
<b>Solution 2</b>	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		
<b>Solution 3</b>	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		

The planned activities, the outputs, the inputs the respective indicators and the time frame can then be consolidated into one matrix-that is reflected HMIS Form below. The form provides the details of all the undertakings of a health facility during a specified FY.

Under the Programme /Function part/Output description, the core functions of the health facility as per the service delivery standards is provided. Under each function, the output, output target are provided alongside the activities to be undertaken, timing, responsible officer, funding source and cost per item.

This table further provides the format for developing a work plan for the service delivery outlets; district, hospitals and HCs, unit by unit.

**Table 26: Annual work plan and budget financial year**

Code / Number	Output Description	Activities	Planned Output Target	Activity Timing				Responsible Officer	Funding Source	Cost Codes	Cost Items	Cost per item ('000)
				Q1	Q2	Q3	Q4					
									<b>21</b>	<b>EMPLOYEE COSTS</b>		
									<b>211</b>	<b>Wages and Salaries</b>		
									211101	General Staff Salaries		
									211102	General Staff Wages		
									211103	Allowances		
									<b>212</b>	<b>Other Staff benefits</b>		
									212101	Pension & Gratuity		
									<b>213</b>	<b>Other Employee Costs</b>		
									213101	Medical Expenses		
									213102	Incapacity, Death Benefits & Funeral Costs		
									<b>22</b>	<b>USE OF GOODS AND SERVICES</b>		
									221	General Expenses		
									221001	Advertising & Public Relations		
									221002	Workshops & Seminars		
									221003	Staff Training/ Upgrading / CME for staff		
									221006	Meetings		
									221007	Books, Periodicals & Newspapers		
										Newspapers		
									221008	Computer supplies & IT Services		
									221009	Welfare & Entertainment		
									221011	Printing, Stationery, Photocopying & Binding		
									221014	Financial & Related Costs		
									221015	Records Management		
									221017	Subscription to professional bodies		

Code / Number	Output Description	Activities	Planned Output Target	Activity Timing				Responsible Officer	Funding Source	Cost Codes	Cost Items	Cost per item ('000)
				Q1	Q2	Q3	Q4					
									<b>222</b>	<b>Communications</b>		
									222001	Telecommunications		
									<b>223</b>	<b>Utility &amp; Property Expenses</b>		
									223002	Water		
									223005	Electricity		
									<b>224</b>	<b>Supplies &amp; Services</b>		
									224001	Medical & Veterinary Supplies		
									224002	General Supply of Goods & Services		
									<b>226</b>	<b>Insurance &amp; Licenses</b>		
									226001	Vehicle Insurance		
									<b>227</b>	<b>Travel and Transport</b>		
									227001	Travel Inland		
									227004	Fuel, Lubricants & Oils		
									<b>228</b>	<b>Maintenance</b>		
									228001	Maintenance Buildings		
									228002	Maintenance Vehicles		
									228003	Maintenance Machinery & Furniture		
									228004	Maintenance Other		
									<b>26</b>	<b>GRANTS</b>		
									<b>2621</b>	<b>Current</b>		
									262103	Contributions to Autonomous Institutions		
									<b>31</b>	<b>CAPITAL DEVELOPMENT</b>		
									<b>312</b>	<b>Fixed Assets</b>		
									<b>3121</b>	<b>Buildings, Roads &amp; Bridges</b>		
									312101	Non Residential Buildings		
									<b>GRAND TOTAL</b>			

## ■ 6.0 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 HCs 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 fulfil these responsibilities are carried out at the LG Department level, the Health Sub-District (HSD) level, Lower Level Health Facilities level and the Community level.

### 6.1.1 Role of Local Governments

The roles of the LGs in Health can be summarized as:

- Mobilize and allocate resources
- Plan and Budget for the services they are responsible for including compiling the LG Budget Framework Papers (BFP)
- Approve District Development Plans (DDP) and Annual Work plans and Budgets (AW&B)
- 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.

### 6.1.2 Role of the District Health Offices and Municipal Health Offices

The District/Municipal Health Office is the technical arm of the District/Municipal Council in the management of the District/urban health system. The core functions of the office revolve around the following management and technical support functions:

- 1) Policy Implementation and Planning:
  - Integration of the National Health Policies into the District/Urban Health System
  - Provision of leadership in the development of District/Urban 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 (CPD).
  - Personnel management functions.
- 3) Quality Assurance / Support Supervision
- Dissemination of national standards and guidelines and ensuring their implementation
  - Provision of technical support and backstopping to the HSDs Team for quality improvement.
  - Conducting support supervision of the public and private sector.
  - Monitoring the implementation of the Municipal Health Plans.
- 4) Coordination and Integration of Health Services
- Fostering inter-sectoral collaboration for health.
  - Fostering collaboration between all providers - Government, PNFP, PHP and Traditional Complementary Medicine Practitioners (TCMPs).
  - Ensuring efficient and cost effective utilization of the available resources including development partner investments.
- 5) Disease and Epidemic Control / Disaster Preparedness
- Conducting diseases surveillance and reporting.
  - Health education and promotion.
  - Health inspection for environment health and sanitation.
- 6) Monitoring and Evaluation (M&E) of District Health Services
- Collecting, analysing, submitting and disseminating 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.

### **6.1.3 Role 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, Biostatistician, 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 chaired by ACHO – Health.

The DHMT is responsible for the following;

- Reviewing and approving the District Health Sector Strategic plans and annual work-plans and budget for presentation to the DTP and Health Committee.
- Monitor implementation of the work plans.
- Mobilize resources for the district health programs.

#### **6.1.4 Role of the General Hospitals**

These provide preventive, promotive, outpatient curative, maternity, inpatient services, emergency surgery, blood transfusion, laboratory services and other general services. They also provide in-service training, consultation and research in support of the community based health care Programmes.

The General Hospital funds should be allocated to the following expenditure categories; capital items, domestic arrears, Hospital based PHC activities, Maintenance of medical equipment and buildings, training and capacity building, cleaning wards and compounds, utilities, vehicles and generator operation and maintenance, medical and office equipment, food supply (including firewood), other supplies, administration, staff allowances, transport and training.

Support for Hospital based PHC activities. About 10% PHC primary health care activities such as immunization, supervision visits, outreach activities, sensitization, health promotion talks, Household/ community based activities e.g. environmental health issues, sanitation etc.

#### **6.1.5 Role of the HSDs**

This is a functional zone of the District Health System created to decentralize planning and management of district health services and is responsible for delivery of the UNMHCP. In a district with more than one constituency, each constituency constitutes a HSD mandated to manage health services at this level and lower levels in terms of planning, implementation, monitoring and supervision of all basic health services.

#### **6.1.6 Role of a HC IV**

The HC IV is responsible for providing the following services;

- Preventive and promotive services
- Curative services (General OPD and In-patient services)
- Maternity
- Blood transfusion
- Ultra sound examinations for abdominal conditions especially obstetric cases
- Caesarean sections and lifesaving surgical operations
- Laboratory services

In addition, a HC IV serves the functions of the basic peripheral unit in the constituency where it is located and also serves the function of a HC III, over and above the functions elaborated above.

### **6.1.7 Role of a HC III**

A HC III serves the functions of the basic peripheral unit in the Sub-county where it is located while at the same time performing the supervisory function for all the HC IIs in the Sub-county. A HC III provides preventive, promotive, outpatient, curative, maternity, inpatient and laboratory services.

### **6.1.8 Role of a HC II**

The lowest planning unit of the district/municipal health system is the HCII and provides preventive, promotive, outpatient, curative health services and emergency delivery.

This is the health unit that serves as the interface between the health care system and 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, Parish Development Committees, Women Councils, Youth Councils and Councils for Disabled Persons.

### **6.1.9 Role of the 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 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 HC 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 MoLG. Comprehensive VHT guidelines and their roles have been developed and should be used during planning and implementation of services.

### **6.1.10 Roles of Other Key Stakeholders**

Key stakeholders health service delivery should be involved in the planning process. They include Health Development Partners (HDPs) or Implementing Partners (IPs); the PNFPs (Medical Bureaus), Private Providers and CSOs.

Their roles include the following:

#### **a) 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 LGs.

- Providing demand driven technical assistance and inputs into implementation of the different LG priorities.
- Complementing financing of the LG priorities.

**b) 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 LGs.
- Promote CPD among the staff and monitor/evaluate staff performance.
- Reporting on service delivery.

**c) 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.
- Feedback on service delivery.

## ■ 7.0 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, M&E.

### 7.1 Human Rights and Gender

The ultimate goal under human rights and gender mainstreaming is to eliminate discrimination and inequalities against any individual or group of persons on the ground of sex, age, race, colour, ethnic origin, tribe, birth, creed or religion, health status, social or economic standing, political opinion or disability, and take affirmative action in favour of groups marginalised in resource allocation and service delivery.

The main objectives in gender and health strategic planning include:

- Creation of an enabling environment for achieving health equity among gender groups.
- Increasing availability of quality gender sensitive health services.
- Ensuring full supply of essential medicines, supplies and equipment at all gender health service delivery points.
- Advocacy and communication for behaviour 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 non 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.

## 7.2 Climate Change and Human Health

Climate change is among the greatest health risks of the 21<sup>st</sup> 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 to reduce morbidity and mortality due to climate related diseases and events.

## 8.0 ANNEXES

### Annex 1: 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	MoFPED	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	Permanent Secretary	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 LG 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	Inter-sectoral priorities identified for potential budget reallocations & flexibility
Early November	Budget Desk prepares LG Budget Call and circulates it to Heads of Department and Lower LGs	LG 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 sectorwork plan	District/Municipal Health Officers & HSD for lower LG	Draft inputs to BFP to be presented to sector (social services) committees and development plans to be Considered by LLG councils.
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

Timing	Activity/event	Responsibility Centre	Output
Beginning of 2 <sup>nd</sup> Week December	A meeting of the Executive Committee, Chairpersons of Sector Committees, HoDs is held to examine draft BFP, and prioritize sector expenditures and programmes.	Executive Committee, Chairpersons of Sector Committees, HoDs	Draft BFP and development plan ready for Budget Conference
End of 2nd Week of December	Holding of Budget Conference	Full council, NGOs, 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.  Executive Committee approves budget framework paper and draft budget	Budget  Executive Committee Desk	Final BFP and draft budget ready to be presented to Finance or Executive Committee Draft budget ready for submission to MoFPED
20th December	MoFPED Consolidates National BFP and submits to Cabinet	MoFPED	National BFP
10th January	2nd BCC with Revised MTEF	MoFPED	PBS 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 PBS and submitted to MoFPED	Budget Estimates	Budget Desk
1st March	Draft Budget Estimates are produced off the PBS and submitted to Parliament	Budget Estimates	MoFPED
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. Minister of Finance	National Budget Speech
31st May	Budget Estimates approved by Parliament	Parliament	Approved Budget Estimates
1st July	Budget Execution	All Votes	Outputs

## Annex 2: Staff List Template

S/N	Title/Facility	Approved No.	Filled	Vacant	Salary Scale	Name	Sex	DoB	Computer No.	Basic Pay	Incremental Date	1st at app	Last appointment	Status / Probation / Confirmed	Qualification	Remarks
<b>DIRECTORATE OF HEALTH SERVICE</b>																
	DISTRICT HEALTH OFFICER	1														
	ASSISTANT DHO ENVIRONMENT' HEALTH	1														
	ASSISTANT DHO NURSING MCH	1														
	SENIOR ENVIRONMENTAL OFFICER	1														
	SENIOR HEALTH EDUCATOR	1														
	BIostatistician	1														
	STENOGRAPHER SECRETARY	1														
	COLD CHAIN TECHNICIAN	1														
	STORES ASSISTANT	1														
	OFFICE ATTENDANT	1														
	DRIVER	1														
	<b>SUB TOTAL</b>	<b>11</b>														
	<b>General HOSPITAL (If Applicable)</b>															
	<b>MEDICAL OFFICERS</b>															
	PRINCIPAL MEDICAL OFFICER	1														
	SENIOR MEDICAL OFFICER	1														
	MEDICAL OFFICER SG (COMMUNITY)	1														
	MEDICAL OFFICER SG OBS & GYN	1														
	MEDICAL OFFICER SG SURGERY	1														
	MEDICAL OFFICER SG PAEDIATRICS	1														
	MEDICAL OFFICER SG INTERNAL MEDICINE	1														
	MEDICAL OFFICER	4														

S/N	Title/Facility	Approved No.	Filled	Vacant	Salary Scale	Name	Sex	DoB	Computer No.	Basic Pay	Incremental Date	1st at app	Last appointment	Status / Probation / Confirmed	Qualification	Remarks
	<b>SUB TOTAL</b>	<b>11</b>														
	<b>DENTAL OFFICERS</b>															
	DENTAL SURGEON	1														
	PUBLIC HEALTH DENTAL OFFICER	2														
	DENTAL ASSISTANT	1														
	<b>SUB TOTAL</b>	<b>4</b>														
	<b>PHARMACIST</b>															
	PHARMACIST	1														
	DISPENSER	2														
	<b>SUB TOTAL</b>	<b>3</b>														
	<b>NURSING</b>															
	PRINCIPAL NURSING OFFICER (MATRON)	1														
	SENIOR NURSING OFFICER	5														
	NURSING OFFICER NURSING	17														
	NURSING OFFICER (PSY- CIATRIC)	1														
	NURSING OFFICER (MIDWIFERY)	3														
	PUBLIC HEALTH NURSE	1														
	ENROLLED PSYCHIATRIC NURSE	2														
	ENROLLED NURSE	46														
	ENROLLED MIDWIFE	25														
	NURSING ASSISTANT	15														
	<b>SUB TOTAL</b>	<b>116</b>														
	<b>ALLIED HEALTH PRO- FESSIONALS</b>															
	SENIOR CLINICAL OF- FICER	1														
	HEALTH EDUCATOR	1														

S/N	Title/Facility	Approved No.	Filled	Vacant	Salary Scale	Name	Sex	DoB	Computer No.	Basic Pay	Incremental Date	1st at app	Last appointment	Status / Probation / Confirmed	Qualification	Remarks
	SENIOR LABORATORY TECHNOLOGIST	1														
	PSYCHIATRIC CLINICAL OFFICER	1														
	OPHTHALMIC CLINICAL OFFICER	1														
	CLINICAL OFFICER	5														
	HEALTH INSPECTOR	1														
	ASS ENTOMOLOGICAL 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														
	<b>SUB TOTAL</b>	<b>28</b>														
	<b>ADMINISTRATIVE STAFF</b>															
	SENIOR HOSPITAL ADMINISTRATOR	1														
	HOSPITAL ADMINISTRATOR	1														
	PERSONEL OFFICER	1														
	MEDICAL SOCIAL WORKER	1														
	NUTRITIONIST	1														
	SUPPLIES OFFICER	1														
	SENIOR ACCOUNTS ASSISTANT	1														
	STENOGRAPHER	1														
	OFFICE TYPIST	1														



S/N	Title/Facility	Approved No.	Filled	Vacant	Salary Scale	Name	Sex	DoB	Computer No.	Basic Pay	Incremental Date	1st at app	Last appointment	Status / Probation / Confirmed	Qualification	Remarks
	STORES ASSISTANT	2														
	RECORDS ASSISTANT	2														
	ACCOUNTS ASSISTANT	2														
	<b>SUB TOTAL</b>	<b>15</b>														
	SUPPORT STAFF															
	DARK ROOM ATTENDANT	1														
	MORTUARY ATTENDANT	2														
	DRIVER	2														
	COOK	3														
	WATCHMAN	2														
	ARTISANS MATE	3														
	<b>SUB TOTAL</b>	<b>13</b>														
	<b>TOTAL GENERAL HOSPITAL</b>	<b>190</b>														
	<b>H/C IV (If there are more than one HC IV, please create rows and list staff per HC IV separately)</b>															
	SENIOR MEDICAL OFFICER	1														
	MEDICAL OFFICER	1														
	SENIOR NURSING OFFICER	1														
	PUBLIC HEALTH NURSE	1														
	CLINICAL OFFICER	2														
	OPHTHALMIC CLINICAL OFFICER	1														
	HEALTH INSPECTOR	2														
	DISPENSER	1														
	PUBLIC HEALTH DENTAL OFFICER	1														
	LABORATORY TECHNICIAN	1														
	ASSISTANT ENTOMOLOGICAL OFFICER	1														
	NURSING OFFICER NURSING	1														
	NURSING OFFICER (MIDWIFERY)	1														

S/N	Title/Facility	Approved No.	Filled	Vacant	Salary Scale	Name	Sex	DoB	Computer No.	Basic Pay	Incremental Date	1st at app	Last appointment	Status / Probation / Confirmed	Qualification	Remarks
	NURSING OFFICER (PHYSICHIATRY)	1														
	ASSTANT HEALTH EDUCATOR	1														
	ANAESTHETIC OFFICER	1														
	THEATRE ASSISTANT	2														
	ANAESTHETIC ASSISTANT	2														
	ENROLLED MIDWIFE	3														
	ENROLLED PSYCHATRIC NURSE	1														
	ENROLLED NURSE	3														
	COLD CHAIN ASSISTANT	1														
	OFFICE TYPIST	1														
	LABORATORY ASSISTANT	1														
	STORES ASSISTANT	1														
	ACCOUNTS ASSISTANT	1														
	HEALTH ASSISTANT	1														
	HEALTH INFORMATION ASSISTANT	1														
	NURSING ASSISTANT	5														
	WATCHMAN	3														
	PORTER	3														
	DRIVER	1														
	<b>Sub total</b>	<b>48</b>														
	<b>HC III; (If there are more than one HC III, please create rows and list staff per HC III separately)</b>															
	SENIOR CLINICAL OFFICER	1														
	CLINICAL OFFICER	1														
	NURSING OFFICER (NURSING)	1														
	ENROLLED MIDWIFE	2														
	ENROLLED NURSE	3														
	HEALTH ASSISTANT	1														
	INFORMATION ASSISTANT	1														

S/N	Title/Facility	Approved No.	Filled	Vacant	Salary Scale	Name	Sex	DoB	Computer No.	Basic Pay	Incremental Date	1st at app	Last appointment	Status / Probation / Confirmed	Qualification	Remarks
	NURSING ASSISTANT	3														
	LABORATORY ASSISTANT	1														
	LABORATORY TECHNICIAN	1														
	WATCHMAN	2														
	PORTER	2														
	<b>Sub total</b>	<b>19</b>														
	<b>HC II; (If there are more than one HC II, please create rows and list staff per HC II separately)</b>															
	ENROLLED NURSE	1														
	ENROLLED MIDWIFE	1														
	HEALTH ASSISTANT	1														
	NURSING ASSISTANT	2														
	WATCHMAN	2														
	PORTER	2														
	<b>Sub total</b>	<b>9</b>														
	<b>G/Total</b>															







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