THE REPUBLIC OF UGANDA

COMPACT BETWEEN

GOVERNMENT OF UGANDA

AND

PARTNERS

FOR IMPLEMENTATION OF THE HEALTH SECTOR DEVELOPMENT PLAN 2015/16 – 2019/20

June 2016

COMPACT FOR IMPLEMENTATION OF THE HEALTH SECTOR DEVELOPMENT PLAN 2015/16 – 2019/20

Interpretation:
The compact complements bilateral agreements/arrangements between the government and relevant partners. It is not a legal document but reflects the moral and ethical commitment of all parties to national goal of reducing morbidity and mortality through the implementation of the Health Sector Strategic Development Plan (HSDP). The parties to the compact will, to the extent possible under their statutory frameworks, respect the principles of this compact.

Commencement date:
This Compact shall be deemed to have come into effect upon signing by the Government of Uganda and health partners. It shall be effective for the duration of HSDP 2015/16 – 2019/20.

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Abbreviations

AAA	Accra Agenda for Action
AHSPR	Annual Health Sector Performance Report
CSO	Civil Society Organisation
DP	Development Partner
GoU	Government of Uganda
HDP	Health Development Partner
HPAC	Health Policy Advisory Committee
HSDP	Health Sector Development Plan
IHP+	International Health Partnership Plus
JAF	Joint Assistance Framework
JRM	Joint Review Mission
LG	Local Government
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
OPM	Office of Prime Minister
PHP	Private Health Practitioner
PNFP	Private-Not-For-Profit
PPDA	Public Procurement and Disposal Act
RBF	Results Based Financing
SBWG	Sector Budget Working Group
SDG	Sustainable Development Goal
SMC	Senior Management Committee
STMC	Senior Top Management Committee
SWAp	Sector Wide Approach
TA	Technical Assistance
TMC	Top Management Committee
TWG	Technical Working Group
UHC	Universal Health Coverage

Definitions

Accra Agenda for Action (AAA): An agenda adopted in Accra on September 4 2008 focuses the aid effectiveness agenda on the main technical, institutional, and political challenges to full implementation of the Paris principles. The Accra Principles include:

- *Predictability* – donors will provide 3 - 5 year forward information on their planned aid to partner countries.
- *Country systems*– partner country systems will be used to deliver aid as the first option, rather than donor systems.
- *Conditionality* – donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.
- *Untying* – donors will relax restrictions that prevent developing countries from buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.

Alignment**:** means that DPs base their overall support to the GoU on the NDP and HSDP, and its Annual Plans; using GoU institutions, systems and procedures that will be strengthened progressively through joint effort to meet internationally accepted standards.

Busan Partnership for Effective Development Co-operation (2011): Sets out principles, commitments and actions that offer a foundation for effective co-operation in support of international development. It offers a framework for continued dialogue and efforts to enhance the effectiveness of development co-operation. The Global Partnership for Effective Development Co-operation was established as a direct result of the Busan Partnership agreement. The Global Partnership will help ensure accountability for implementation of Busan commitments at the political level.

Development Partner (DP**):** includes each and all of external Governments, bilateral agencies, multilateral agencies, funding foundations and global/regional health initiatives that are committed to working together and with the GoU in a joint effort to support the funding, whether in pooled or non-pooled funding arrangements, and management of the implementation of the NDP/HSDP and Annual Plans.

Government of Uganda**:** means the entire apparatus of Government and its institutions, represented in this context by the MoH unless a specific distinction is made from other government ministries.

Harmonisation**:** Extent to which all parties use common arrangements or procedures and encourage shared analysis of performance.

Harmonization for Health in Africa (HHA) Action Framework: A regional mechanism through which collaborating partners agree to focus on providing support to the countries in the African region for reaching health MDGs.

International Health Partnership Plus ((IHP+): a partnership that focuses on ways to put into practice the principles of aid effectiveness elaborated in the Paris Declaration and Accra Agenda for Action, namely; National ownership; Alignment with national systems; Harmonization between agencies; Managing for results; and Mutual accountability. IHP+ is regarded as a logical extension of what governments and partners are already doing under the SWAp and builds on the Harmonisation for Health in Africa Initiative (HHA).

Joint Assistance Framework (JAF): This provides indicators and actions against which Government performance is assessed on an annual basis and lays the basis for donor disbursement of funds. It was jointly developed under the Joint Budget Support Framework between the GoU and DPs.

Mutual accountability*:*an agreement between two or more parties under which each can hold the other responsible for delivering on its commitments.

Party/Parties**:** encompasses all institutions or entities which may become signatories to this Compact and includes the DPs and:

a) Faith Based Non-Governmental Organizations
b) Other Non-Governmental Organizations, including CSOs
c) Private enterprises such as private hospitals, clinics, nursing homes, maternity homes, pharmacies and industry

Paris Declaration on Aid Effectiveness**:** The global commitment by governments and funding agencies in 2005 to reform their ways of delivering and managing aid to increase the impact aid has in reducing poverty and inequality, increasing growth, building capacity and accelerating achievement of the MDGs.

Sector wide Approach (SWAp)**:** "A sustained partnership led by national authorities, with the goal of achieving improvements in people's health in the context of a coherent sector. It is defined by an appropriate institutional structure and national financing programme through a collaborative programme of work. It uses established structures and processes for negotiating strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets". Its core principles are; it is sector-wide in the sense that it includes all key players in the sector; the MoH provides national leadership; it uses a programme of work derived from national development framework; it requires joint planning and budgeting with flexible funding modality among all key players and who agree to use common management arrangements based on national systems of accounting, monitoring and evaluation; there is joint ownership of results – successes as well as failures; it is built upon strong partnerships and trust; and, it promotes national capacity development.

Technical Assistance**:** refers to the transfer, adaptation, mobilization and utilization of services, skills, knowledge and technology. In practical terms it is mostly the provision of national and international consultants/experts needed to support the MoH in its work. This support is often in the form of advice, skills, expertise and knowledge. It ideally should increase capacity through at least the transfer of skills and knowledge, and it usually involves the production of one or more documents such as a manual or report. It can be short term or long term.

Transparency**:** Full, accurate, and timely disclosure of information. In this context it often refers to financial information. Greater transparency provides everyone a better understanding of how the partnership and programmes are working and in turn, places greater pressure on management to produce results that are acceptable to all stakeholders.

Universal Health Coverage (UHC): Ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

COMPACT FOR IMPLEMENTATION OF THE HEALTH SECTOR DEVELOPMENT PLAN 2015/16 – 2019/20

Introduction

This is a Compact between the Government of Uganda (GoU) and its partners in the health sector for the purpose of maintaining policy dialogue, promoting joint planning, and effective implementation and monitoring of the Health Sector Development Plan (HSDP) 2015/16 - 2019/20. The partners include Health Development Partners (HDPs), Private-Not-For-Profit Organizations (PNFP), the Private Health Practitioners (PHP) and Civil Society Organisations (CSO) and are collectively referred to as Health Sector Partners.

Section 1: Partnership Objective and Principles

The overall objective of the partnership under this Compact is to contribute to the national development goal of attaining middle income status by 2020 through strengthening the country's competitiveness for sustainable wealth creation, employment and inclusive growth by facilitating implementation of the second National Health Policy (2010/11 – 2019/20) and HSDP (2015/16 – 2019/20) through a sector-wide approach. This approach will address the health sector as a whole in planning and management, and in resource mobilization and allocation and aim at ensuring transparency and accountability between the Government and Health Sector Partners and to Ugandan citizens in the implementation of the HSDP.

The HSDP goal is *'To accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life'.*

UHC aims at ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives:

- equity in access to health services - those who need the services should get them, not only those who can pay for them;
- that the quality of health services is good enough to improve the health of those receiving services; and
- Financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship.

The principles guiding this Compact are:

- Ownership and leadership by Government
- Alignment of all partner programmes, activities and funding to one national plan and harmonized/integrated annual health plans; one national budget; and one monitoring framework to promote accountability at the national level.
- Building and use of common management arrangements
- Mobilisation of resources to finance the HSDP
- Mutual accountability and transparency in use of resources

The principles are consistent with national policies, with bilateral and multilateral agreements between the GoU and its Development Partners (DPs) and with international agreements ratified by Uganda including the Paris Declaration on Aid Effectiveness (2005), Accra Agenda for Action (2008), the Busan Partnership for Effective Development Co-operation (2011), Harmonization for Health in Africa (HHA) Action Framework, the Global International Health Partnerships and related Initiatives (IHP+) and the Sustainable Development Goals (SDGs).

Section 2: Commitment of Government

Recognizing that partners' willingness to commit to longer term partnerships or financial support depends on strong and consistent leadership and mutual confidence in the transparency, predictability, equity, efficiency and effectiveness of governments' planning and budgeting systems and monitoring and evaluation processes, Government will:

Ownership and Leadership

2.1 Demonstrate its stewardship role in the health sector by initiating and coordinating all components of the HSDP through ensuring functionality of all health systems; filling of critical positions in the sector, active participation in the governance structures like the Health Policy Advisory Committee (HPAC) (Annex 1) and functionality of the Technical Working Groups (TWGs).

2.2 Ensure that Top Management of the Ministry of Health (MoH) is adequately and continuously equipped with skills and material inputs to provide leadership consistent with the demands of a major sector of the national economy.

2.3 Continuously strengthen its functional links with the Office of Prime Minister (OPM), Ministry of Finance, Planning and Economic Development (MoFPED), Ministry of Local Government (MoLG) and other health-related sectors through Multi-sectoral committees to follow up implementation of interventions for the social determinants of health.

2.4 Establish and maintain an environment in which all partners can operate efficiently and effectively with Government by having allocated functional responsibilities within the sector with the HDPs and CSOs.

2.5 Strengthen capacity and monitoring of the all partnership structures like the TWGs to ensure their functionality and maintaining an environment in which all partners can operate efficiently and effectively with Government.

2.6 Reaffirm the country's commitment towards achievement of the SDG agenda.

2.7 Ensure all health sector reforms and policy shifts are discussed and agreed upon with the Health Sector Partners before implementation.

2.8 Take active steps to promote good governance, transparency and accountability and fight corruption through ensuring timely audits and discussion of audit reports in HPAC.

Planning

2.9 Ensure that all central level and district health plans, Medical Bureaus, PHPs and CSO plans are consistent with the HSDP and all parties are informed about the key outputs and targets.

2.10 Demonstrate transparency by involving its partners in developing annual central and district level plans derived from the HSDP.

2.11 Maintain a comprehensive and updated inventory and mapping of health projects, HDPs, PNFPs, PHPs and CSOs to be used in the strategic planning and resource allocation.

2.12 Coordinate Health Sector Partners under the MoH Planning Department to have effective and harmonised coordination of health program implementation.

2.13 Coordinate Technical Assistance (TA) to support implementation of the HSDP according to the guidelines (Annex 2). Such TA will be focused on capacity building at national and Local Government (LG) levels and will be developed jointly as part of a multi-year and annual planning process. The MoH will lead and control the process of identifying the need and requesting for TA in the sector. This will be the reference for a harmonised annual TA plan to be discussed and endorsed by HPAC.

Budget and Finance

2.14 Demonstrate financial commitment towards implementation of HSDP as detailed in the annual approved work-plan and budget and ensure timely release of such funds to its programmes and beneficiary parties (Annex 3).

2.15 Implement the budget in a manner consistent with the priorities of the HSDP by regular monitoring and providing feedback to all the relevant stakeholders in HPAC, TWGs, Quarterly review meetings and Joint Review Mission (JRM) on any envisaged major changes to priorities and budget allocations during the course of the financial year.

2.16 Establish a Joint partnership fund between HDPs and Government for joint commitments with agreed terms.

2.17 Strengthen its internal measures to improve timely submission of its operational plans and budgets to MoFPED as part of the overall strategy to get timely and adequate releases of Government Funds.

2.18 Government will inform all parties about submissions and delays that may arise in budget implementation during HPAC, TWGs and quarterly reviews.

Effectiveness, efficiency and equity

2.19 Ensure improved aid effectiveness by demonstrating cost-effective use of resources and by encouraging all partners to align to the One Plan, One Budget, One Monitoring and Evaluation Framework. Better programming and management of development assistance for health.

2.20 Continue to improve the quality of public financial management and procurement systems through strengthening human resource capacities at national and local council levels for financial management and procurement. Define responsibilities and reporting channels.

2.21 Strengthen existing financial management control systems to better manage financial records, budgetary controls (approval and control of documents) and project performance appraisals.

2.22 Demonstrate LG commitment to improving management and performance of the decentralized District Health Service delivery (Annex 4).

2.23 Linking funding to results and avoiding resource wastage; revising the resource allocation formula as need arises.

Monitoring and Evaluation

2.24 Provide complete, accurate and timely feedback on health sector performance towards the HSDP targets and discuss these with all parties each quarter.

2.25 Initiate and oversee Regional Joint Review Meetings to comprehensively assess implementation of strategies and performance against district workplans and to determine the sector priorities based on the district needs. Proceedings of the regional review meetings will be synthesised to inform the strategic and policy discussions during the annual JRM.

2.26 Initiate and oversee the annual JRM to comprehensively assess policies, strategies, performance and capacity needs in line with the HSDP and to determine future health priorities (Annex 5).

Section 3: Commitment of Health Sector Partners

The Health Sector Partners commit to:

3.1 Enhance the capacity of the Government to meet its commitments under the HSDP by engaging in policy dialogue, supporting appropriate capacity building through joint planning and supporting development and implementation of a harmonised TA plan and working within processes as stipulated under this Compact.

3.2 Use the HSDP and its prescribed structures and guidelines as their standard reference for partnership, collaboration, designing, monitoring performance, reviewing and updating development programmes.

3.3 Promote transparency by providing complete, accurate and timely reports and providing any additional information during HPAC, TWGs, quarterly reviews and JRM that will enhance the quality of discussions with Government on planning for health services, allocating resources and monitoring performance.

3.4 Participate fully in the sector review processes including the HSDP Mid-term and End evaluation, the Annual JRM to review health sector performance of the previous financial year and agree on sector policies and strategic interventions, identify priorities and mobilise resources and allocation for the subsequent financial year.

3.5 Promote predictability in their operations by basing discussions and assessments of Government performance on the commonly agreed aide memoire, quarterly performance reports and Annual Health Sector Performance Reports (AHSPRs) based on the HSDP results framework and underlying principles in the manner outlined in this Compact.

3.6 Partners providing funding and other resources to implementing parties in support of the health sector in Uganda commit to:

- Provide comprehensive information regarding funding and other resources during HPAC, TWGs, quarterly reviews and JRM.
- Provide multi-year (3-5 years) forward information regarding indicative funding if applicable to allow the government adequate time to plan for sector priorities. Where HDPs work within annual plans the information regarding Indicative Planning Figures shall be shared in HPAC and TWGs.
- Align their financial and technical assistance to the HSDP and fully participate in all processes of planning, budgeting and monitoring to ensure successful implementation of the strategic plan.
- Fully participate in the preparation of the TA plan and recruitment to support the health sector, and align any funding to the agreed plan.

3.7 Partners primarily involved in service delivery commit to:

- Fully participate in the planning and budgeting processes at the relevant levels promoting harmonization and alignment.
- Share on a routine basis, service data and financial returns during TWGs and quarterly performance reviews.
- Comply with mandatory reporting for epidemiological surveillance purposes.
- Provide any other operational reports as required within the Health Management Information System.

3.8 Partners with lead advocacy and oversight functions commit to:

- Organize themselves into fully distinct umbrella bodies with specific mandates and democratic representation for purposes of interacting with other stakeholders in the SWAp.
- Promote the dissemination of the key principles and obligations of the HSDP to the general population.
- Advocate for improved access to health information and quality health services for underserved communities, households and individuals in particular.
- Advocate for increasing use of community structures defined in HSDP.
- Independently monitor compliance of the Government and other health sector partners with the commitments made in this Compact.

Section 4: Common Working Arrangements

Structures for implementing the Compact

4.1 All parties will use the health sector organizational framework and health partnership structures for implementing this compact. The specific structures for the health sector governance and management under the Long Term Institutional Arrangements include: Senior Top Management Committee (STMC), Top Management Committee (TMC), Health Policy Advisory Committee (HPAC), Senior Management Committee (SMC), TWGs and Heads of Departments as illustrated in Annex 6. The Terms of Reference for the different bodies are provided in the MoH Guidelines for Governance and Management Structures, 2013.

4.2 At the decentralized level the key governance and management structures include the District / Municipal Council, the District Executive Committee, District Health / Social

Services Committee, Technical Planning Committee, District Health Management Team, District Health Team, Health-Sub-District Team and Health / Hospital Management Committees.

Planning and Budgeting cycle

4.3 All parties (HDPs, IPs, CSOs, PNFPs & PHPs) will increasingly align their consultations, appraisals, decisions and disbursement with the Government planning and budgeting cycle to maximise impact of their support and minimise transaction cost. The calendar of activities to guide planning and budgeting is outlined in Annex 7.

4.4 To integrate and address Social Determinants of Health, the MoH Planning department will strengthen intersectoral collaboration and partnerships and establish a functional monitoring framework to monitor progress on engagements.

4.5 The Planning Department will initiate the planning cycle each year after the JRM and ensure that each partner and stakeholder to the compact has prior and timely information on the planning calendar and receives invitation to key planning forums and activities.

4.6 The Sector Budget Working Group (SBWG) will review on-going and new projects and present its recommendations to HPAC for its endorsement. The Terms of Reference for the SBWG are defined in the MoH for Governance and Management Structures.

Financing the Sector Plans

4.7 The Health Financing Strategy HFS will guide the country in equitably and sustainably mobilizing resources and efficiently utilizing them to implement sector plans.

4.8 Government's preferred mode of financing for the HSDP is general budget support. However other modalities such as Basket funding, projects and programme support may be negotiated while maintaining a harmonized process for prioritization, planning and management of health programmes.

4.9 Other health financing mechanism like health insurance will be promoted. MoH and its partners will be required to intervene in the establishment of the National Health Insurance Scheme.

4.10 Government shall embrace the Results Based Financing (RBF) framework and implement critical activities using the framework but continue using the input based financing too. In line with the HFS pooling arrangements, partners who want to support and implement RBF should align within the national RBF framework.

Financial Management

4.11 All parties recognise various efforts within MoFPED and relevant sector ministries to improve financial management in the public sector and will seek or provide assistance to improve the performance of the health sector in order to align to overall Government initiatives.

Auditing

4.12 The MoH expenditure shall be audited by Auditor General once annually, supplemented by periodic external independent audit as agreed by all parties. Financial flow audits

(tracking studies), covering previous financial years and audits of agreed financial sub-systems such as payroll and value-for-money audits shall also be conducted as and when necessary.

4.13 The MoH will respond to the Auditor-General's report after 4 months from the time the report is published and present progress on the implementation of the Auditor-General's recommendations to HPAC TMC and later in the year to JRM.

Procurement

4.14 An annual procurement plan integrating all the planned procurement in the health sector shall be prepared and appraised by stakeholders and approval by HPAC and TMC as part of the annual planning process. The plan shall integrate all procurement by both government and HDPs.

4.15 TMC and HPAC shall request for an assessment of any procurement process in the health sector if deemed necessary as long as it is in line with the Public Procurement and Disposal Act (PPDA).

4.16 The HDPs shall work towards strengthening and the use of Government procurement procedures taking into account the legal obligations of the HDPs. Transparency, cost effectiveness and value for money will be guiding principles in procurement. Annex 8 and 9 details the Guidelines on Programme Implementation, Procurement and Financial Management for Public and Private Sector Recipients in the Health Sector and requirements for compliance with national specifications and standards for medicines, medical supplies and medical equipment.

4.17 Government will progressively increase the proportion of agreed priority commodities financed by government to ensure availability and sustainability of the same commodities.

4.18 The MoH – Procurement Unit will provide consolidated quarterly progress reports on the implementation of the procurement plan to SBWG, HPAC and TMC.

Monitoring, Review and reporting

4.19 The HPAC will review the following monitoring reports and recommend action to the Top Management or the TWGs as appropriate:

- Area Teams (supervision) reports – quarterly
- Quarterly update on budget processes
- Auditor General's Report
- Special audit reports
- Annual Health Sector Performance Report - annually
- Progress on implementation of JRM aide-memoires - quarterly.
- Technical Review meeting report – annually
- HSDP Mid-Term review report
- HSDP End evaluation report

4.20 Indicators for monitoring the HSDP (Annex 10) will be used for monitoring overall performance of the health sector.

4.21 The MoH will organize a review of the HSDP at mid-term and an end evaluation in the last year of the HSDP.

4.22 The Planning and Development Directorate through the Supervision Monitoring Evaluation and Research TWG will have lead responsibility for preparing the terms of reference for these reviews. The Terms of reference should specify among other things, the objectives, timing, composition of team and preparatory studies for the assignment.

4.23 The Government shall, based on the approved budgeting program output targets, produce quarterly performance reports for each Vote.

4.24 The Government shall, based on annual output targets, produce an annual report on the performance of the sector within three months of the end of every financial year. The annual report shall contain league tables of performance against agreed indicators for districts, hospitals and MoH departments and divisions.

Section 5: Monitoring the Compact

5.1 The TMC and HPAC will serve as the main oversight and steering body for monitoring the implementation of the Compact. A detailed list of Indicators for monitoring progress of this Compact is in Annex 11.

5.2 At least biannually TMC and HPAC will jointly review progress in implementation of the Compact.

5.3 HPAC will specifically review:

- At least quarterly, whether signatories are on track with their commitments to support implementation of the HSDP. These include their mutual commitments to dialogue effectively, to finance and support and monitor the implementation of the HSDP. This will include following the participatory processes set out in the fiscal calendar and the specified reporting arrangements. It will also include processes for public expenditure and public finance management reviews and any other reviews to be carried out by the government and its partners.

- At least quarterly, attendance at HPAC meetings and measures taken to discourage non-participation and encourage full participation. Issues of compliance to attendance of HPAC meetings shall be communicated and record noted in every HPAC meeting.

5.4 Monitoring of the Compact will aim to identify the health sector partners who may need encouragement and support. The measures include regular publication of monitoring results and distribution to partners.

5.5 This Compact is prepared in the spirit of cooperation. Signatories to this Compact will adhere to the Code of Conduct for all parties to the Compact (Annex 12).

5.6 The HPAC will set up a Panel of Eminent Members to address cases of non-compliance to the compact as well as recognise well-performing health sector partners and report to HPAC (Annex 13).

5.7 There shall be openness and sharing of information in rewarding performance and sanctioning poor performance of the health sector partners.

5.8 The extent to which performance of signatories impacts on achievement of organizational or national objectives will be the basis for rewards or sanctions.

Section 6: Prevention and Settlement of Disagreements and Conflicts

6.1 The Parties shall work in a spirit of openness, transparency and consultation guided by the code of conduct (Annex 12).

6.2 In the event of disagreement or conflict, dialogue in HPAC will be the first recourse for resolving the problem. The HPAC and the JRMs offer opportunity to identify and address potential problems. Unilateral actions shall be avoided.

Section 7: Amendment / Termination of Compact

7.1 Any amendments to the terms and provisions of this Compact may only be made through a written agreement by all parties.

7.2 Any signatory may terminate their obligations to the partnership on giving three months' notice (which will include the reasons for the termination) to all parties. Termination from this Compact will be interpreted to mean a partner is unwilling or unable to meet the obligations set out in this Compact.

Section 8: Inclusion of new partners

8.1 Any new partner wishing to support the implementation of the HSDP under the provisions of this Compact is be free to do so upon signing this Compact. The new partner must present their development assistance programme to the GoU and health sector partners in accordance with the principle of harmonization and alignment.

Section 9: Signatories of the Compact for the Health Sector Development Plan 2015/16 – 2019/20

HON. JANE RUTH ACENG
MINISTER OF HEALTH
FOR GOVERNMENT OF UGANDA

For AFRICAN DEVELOPMENT BANK

For EMBASSY OF SWEDEN

For KINGDOM OF BELGIUM

For UNITED NATIONS DEVELOPMENT PROGRAMME

For CIVIL SOCIETY ORGANIZATIONS

For UNITED NATIONS POPULATION FUND

For DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (UK)

For UNITED NATIONS HIGH COMMISSION FOR REFUGEES

For GLOBAL ALLIANCE ON VACCINES AND IMMUNIZATION

For UNITED NATIONS JOINT PROGRAMME ON HIV/AIDS

For GLOBAL FUND TO FIGHT HIV/AIDS, TUBERCULOSIS AND MALARIA

For UNITED NATIONS WOMEN

For ITALIAN COOPERATION

For UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

For EMBASSY OF THE NETHERLANDS

For US CENTERS FOR DISEASE CONTROL AND PREVENTION

For PRIVATE HEALTH PRACTITIONERS

For THE WORLD BANK

For PRIVATE NOT-FOR-PROFIT ORGANIZATIONS

For WORLD HEALTH ORGANIZATION

For UNITED NATIONS CHILDREN'S FUND

For EMBASSY OF JAPAN

For ROYAL NORWEGIAN EMBASSY

Annexes

Annex 1: Terms of Reference for the Health Policy Advisory Committee

The Health Policy Advisory Committee (HPAC) was established as a forum for the Government, Health Development Partners (HDPs), Civil Society, Private Sector and other stakeholders to discuss health policy and to advise on the implementation of the HSSIP and policies. HPAC is a Development Partners / stakeholder coordination mechanism which supports the functions of the Ministry of Health Top Management in policy related issues.

Composition of HPAC
Chairperson: Permanent Secretary

Co-Chairperson: Head of Development Partners

Secretary: HPAC Secretariat under Planning Department

Members:

a. Director General Health Services
b. Director Health Services Planning & Development
c. Director Health Services Clinical & Community Health Services
d. Under Secretary - MoH
e. Executive Director Mulago National Referral Hospital
f. Executive Director Butabika National Referral Hospital
g. Secretary of the Health Services Commission
h. Commissioners of Health Services: Clinical, National Disease Control, Quality Assurance, Planning, Community Health and Nursing, Human Resource Management
i. Representatives of the HDPs
j. Representatives of Bilateral Agencies
k. Board Chairperson National Medical Stores
l. General Manager National Medical Stores
m. Representatives of:
    - Medical Bureaus
    - Civil Society Organizations (CSOs)
    - Health Consumers
    - Private Health Providers
n. Representative of Ministry of Finance, Planning and Economic Development (MoFPED)
o. Other members e.g representatives of Ministry of Local Government, Ministry of Public Service, Ministry of Education and Sports, Ministry of Water and Environment, Ministry of Gender, Labour and Social Development, Regional Referral Hospitals and District Health Officers shall be co-opted as need arises to address specific issues during HPAC proceedings.

Functions of HPAC

1. Review, discuss and advise on policies under development or review and policy related issues submitted by Senior Management Committee before they are presented to TMC by the respective programs.
2. Receive and advise on the following monitoring reports:

- Implementation of the Compact
- International Health Partnerships reports
- Quarterly Area Team monitoring reports
- Annual Health Sector Performance Report.
- Progress report on implementation of JRM Aide-memoires - quarterly.
- Technical Review meeting reports.
- Quarterly sector performance review reports.
- Other mandatory reports e.g. project or program reports

3. Participate in strategic planning for the sector.
4. Participate in Technical Assistance identification and analysis of needs.
5. Harmonize resource mobilization.
6. Participate in joint monitoring and evaluation of health programmes.
7. Strengthen collaboration and partnership with the ministry and other stakeholders.

HPAC Meetings

1. HPAC meetings shall take place on a monthly basis.
2. The schedule will be published annually.
3. Pre-HPAC meeting (Chair, Co-Chair and Secretariat) shall be conducted to decide the agenda.
4. The Secretariat to HPAC shall invite and communicate the agenda at least one week prior to the meeting.
5. All relevant information will be provided to members at least one week prior to the meeting.

Duration of Membership to HPAC

HPAC remains in operation for the duration of each Health Sector Development Plan. The Terms of Reference of HPAC and membership will be reviewed during the Mid Term Review and End Term evaluation of the HSDP to reflect appropriate response to changing health needs.

Appointment of Members to HPAC

Appointment of members to HPAC will be done at the beginning of the 5-year sector strategic plan by the Permanent Secretary MoH after approval by MoH Top Management.

Funding for HPAC Activities

All HPAC activities including special assignments will be funded from the health sector budget and other agreed sources like the Basket Fund, among others.

Annex 2: Technical Assistance Guidelines

1. All Technical Assistance (TA) shall support and arise out of the National Health Policy (NHP) and the Health Sector Development Plan (HSDP).

2. TA shall be requested for by the Government of Uganda (GoU). TA shall be identified, analyzed and determined on a demand driven basis according to the needs and priorities of the Government in collaboration with HDPs. Use of Ugandan or regional consultants will be encouraged where expertise is available.

3. The terms of reference for each TA will be developed by the Government and agreed with DPs. Candidates for TA will be reviewed and approved by the Government and DPs. The forum to discuss TA will be the HPAC.

4. The GoU will, in consultation with DPs, define TA priorities of the heath sector.

5. The GoU will in each instance designate explicitly, the national counterpart for the TA.

6. The MoH will take appropriate measures to strengthen capacity in management of TA including;
    - Identification of TA needs
    - elaboration and development of terms of reference
    - identification and recruitment of consultants
    - management of consultants, TA outputs, follow-up of next steps and recommendations.

7. A joint review of progress in the areas supported by TA will be undertaken annually. The objective of this review will include to:
    - assess the effectiveness of TA in the health sector
    - make recommendation for improvement
    - agree on plans for future TA.
    - encourage overall coordination of TA

8. The DPs will ensure that each TA to the GoU:
    - reports primarily to Government officials
    - supports Government capacity building through transfer of skills.

Annex 3: Government of Uganda's Commitment to Financing the Health Sector

OFFICIAL STATEMENT ON THE GOVERNMENT OF UGANDA'S COMMITMENT TO FINANCING THE HEALTH SECTOR DEVELOPMENT PLAN 2015/16 - 2019/20

The Government of the Republic of Uganda launched the Uganda Vision 2040 in April 2013 to provide development paths and strategies aiming at transforming Uganda into a competitive upper middle income country.

The Goal of the NDP 2015/16 - 2019/20 is to attain middle-income status by 2020 through strengthening the country's competitiveness for sustainable wealth creation, employment and inclusive growth. The NDP clearly identifies enhancing human capital development, and strengthen mechanisms for quality, effective and efficient service delivery as key development objectives.

To maximize the contribution of the budget to meeting the sector priorities, it is imperative to ensure that aggregate public expenditure remains consistent with the key macro-economic policy objectives, which underpin the Medium and Long Term Expenditure Frameworks. Crucially, these include low and stable inflation and a consistent increase in the proportion of the budget, which is financed by domestic revenue. This is geared to ensuring sustainability of public financing, and a conducive macro-economic environment for private sector led growth.

In accordance with the Partnership Principles spelt out in the Uganda Partnership Policy, 2013, the donors are encouraged to support Government Progress through budget support rather than through projects. With the introduction of integrated sectoral ceilings both Sectoral Ministries and DPs need to understand that each additional project will have an opportunity cost for the sector in terms of flexible resources.

This statement has been issued as a confirmation of government's recognition of the preparation of the Health Sector Development Plan 2015/16 - 2019/20 and to affirm the commitment of the government to allocating resources to the health sector based on the GOU priorities and the available resource envelope.

KEITH MUHAKANIZI
PERMANENT SECRETARY/SECRETARY TO THE TREASURY

Annex 4: Local Government Commitment to Improving Management and Performance of the Decentralized District Health Service Delivery.

The Constitution and the Local Governments Act 1997 (with Amendment Act 2001) defines the legal mandate of the Local Governments in service delivery. In the health sector, the District/Municipal Councils are responsible for medical and health services including: Management of General Hospitals, all Health Centres, Implementation/Enforcement of the various Health Acts, community mobilization and education, Supervision and Monitoring within the local government. 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 using the health management structures at district, municipal, Health Sub-district and health facility level.

The Ministry of Local Government in collaboration with the Local Governments at all levels, Ministry of Health and health related Ministries, Departments and Agencies towards enhancement of human capital development, and strengthen mechanisms for quality, effective and efficient service delivery as key development objectives as stipulated in the NDP II.

The key responsibilities of the Local Governments in health service delivery include;

- Making district health sector plans aligned to the Health Sector Development Plan and coordinating implementation of the plans.
- Implementation of the National Health Policy and the Uganda National Minimum Heath Care Package which includes;
    - Management of hospitals, other than hospitals providing referral and medical training;
    - health centres, clinics and Community Health Providers;
    - maternity, child and adolescent health services;
    - control of communicable diseases, including malaria, HIV/AIDS, leprosy and tuberculosis;
    - control and management of epidemics and disasters in the district;
    - rural ambulance services;
    - Primary Health Care services;
    - vector control;
    - environment sanitation;
    - health education.
    - Registration of births and deaths
- Monitoring the overall performance of the district/municipal health care delivery system.
- Human resources for health management (recruitment, deployment, in-service training, career development, payroll management, performance monitoring, etc.)
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- Promoting transparency and accountability to the population
- Other functions delegated by central government

This statement has been issued as a confirmation of the Ministry of Local Government's recognition of the preparation of the Health Sector Development Plan 2015/16 - 2019/20 and

to affirm our commitment to supporting and participating in the health sector agenda in line with the key responsibilities above.

PERMANENT SECRETARY
MINISTRY OF LOCAL GOVERNMENT

Annex 5: Terms of Reference for the Joint Review Mission (JRM), Regional JRM sessions and Technical Review Meeting

Annex 5a: Terms of Reference for the JRM

1. Under the Sector Wide Approach (SWAp), the JRMs will continue to take place. JRMs will help both the Government and all stakeholders to jointly assess how effectively the HSDP is being implemented, what progress is being made towards agreed outputs, and how efficiently inputs provided are being utilized.

Objectives

2. The main purpose of the JRM is to comprehensively review policies, strategies, performance and capacity needs of the health sector in line with the sector strategic and operational plans and determine future health priorities.

3. The specific objectives are to;

   - Receive and discuss the annual sector performance report against the targets, actions and indicators set out in annual operational plan.
   - Review expenditures of the previous FY and any additional expenditure information, which will assist in developing the draft budget for the next FY.
   - Discuss the implementation of the Compact, propose ways of improved application and further its observations to the signatories.
   - Discuss and agree on reasons for good and poor performance and agree on ways to improve performance of the sector in the next FY.
   - Recognize and reward good performance.

Timing

4. To link the JRMs to the GoU annual planning and budget cycle, and to make the necessary information available, the JRMs will be held in the month of September when performance data from the previous financial year (FY) will have been analyzed and a report prepared and when budget allocation and financing plan for the upcoming year will be discussed.

JRM Participants

5. The GoU participants in the JRM will be from the MoH, MoLG, MoFPED, MoES, MoWE and other related MDAs. Other members will include representatives of the HDPs, CSOs, private sector, academia, beneficiaries and other stakeholders.

Preparation

6. The MoH will organize and manage the JRM with support from HPAC using the GoU budget for monitoring the HSDP. In addition, resources maybe available from the HDPs.
7. MoH will prepare a concept note containing the details of the review methodology and program, provide the require reports well in advance, and issue invitations to those who

will take part in the JRM at least one month in advance. MoH will also make the necessary logistical arrangements.

8. Prior to the JRM, the MoH will ensure that the MoH Top Management and the HPAC receive and discuss;
    - The Annual Health Sector Performance Report for the previous FY showing achievements and expenditures of the sector according to agreed indicators. The report will make recommendations for improvements.
    - Response to the Auditor General's report for the previous FY.
    - Key management issues, including progress with SWAp and experience gained with the financing arrangements.
    - Any client satisfaction, service delivery or similar survey reports, which have been decided upon as monitoring instruments.

JRM process

9. The JRM will be a participatory process and will take 2 days. Most of the discussions during the review will be held in plenary.
10. The MoH, MoFPED and HDPs will be engaged to agree on their broad support to the budget.
11. The JRM secretariat will summarize the proceedings and present them to the participants to agree on the key issues and sector priorities for the next FY.
12. The key issues and sector priorities will be captured in the JRM aide memoire. This will be presented to HPAC by November for approval by the stakeholders.

Annex 5b: Terms of Reference for the Regional JRM sessions

1. Just as it is important to take stock and review performance at a national level, so it is important to review and provide feedback on performance at sub-national levels. During this five-year period, the MoH will introduce Regional JRM sessions prior to the national JRM. This aims at decongesting the national JRMs and promote strategic and more productive discussions at the JRM. In addition, the Regional JRMs will help both the Local Governments and key stakeholders to jointly assess how effectively the HSDP is being implemented, what progress is being made towards agreed outputs, and how efficiently inputs provided are being utilized.

2. Regional JRMs shall be conducted in the regions as defined by the Regional Referral Hospital catchment.

Timing

3. Regional JRMs shall be held at least a month prior to the national JRM and reports of the proceedings will form part of the national JRM discussion papers.

Objectives

4. The overall objective of the Regional JRM is to review technical, financial, and institutional progress in the districts within the Regional Referral Hospital catchment on a yearly basis, and agree on the outputs and resources allocated for the upcoming FY.

5. The specific objectives are to;
   - Receive and discuss the District Annual Health Performance Report for the year under review, focusing on achievements against the key sector performance indicator targets and outputs in the annual operational plans.
   - Review expenditures of the previous FY and any additional expenditure information, which will assist in developing the draft budget for the next FY.
   - Review of key management issues (supervision, financial management, supply chain management, etc), including progress with coordination, multi-sectoral collaboration and community involvement and participation in health.
   - Receive and discuss service delivery or similar survey reports, which have been decided upon as monitoring instruments.
   - Make recommendations for improvement of district health services.
   - Recognize and reward good performance.

Timing

6. To link the JRMs to the GoU annual planning and budget cycle, and to make the necessary information available, the JRMs will be held in the month of September when performance data from the previous financial year (FY) will have been analyzed and a report prepared and when budget allocation and financing plan for the upcoming year will be discussed.

Regional JRM Participants

7. The participants in the Regional JRM will include; Members of Parliament, District Chairpersons and Secretary for Health / Social Services Committee, Chief Administrative Officers, representatives of the District Health Teams, representatives of Public and non-public health facility managers, Heads of Departments from the health related sectors e.g. Education, Water, Community Development, HDPswithin the region, CSO groups, Community, and / or cultural leaders

8. Each district will be represented by 8 to 10 participants for purposes of having manageable and effective discussions.

Preparation

9. The Regional Monitoring Teams with support of the MoH will take the lead in organising Regional JRM sessions using the GoU budget for monitoring the HSDP. In addition, resources maybe available from the HDPs.

10. MoH will prepare a concept note containing the details of the review methodology and program and issue invitations to those who will take part in the regional JRM at least one month in advance.

11. The District Health Officers (DHOs) will compile and submit the annual district performance reports to the MoH – Health Information Division by 30th July to enable the Regional Teams compile a regional performance report for discussion at the review.

12. Prior to the Regional JRMs, the DHOs will ensure that the District Health Management Teams and the Health / Social Services Committee;
    - Receive and discuss the District Annual Health Performance Report for the year under review, showing achievements and expenditures of the sector according to key sector performance indicators.
    - Review of key management issues (supervision, financial management, supply chain management, etc), including progress with coordination, multi-sectoral collaboration and community involvement and participation in health.
    - Make recommendations for improvement of district health services.

Activities and process

13. The Regional JRM will take 2 days and most of the discussions during the review will be held in plenary.

14. The Regional JRM secretariat will summarize the proceedings and present them to the participants to agree on the key issues and priorities for the next FY.

15. The key issues and sector priorities will be captured in the Regional JRM report.

16. The Regional JRM reports will be submitted to the MoH Planning Department for synthesis and incorporation in the discussions of the national JRM.

Annex 5c: Terms of Reference for the Technical Review Meeting (TRM)

The TRM is a forum for detailed review of priority technical areas selected at the previous JRM.

Objectives

The overall objective of the TRM is to undertake a detailed review of the priority interventions in the sector on a yearly basis.

The specific objectives are to;

- Review progress in implementation the selected priority interventions and related policies.
- Discuss and agree on reasons for good and poor performance and agree on ways to improve performance of the sector in the next FY.

Timing

The TRM will take place once a year March / April.

TRM Participants

The TRM participants will include MoH, MoLG, representatives of the HDPs, CSOs, private sector, academia, beneficiaries and other stakeholders in respect to the review priorities.

Preparation

The MoH will organize and TRM with support from HDPs.

MoH will prepare a concept note containing the details of the program, provide the require reports well in advance, and issue invitations to those who will take part in the TRM at least two weeks in advance.

Prior to the TRM, the DGHS will ensure that the respective TWGs review and discuss the reports and interventions / policies to be discussed at the TRM.

Activities and process

1. The TRM will take 3 days.
2. The TRM secretariat will summarize the proceedings and present them to the participants to agree on recommendations and next steps.
3. The recommendations and next steps will be presented to SMC, HPAC and Top Management for action.

Annex 6: Governance and Management Structure in Health Sector

The health sector has three oversight structures;

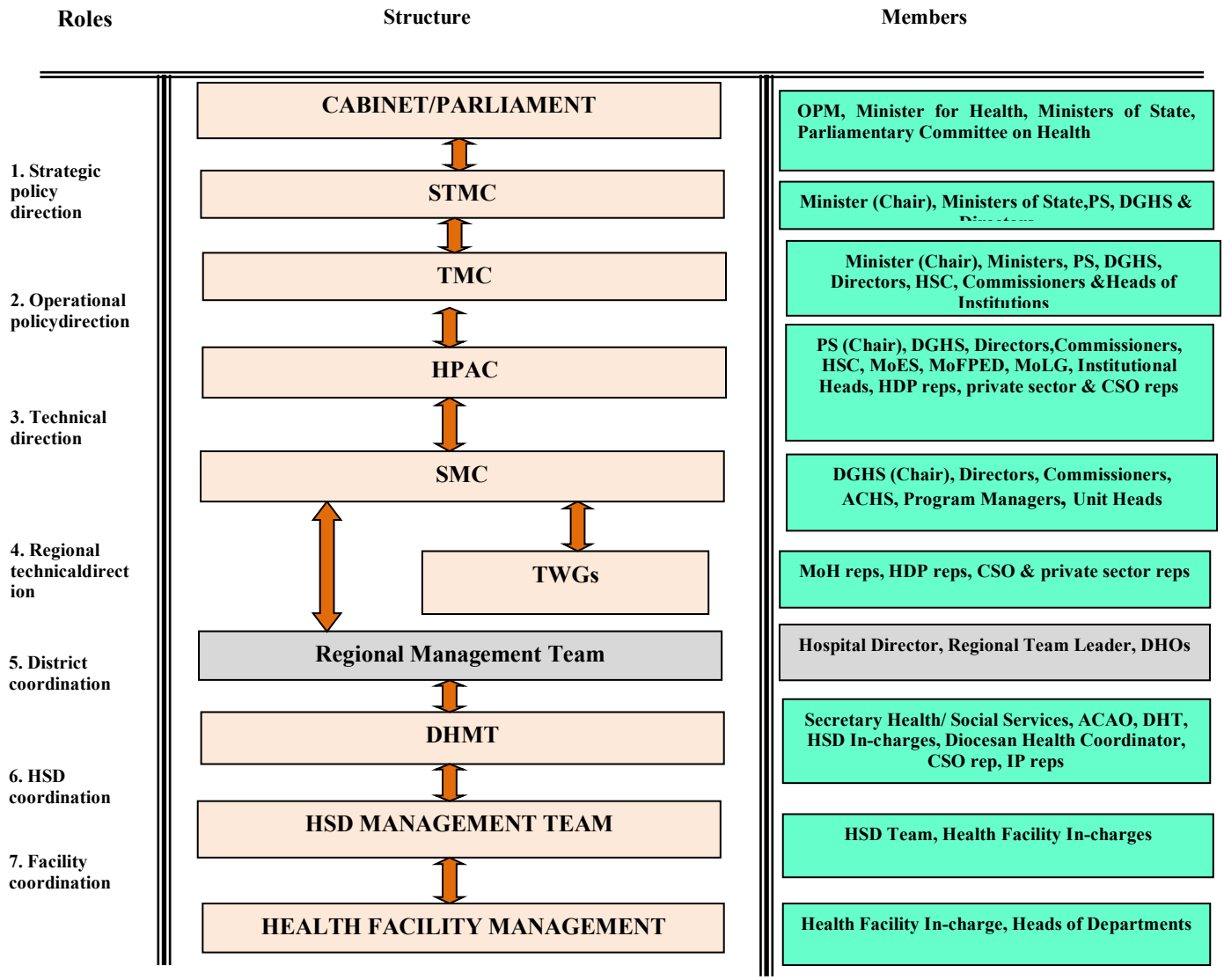
- Governance structure: This looks at defining the sector's strategic direction and following up on the operation of interventions. It is largely defined through formal legislation, with members and functions formally gazetted by the Government.

- Management structure: This guides internal Ministry coordination of implementation of defined interventions and activities at all levels.

- Partnership structure: This guides external coordination of service delivery and sector support by all stakeholders at the respective levels of care. All partners providing services at a given level of care engage with each other through this structure.

The governance and management structures are intended to establish a sector-wide governance mechanism that will foster agreement on other common procedures for consultation and decision–making.

Figure 1: Governance, Management and Partnership Structure



Annex 7: Schedule of Events

No	Item	Qtr 1			Qtr 2			Qtr 3			Qtr 4			Comment
		Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
1	Planning and Budgeting													
1.1	Budget Call Circular and Expenditure Ceilings													For next FY
1.2	JRM Aide Memoire - Identification of priorities													For next FY
1.3	GoU/Partners Health Planning Meeting													For next FY
1.4	Regional Planning Meetings													For next FY
1.5	National Budget Meeting													For next FY
1.6	Sector Budget Framework Paper													For next FY
1.7	National Budget Framework Paper													
1.8	Ministerial Policy Statement													For next FY
1.9	MoH and District Annual Workplans													For next FY
1.10	Parliament Approval of Budget													For next FY
2	Monitoring Programme Implementation and Performance													
2.1	Area Team Visits - Quarterly Reports													
2.2	Technical Review Meeting													
2.3	Technical Working Group meetings													Held monthly, and as necessary
2.4	Annual Health Sector Performance Report													For previous FY
2.5	Joint Review Mission													For previous FY
2.6	National Health Assembly													Held every two years
3	Policy Guidance and monitoring													
3.1	Senior Management Committee													Every third Thurs. of the month
3.2	Health Policy Advisory Committee													Every first Wed.
3.3	Top Management Committee													Every month
3.4	Senior Top Management Committee													Every two weeks
3.5	GFTAM Coordination Committee Meeting													Every quarter

Annex 8: Guidelines on Programme Implementation, Procurement and Financial Management for Public and Private Sector Recipients in the Health Sector

Uganda has a decentralized service delivery system with central ministries retaining the role for policy formulation, standards setting, resource mobilization, and overall sector performance monitoring, while the Local Governments carry out the delivery of services to the population across all sectors. Service delivery is also carried out by implementing partners in the Private not-for Profit Sector, Private Health Practitioners and Civil Society Organizations.

Programme Implementation

a) MOH maintains oversight on actions of implementers within their mandate to ensure attainment of strategic plan objectives
b) All interventions with appropriate costs are reflected in the comprehensive sector annual operational plans that are derived from the HSSIP.
c) The interventions are linked to agreed performance indicators to be achieved by all stakeholders through collective attribution.

Financial Management

a) In line with the Public Finance and Accountability Act (2003), the disbursement of funds is conditional on the receipt of quarterly and cumulative progress reports accompanied by a budget request form. The requests, reports and approval of releases are tracked electronically under the Integrated Financial Management System (IFMS).
b) Accountability statements shall be prepared by implementers and submitted to central government in line with government financial and accounting regulations
c) In accordance with Public Finance and Accountability Act (2003), all health grants shall be audited annually (or as needed) by Auditor General and reports submitted to Parliament.
d) The MoFPED, Directorate of Inspection,MoLG, other line ministries and the Inspector General of Government shall undertake monitoring of financial flows and ensuring value for money for all health grants;
e) Disbursement and accountability for Non Government actors is against an agreed workplan and outputs to be achieved, governed by a signed MoU.
f) Civil society and private sector actors shall ensure transparency, financial and programmatic accountability and demonstrate effective and efficient use of resources.

Procurement

a) Procurement of health and non health products is governed by the PPDA (2003) and its Regulations at the central and local government levels.
b) The procurement and distribution of health and non health products to follow an overall sector Procurement and Supply Management (PSM) plan agreed by stakeholders.
c) Procurement will be undertaken using both government and third party procurement for public actors.
d) The statutory mandate and role of the National Medical Stores in the procurement, storage and distribution of medicines and medical supplies shall be recognized
e) Joint Medical Stores (JMS) shall participate in procurement and supply management in line with the Public Private Partnership principles.

Annex 9: Compliance with National Specifications and Standards for Medicines, Medical Supplies and Medical Equipment

All pharmaceutical products must be registered in Uganda before sale or distribution. This is to ensure quality, safety and efficacy of these products, be they imported or locally manufactured. The MoH provides guidance on selection through reference to standard therapeutic guidelines (e.g. The Uganda Clinical Guidelines), compilation of an essential medicines list, essential medical equipment list, essential medical supplies list and essential laboratory reagents list to guide national procurement and supply agencies. There are standardized specifications, inventories and catalogues designed to meet the requirements of health care providers. The suppliers and users benefit from continuity of supply, which promotes knowledge, familiarity, and ultimately, appropriate utilization of resources. The National Advisory Committee on Medical Equipment (NACME) provides guidelines, selection criteria, and standard specifications by level to ensure compatibility with existing equipment, user requirements, and locally available capacity for maintenance and repair.

Area of interest	Source/Reference	Responsible Agency	Contact
Specific Guidance on essential medicines, health supplies and laboratory reagents.			
Guidance on selection	Uganda Clinical Guidelines 2012 Uganda Essential Medicines and Health Supplies List	Ministry of Health	Director General of Health Services Permanent Secretary
Procurement/supply (government)	Inventory/Catalogues	National Medical Stores	web@nms.go.ug Tel: +256 414 320089
Procurement/supply (PNFP)	Inventory/Catalogues	Joint Medical Store	store@jms.co.ug +256 414 510096 +256 414 510097
Registration, importation, sale/distribution, donation, disposal	Guidelines and regulations	National Drug Authority	ndaug@nda.or.ug Fax +256-414-255758
Specific Guidance on Medical Equipment and Appliances			
Guidance on selection	Medical Equipment Policy and Guidelines	Ministry of Health	NACME Health Infrastructure Division
Procurement/supply	Inventory Catalogues Procurement Act (PPDA Act 2003) and Regulations	Ministry of Health Procurement Authority (PPDA)	Permanent Secretary Health Infrastructure Division MoH Procurement Unit

Annex 10: HSDP 2015/16 - 2019/20 Key Performance Indicators and Targets

Specific Objective	Key Result Area	Indicator	Baseline		Target 2019/20
To contribute to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.	**HEALTH IMPACT**				
	Health impact trends	Maternal Mortality Ratio (per 100,000)	438 (UDHS 2011)	360 (WHS 2014)	320
		Neonatal Mortality Rate (per 1,000)	26 (UDHS 2011)	23 (WHS 2014)	16
		Infant Mortality rate (per 1,000)	54 (UDHS 2011)	45 (WHS 2014)	44
		Under five mortality rate (per 1,000)	90 (UDHS 2011)	69 (WHS 2014)	51
		Total Fertility Rate	6.2 (UDHS 2011)		5.1
		Adolescent Pregnancy Rate	24% (UDHS 2011)		14%
	HEALTH & RELATED SERVICES OUTCOME TARGETS				
	Communicable disease prevention & control	ART Coverage	42% (HMIS 2013/14)		80%
		HIV+ women receiving ARVsfor EMTCT during pregnancy & delivery	72% (HMIS 2013/14)		95%
		TB Case Detection Rate (all forms)	80% (HMIS 2013/14)		95%
		Intermittent Presumptive Treatment (IPT) 3 or more doses coverage for pregnant women	NA		93%
		In patient malaria deaths per 100,000 persons per year	30 (HMIS 2013/14)		5
		Malaria cases per 1,000 persons per year	460 (HMIS 2013/14)		198
		Under-five Vitamin A second dose coverage	26.6% (HMIS 2013/14)		66%
		DPT3Hib3Heb3 coverage	93% (HMIS 2013/14)		97%
		Measles coverage under 1 year	87% (HMIS 2013/14)		95%
	Essential clinical and rehabilitative care	Bed occupancy rate (Hospitals & HC IVs)	59% (HMIS 2013/14)		90
			50% (HMIS 2013/14)		75
		Average length of stay (Hospitals & HC IVs)	Hospital 4 (HMIS 2013/14)		3
			HC IV 3 (HMIS 2013/14)		3
		Contraceptive Prevalence Rate	30% (UDHS 2011)		50%
		Couple years of protection	4,074,673 (HMIS 2013/14)		4.7 M
		ANC 4+ coverage	32.4% (HMIS 2013/14)		45%
		Health Facility deliveries	44.4% (HMIS 2013/14)		64%
		HC IVs offering CEmOC Services	37% (HMIS 2013/14)		60%
	HEALTH SYSTEMS OUTPUT TARGETS				

Specific Objective	Key Result Area	Indicator	Baseline	Target 2019/20
	Health Infrastructure	New OPD utilization rate	1.0 (HMIS 2013/14)	1.5
		Hospital (inpatient) admissions per 100 population	6 (HMIS 2013/14)	10
		Population living within 5km of a health facility	75% (MoH Inventory)	85%
	Medicines and health supplies	Availability of a basket of commodities in the previous quarter (% of facilities that had over 95%)	To be determined	100%
	Improving quality of care	Facility based fresh still births (per 1,000 deliveries)	16 (HMIS 2013/14)	11
		Maternal deaths among 100,000 health facility deliveries	132 (HMIS 2013/14)	115
		Maternal death reviews conducted	33.3% (HMIS 2012/13)	65%
		Under five deaths among 1,000 under 5 admissions	17 (HMIS 2013/14)	16.1
		ART Retention rate	79.7% (HMIS 2013/14)	84%
		TB Treatment Success Rate	80% (2013 Cohort)	90%
	Responsiveness	Client satisfaction index	69% (USSP Survey 2014)	79%
	Human Resources	Approved posts in public facilities filled with qualified personnel	69% (AHSPR 2013/14)	80%
		Number of health workers (doctors, midwives, nurses) per 1,000 population	Doctors 1:24,725 (HSSIP MTR 2013)	1:23,500
			Midwives 1:11,000 (HSSIP MTR 2013)	1:9,500
			Nurses 1:18,000 (HSSIP MTR 2013)	1:17,000
To increase financial risk protection of households against impoverishment due to health expenditures.	Health Financing	Out of pocket health expenditure as a % of Total Health Expenditure	37% (NHA 2011/12)	30%
		General Government allocation for health as % of total government budget	8.7% (AHSPR 2013/14)	15%
To address the key determinants of health through strengthening intersectoral collaboration and partnerships.	Social and economic determinants of health	Children below 5 years who are stunted	33% (UDHS 2011)	29%
		Children below 5 years who are under weight	14% (UDHS 2011)	10%
	Health promotion & environmental health	Latrine coverage	73% (AHSPR 2013/14)	82%
		Villages/ wards with a functional VHT, by district	72% (AHSPR 2013/14)	85%

Annex 11: Monitoring the Compact

No	Indicator	Compliance	Non-compliance	Measurement
1	**Planning and Budgeting**			
1.1	MoH Annual Workplan reflecting stakeholder contribution	Partners' support is captured in the plan	Partners' support is partially / not captured in plan	Comprehensiveness of Annual Workplan
1.2	All new sector investments are appraised by SBWG	Submission of new projects to SBWG	Programming of new projects without SBWG appraisal	Reports from SBWG on appraised Projects submitted to HPAC bi-annually
1.3	Comprehensive procurement plan developed and adhered to	Adherence to procurement plan	Parallel procurements	Quarterly assessment of implementation of procurement plan to HPAC
1.4	Response to Auditor General's report	Timely response to AG's report	non-response to AG report	Response to AG report presented to HPAC
1.5	Implementation of harmonized TA Plan	Adherence to TA plan and guidelines	Unsolicited TA, non-compliance to guidelines for TA	Progress towards implementation of agreed TA Plan
2	**Monitoring Programme Implementation and Performance**			
2.1	Quarterly Area Team Visits	Area Team visits held	Unjustified rescheduling, cancellation of visits	Area Team reports
2.2	MoH Quarterly Performance reviews	Quarterly Performance review	Cancellation of meeting	Quarterly progress reviews held
2.3	Technical Review Meeting	Timely holding of report	Delayed scheduling of TRM	Present of report to HPAC by 30 May
2.4	Technical Working Group meetings	Meetings held as scheduled with record of meeting	Meetings not held / no record of meetings	Target 80% of TWG meetings held and minutes available
2.5	Annual Health Sector Performance Report	Timely compilation of report	Delayed compilation	Submission of Final Report by 30 Sept
2.6	Submission of Annual Report to OPM	Timely reporting to OPM	Delayed/non-reporting	Submission to OPM by 30 September
2.7	Joint Review Mission	Timely holding of JRM	Unjustified rescheduling, cancellation of JRM	Aide Memoire presented to HPAC by 30 Nov
2.8	MTR of HSDP	Timely MTR	Unjustified rescheduling, cancellation of MTR	Completion of MTR of HSDP by May 2018
2.9	End of HSDP Evaluation	Timely end of HSDP evaluation	Unjustified rescheduling, cancellation of evaluation	End evaluation of HSDP reviewed by May 2020
3	**Policy Guidance and monitoring**			
3.1	Senior Management Committee	Regular scheduling of meetings	Cancellation of meeting	Proportion of planned meetings held
3.2	Health Policy Advisory Committee	Regular attendance of members or alternates	Absence without apology	Attendance of at least 3/4 of meetings by all members
3.3	Country Coordination Mechanism	Regular attendance of members or alternates	Absence without apology	Attendance of at least 3/4 of meetings by all members

Annex 12: Guidelines for Code of Conduct for all Parties to the Compact

1. All parties shall ensure that relevant information of the health sector is made available to the Government and other partners.
2. DPs and their representatives shall respect the aspirations, policies and sovereignty of the GoU and the people of Uganda.
3. Meetings, deliberations and communications between GoU and Health Sector Partners and among Partners shall be carried out with mutual respect and in a transparent manner.
4. In accordance with the decentralization policy HDPs, Implementing Partners, UN agencies and line ministries shall only provide support to the districts and urban authorities and will not directly undertake implementation.
5. Development assistance to CSOs shall promote collaboration between CSOs and local authorities, and supplement development efforts.
6. The independent nature of CSOs shall be respected and unnecessary bureaucratic controls in dealing with CSOs shall be avoided.
7. The positive contribution of CSOs shall be recorded and incorporated into central and Local Government planning.
8. Funds and other resources transferred to Local Governments shall become the full responsibility of that Local Government, and shall be managed and accounted for in accordance with the statutory accounting system. Ideally no special or additional accounting system will be necessary, except in cases of occasional external audits as agreed by all parties. This will be followed as far as possible taking into account the legal obligations of the DPs.

Annex 13: Terms of Reference for Panel of Eminent Persons for addressing Non-Compliance to the Compact

Reports to;
Chair HPAC

Composition
Membership of this body will include;

- Chairperson of the HDPs
- Top Management member from MoH
- WHO as lead agency for Health
- A senior representative of the PNFP
- A senior representative of the CSO

Responsibilities

1. Develop the guidelines for reward and sanctions of health sector partners who are signatory to this Compact.

2. Review performance of the health sector partners against their commitments in the Compact on a quarterly basis and submit to HPAC.

3. Submit timely reports of non-compliance for corrective action or alternate planning to mitigate effects.

Annex 14: Key Reference Documents

1. Accra Agenda for Action, 2008
2. Busan Partnership for Effective Development Co-operation, 2011
3. Compact for Implementation of the HSSIP 2010/11 – 2019/20, MoH 2010
4. Guidelines for Governance, Management and Partnership Structures, MoH 2013
5. Global Compact for the International Health Partnerships and related Initiatives, 2009
6. Health Sector Development Plan 2015/16 - 2019/20
7. National Development Plan 2015/16 - 2019/20
8. National Health Policy 2010/11 – 2019/20
9. Paris Declaration on Aid Effectiveness, 2005