

THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

A ROADMAP TOWARDS UNIVERSAL HEALTH COVERAGE IN UGANDA 2020/21 to 2029/30

PRIORITY ACTIONS FOR ORIENTING IMPLEMENTION OF EXISTING POLICIES AND STRATEGIES COHERENTLY IN A MANNER THAT MOVES TOWARDS UHC AND ENSURE LONG-TERM SUCCESS

FEBRUARY 2020

WITH SUPPORT FROM





Table of Contents

| TABLE | OF CONTENTS II |
|---|---|
| TABLE | S III |
| FIGUR | ES III |
| ABBRE | EVIATIONSIV |
| FOREV | NORDV |
| АСКИ | OWLEDGMENTVI |
| EXECU | ITIVE SUMMARY VII |
| 1. INTI | RODUCTION8 |
| 1.1 1.2 1.3 1.4 1.5 1.6 1.7 | THE NON-HEALTH SECTOR DIMENSION FOR UHC 4 THE HEALTH FINANCING DIMENSION FOR UHC 5 POLICY FOUNDATIONS FOR UHC IN UGANDA 7 PROCESS OF DEVELOPING THE UHC ROADMAP 8 THEORETICAL UNDERPINNINGS TO THE UHC ROADMAP 9 |
| 2. STR | ATEGIC ACTIONS FOR UHC ADVANCEMENT11 |
| 2.2 MITI 2.3 INCF 2.4 VAC 2.5 | REASINGLY SPECIALIZED SERVICES 15 STRATEGIC ACTION 4: SUPPORT SYSTEMS IMPROVEMENT IN GOVERNANCE, INFRASTRUCTURE, MEDICINES, SUPPLIES AND CINES, HEALTH WORKFORCE EXPANSION, HEALTH INFORMATION, RESEARCH AND TECHNOLOGY STRATEGIC ACTION 5: DEVELOP THE RIGHT MIX OF FINANCING SOURCES TO INCREASE PUBLIC EXPENDITURES ON HEALTH O SOCIAL PROTECTION PROGRAMS TO EXPAND FINANCIAL RISK PROTECTION FOR THE POPULATION 19 |
| 3. PRIC | ORITY INTERVENTIONS FOR THE UGANDA UHC ROADMAP 2020 – 2030 |
| 4. MO | NITORING AND EVALUATION OF THE UHC ROADMAP54 |
| 5. IMP | PLEMENTATION ARRANGEMENTS60 |
| 5.1 5.2 | |

Tables

| Table 1: Uganda's Current Value of the UHC Index of Coverage of Essential Health Services | 5 |
|---|-----|
| and Values of each of the Tracer Indicators used to calculate the Index | 3 |
| Table 2: Additional Coverage of Essential Health Services' Tracer Indicators | 4 |
| Table 3: Uganda's Current Performance on the Non-Health Sector UHC Tracer Indicators | 5 |
| Table 4: Health budget as proportion of total Government budget | 5 |
| Table 5: Uganda's Current Values of UHC Financial Protection Indicators | 6 |
| Table 6: Outline of ideal contribution of different sectors to the UHC roadmap | .13 |
| Table 7: The UHC Roadmap M&E Framework | .55 |

Figures

| Figure 1: Uganda's summary coverage indicators for SDG 3 – Global Burden of Disease | |
|---|----|
| (WHO 2016) | 3 |
| Figure 2. UHC Cube | |
| Figure 3: Framework for health determinants | 10 |
| Figure 4: UHC Roadmap Performance Framework | 61 |

Abbreviations

| ACS | African Collaborative for Health Financing Solution |
|--------|--|
| AHSPR | Annual Health Sector Performance Report |
| ART | Anti-Retroviral Therapy |
| BoD | Burden of Disease |
| CEmNOC | Comprehensive Emergency Neonatal and Obstetric Care |
| CPR | contraceptive prevalence rate |
| DHIS | District Health Information System |
| GDP | Gross Domestic Product |
| GoU | Government of Uganda |
| HC | Health Centre |
| HMIS | Health Management Information |
| HSDP | Health Sector Development Plan |
| HSS | Health System Strengthening |
| HTA | Health Technology Assessment |
| IP | In-Patient |
| IRS | Indoor Residual Spraying |
| LLIN | Long Lasting Insecticides Net |
| MDAs | Ministries, Departments and Agencies |
| MoFPED | Ministry of Finance Planning and Economic Development |
| МоН | Ministry of Health |
| NCD | Non-Communicable Diseases |
| NDP | National Development Plan |
| NHA | National Health Accounts |
| NHI | National Health Insurance |
| NPA | National Planning Authority |
| OOP | Out of Pocket |
| OPD | Outpatient Department |
| PEC | Presidential Economic Council |
| РНС | Primary Health Care |
| РМТСТ | Prevention of Mother-To-Child Transmission of HIV |
| PNFP | Private Not for Profit |
| RMNCAH | Reproductive Maternal Neonatal Child and Adolescent Health |
| SDG | Sustainable Development Goal |
| ТВ | Tuberculosis |
| UHC | Universal Health Coverage |
| UNMHCP | Uganda National Minimum Health Care Package |
| WASH | Water, Sanitation and Hygiene |
| WHO | World Health Organisation |
| - | · · · · · · · · |

Foreword

The Government of Uganda recognizes that reaching Universal Health Coverage (UHC) is an important goal in its path to get Middle-income country status. Prosperity and wellbeing are of its greatest preoccupations. So, enabling all persons living in Uganda access to comprehensive quality health and related services is the cornerstone to healthy life for the entire society.

We know that UHC contributes to social, economic development, an increase of workforce productivity, and poverty reduction. The UHC roadmap is an action-oriented plan that outlines how existing policies and strategies can be implemented coherently in a manner that moves Uganda towards UHC.

As our country subscribed numerous global commitments for health and the Sustainable Development Goals and its target 3.8 Achieving UHC, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all, Uganda is more than ever mobilized to ensure decisive strides towards UHC.

The major sources of slow progress in the UHC coverage index in Uganda are related to community and household determinants of health. Overall, coverage of the key services to address the social determinants of health is low contributing to the bulk of the 75% preventable burden of disease in Uganda.

The Government of Uganda is fully aware that achieving UHC requires enhanced stewardship of the UHC agenda, the collective effort of public and non-state actors, greater collaboration and better coordination across sectors. The UHC roadmap is the expression of the Government of Uganda to pave the way towards UHC by stating clear strategic actions to deal with health system challenges that preclude people living in Uganda to enjoy the highest possible health outcomes.

Because UHC expresses a certain societal vision, successful roadmap implementation is only possible with greater engagement of citizens, the private sector, local governments, donors, etc. These stakeholders will work together in a more effective and coordinated way to perform activities under their responsibility by approaching them with a systemic view to produce sustained outcomes for the population.

For God and my country

Hon. Dr. Jane Aceng Ocero

MINISTER OF HEALTH

Acknowledgment

The Ministry of Health would like to express its appreciation to all key stakeholders who supported the process of developing the UHC Roadmap for Uganda through technical and financial support. The development process was consultative covering a wide range of stakeholders including the Health Policy Advisory Committee, Health Sector Budget Working Group, private and public sector representatives during different fora.

I would like to recognize the contribution made by the National Planning Authority through its policy recommendations in the UHC Paper to the Presidential Economic Council which included the development of this UHC Roadmap. I would also like to appreciate the invaluable contribution of the Multi-Sectoral UHC Roadmap Development Committee and the Core Committee under the Chairmanship of Commissioner Planning, Financing and Policy, which did a commendable job in reviewing and aligning the roadmap to the national, regional and global health agenda.

The funding for the development of the roadmap was generously supported by the World Bank Country Office and USAID and this is highly appreciated.

Thank You all



Dr. Henry G. Mwebesa
DIRECTOR GENERAL HEALTH SERVICES

Executive Summary

Uganda has made major progress over the last two decades to move towards Universal Health Coverage (UHC). Significant reform efforts include establishing a well-defined essential package of health services, improving the financing of healthcare by introducing free health services in public hospitals, providing grants to private non-profit health providers to enable them to lower the costs of services, and developing policies to address some of the pressing healthcare needs in the country.

Among other gains, this has led to a reduction in infant and maternal mortality, reduction in HIV prevalence rates, and a reduced burden of malaria. Because of this, Ugandans today are expected to live longer, with life expectancy increasing from 46 years in 2000 to today's 63.3 years (62.3 and 64.3 years for women and men respectively). Population growth has also considerably increased, with about 1.4 million people requiring health services annually, putting pressure on existing health services.

However, this population growth has not been matched with expansion and investments in the health system, which still faces several challenges that hinder the country from addressing the rapidly expanding health needs. These challenges include poor quality of health services, low hospital coverage, inadequate infrastructure in rural areas, and about 30-60 percent shortage of health workers and medicines. While Uganda also has a well-defined essential health services package, health is still greatly under-funded, with government funding 15% of the total health expenditure, leading to high out-of-pocket expenditures by households (about 41% of total health expenditure), and reliance on unstable external aid (of about 42% in 2016). There are also capacity gaps in the decentralized system for service delivery, poor coordination with other sectors, and low accountability at the community and local government level.

The Government of Uganda (GoU) is committed to addressing these challenges by ensuring all citizens have access to quality and affordable health services by enacting policies and strategies that facilitate the achievement of UHC and has affirmed its intention to work across sectors to do so. These include the removal of user fees to improve access to health services, developing a Health Financing Strategy which details how to mobilize and direct investments and identifying opportunities for efficiency gains in the health sector.

This roadmap will guide the strategic direction of the GoU in its pursuit towards UHC and give a clear picture of the major steps, resources and capacity required to enable better planning to realize the related UHC policy aspirations. This will call for strategic shifts in policy and programming to ensure that communities, government and its partners across sectors focus on programs with the highest potential to improve outcomes in population health and well-being in the short term while building vital capabilities for the health and related systems to deliver on UHC targets in the medium to long-term. The UHC roadmap identifies measurable benchmarks, clear roles of the key stakeholders, and sets the course for sustainable progress for moving towards UHC aspirations.

Six strategic actions are identified to support the rapid realization of UHC in Uganda. These are:

- 1. Expand community-level health promotion and prevention programs to ensure equity, inclusion and responsiveness to the needs of all citizens, including excluded or disadvantaged groups working with communities, civil society, private sector and Local Governments (LGs) to design, operationalize.
- 2. Develop and operationalize workable integrated multi-sectoral government-wide programs to address health determinants at the community and Government level. Governance and coordinated strategic actions in other sectors to address health determinants such as sanitation, food security, education, safe transport and housing can improve the coherence of health programs across both public and private sectors.

- 3. Improve the quality, availability and breadth of essential, and increasingly specialized health care services by taking both demand and supply-side views. On the supply side, improving technologies and health inputs, while on the demand side, meaningfully including the perspectives of patients and their communities to support accountability, performance management, and other feedback mechanisms including workforce production and performance management systems that incorporate the perspectives of patients.
- 4. Support systems improvement in governance, infrastructure, medicines, health supplies and vaccines, health workforce expansion and health information, research and innovation.
- 5. Determine the right mix of financing sources around which to structure a universal coverage scheme that focuses on both increased allocation of public resources to health and social protection programs and expanding financial risk protection for the population.
- 6. Strengthening the decentralized delivery of health services needs a higher priority in resourcing and capacity development.

1. Introduction

Uganda like several other countries in the world has committed to achieving Universal Health Coverage (UHC) by 2030, as indicated in the Sustainable Development Goals (SDGs). SDG goal 3 targets 3.8. spells out the need to achieve UHC, including protection from financial risk, access to quality health services, and quality and affordable essential medicines and vaccines for all. For Uganda, the UHC goal aligns with Vision 2040, the National Health Policy (NHP), the Health Sector Development Plan (HSDP) 2015 - 2020 and other policy commitments that the government has developed to address the challenges in Uganda's health system.

The Ministry of Health (MoH) in Uganda has adopted the UHC definition that extends beyond the provision of health services – to include the contribution of other interventions that address the determinants of health and wellbeing. The Ugandan definition is "all persons in Uganda have equitable access to comprehensive quality health and related services without financial constraints – all delivered through a multi-sectoral approach". This definition is strong in realizing the competencies, asserts and mandates that need to bear on the UHC agenda but outside of the realm of the health sector governance and mandates.

Uganda's movement towards UHC must recognize its current disease burden and other health system challenges. The leading causes of death in Uganda are HIV/AIDS and Sexually Transmitted Infections at 13.2%, respiratory infections and Tuberculosis (TB) at 12.6%, maternal and neonatal disorders at 12.1%, malaria and cardiovascular diseases at each at 9.8%¹. Preventable health issues also continue to rise and make up over 75% of the disease burden in Uganda. For example, diarrhoea contributed to 69% of childhood illnesses in 2016. Additionally, Non-Communicable Diseases (NCDs) such as cancer, heart disease and diabetes now also make up 40% of the disease burden, contributing to a dual burden of disease. These are often linked to other multisectoral issues related to the determinants of health, calling for efforts from beyond the health sector to ensure the welfare of the population and the realization of the goal of UHC.

1.1 The Health Services Dimension for UHC

Uganda's health system faces several challenges that limit the country from addressing rapidly expanding health needs. These range from poor quality of health services to inadequate health workers, medicines and infrastructure in rural areas. Despite these challenges, Uganda's health

¹ Global Burden of Disease Report 2017

system has made major progress over the last few decades, leading to the reduction in the Maternal Mortality Ratio (MMR), which currently stand at 336 per 100,000 live births², with 87% vaccination completion rates; the reduction in HIV prevalence which stands at 6.2% (4.7% and 7.6% among male and female respectively)³, with 86% Anti-retroviral Therapy (ART) coverage; and a reduction in the burden of malaria which stands at 17%⁴ in children under five years tested by rapid diagnostic test.

Currently, all the districts in Uganda have a hospital or a level IV primary care facility, with up to 86% of the population living within a 5km access to a health facility providing basic health services. Government's efforts to provide health services are also being supplemented by the private sector, which delivers about 50% of hospital health services and 35% of services at the primary care level. While a majority of the private or-profit health facilities are located in urban areas⁵, private not-for-profit (PNFP) providers do serve rural populations throughout Uganda⁶.

Despite these advancements, there has also been an increase in the population in Uganda, placing further pressure on existing health services: every year, an additional 1.2 - 1.4 million people need to be served by the health system. This population growth has not been matched with expansion and investments in the health system, which still faces several challenges.

The Global Burden of Disease (BOD) study by the WHO and the Health Matrices and Evaluation provide the latest estimates of UHC-related goals (SDG Goal 3) with a more comprehensive set of 33 health-related indicators. From this tracking of UHC progress, Uganda at 31% SDG index and 173rd out of 188 countries assessed (Lancet 2017)⁷.

² Uganda Demographic Health Survey 2016

³ WHO 2017 (https://www.afro.who.int/sites/default/files/2017-08/UPHIA%20Uganda%20factsheet.pdf)

⁴ Malaria Indicator Survey 2019

⁵ NPA (2018)

⁶ Uganda Private Sector Assessment In Health, November 2017

⁷ GBD 2015 SDG Collaborators 2016; 388: 1813-50

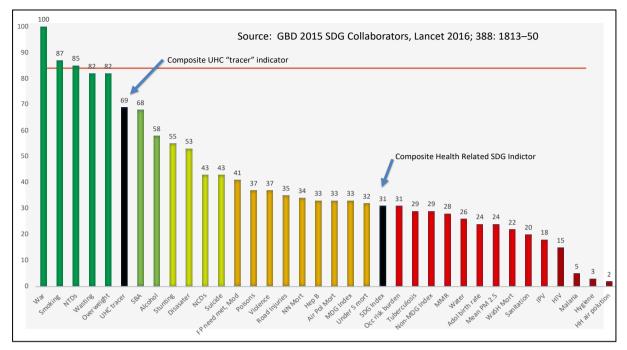


Figure 1: Uganda's summary coverage indicators for SDG 3 – Global Burden of Disease (WHO 2016)

For a limited set of indicators restricted to the UHC, Uganda's performance was estimated at 69% as per figure 1 above. The limited set of indicators is closely matched to the priority interventions in the essential health care package. These include: 1) met need with modern contraception; 2) antenatal care (one or more visits and four or more visits); 3) skilled birth attendance coverage; 4) in-facility delivery rates; 5) vaccination coverage (three doses of diphtheria–pertussis–tetanus, measles vaccine, and three doses of oral polio vaccine or inactivated polio vaccine); 6) TB case detection rate; 7) coverage of ART for populations living with HIV, and 8) coverage of Long Lasting Insecticides Nets (LLINs) for malaria-endemic countries. This fairly high coverage for these indicators is proof that Uganda has made progress on the core elements in the essential health care package.

Table 1 summarizes Uganda's performance on the 16 tracer UHC indicators for access to essential health services. Overall, Uganda's index is 44%, with the highest coverage being a percentage of tobacco non-smoking population at 90% and the lowest being physicians per 1,000 population at 0.1 and psychiatrists per 100,000 population at less than 0.05.

Table 1: Uganda's Current Value of the UHC Index of Coverage of Essential Health Services and Valuesof each of the Tracer Indicators used to calculate the Index

| Tracer Indicators | UHC Index Score | Ideal score |
|--|--------------------|-------------|
| SDG-UHC indicator 3.8.1: Service coverage index, 2015 | 44 | >90 |
| Family planning demand satisfied with modern methods (%) | 46 | >90 |
| Antenatal care, 4+ visits (%) | 48 | >90 |
| Child immunization (DTP3) (%) | 78 | >90 |
| Care-seeking behaviour for child pneumonia (%) | 79 | >90 |
| Tuberculosis effective treatment (%) | 40 | >90 |
| HIV treatment (%) | 60 | >90 |
| Insecticide - treated nets for malaria prevention (%) | 66 | >90 |
| Surgeons per 100 000 population | 0.6 | 1 |

| Tracer Indicators | UHC Index Score | Ideal score |
|--|--------------------|-------------|
| At least basic sanitation (%) | 19 | >90 |
| Normal blood pressure (%) | 73 | >90 |
| Mean fasting plasma glucose (mmol/L) | 5.22 | <5.6 |
| Tobacco non-smoking (%) | 90 | >90 |
| Hospital beds per 10,000 population | 5 | 30 |
| Physicians per 1,000 population | 0.1 | 2.3 |
| Psychiatrists per 100,000 population | <0.05 | 0.1 |
| International Health Regulations core capacity index (%) Country | 73 | >90 |

Source: WHO & WB, 2017

Table 2: Additional Coverage of Essential Health Services' Tracer Indicators

| Additional Country Tracer Indicators | UHC Index Score | Ideal score |
|---|--------------------|-------------|
| Births attended by skilled a health provider (%) | 74 | >90 |
| Deliveries in health facilities (%) | 73 | >90 |
| Ratio of maternal deaths in health facilities /100,000 | 148 | <41 |
| The proportion of health facilities without drug stock-outs for 41 tracer medicines | 85 | 100 |
| Under five facility based deaths /1,000 | 18 | <6 |
| Malaria incidence cases | 12,224,100 | 650,000 |
| Diabetic rate (%) | 3.4 | 0.4 |
| Hypertension rate (%) | 25 | 19 |
| Cardiovascular proportional mortality rate (%) | 9 | <5 |
| Annual cancer incident cases | 80,000 | <50,000 |
| Cancer proportional mortality rate (%) | 5 | <3 |
| Approved posts in public facilities filled with qualified personnel (doctors, nurses and midwives) (%) | 75 | 100 |
| Alcohol use (%) | 5.8 | 1.3 |
| Population accessing health insurance (%) | 1 | 46 |

Source: UDHS, 2016; MoH AHSPR, 2018/19; UCI SP, UHI SP

1.2 The Non-Health Sector Dimension for UHC

The BOD study indicates that the major sources of slow progress in the UHC coverage index are related to community and household determinants of health. Key of the services to address the social determinants of health are; safe water, sanitation and hygiene, clean energy, road safety, good nutrition for all age groups, housing conditions, environmental health, alcohol and drug consumption, and physical activity services which are largely carried out by other sectors. Overall, coverage of these services is low contributing to the bulk of the 75% preventable burden of disease in Uganda. For instance, diarrheal diseases contribute to 69% of childhood illnesses, child stunting is at 29%, malaria prevalence is 19%, accidents/injuries at 13%. Sanitation coverage is low - improved toilet coverage (19%), unimproved (55%), shared toilet (20%), and lack toilet (7%). Hand washing with soap and water is only 34%, under-nutrition is high especially among children and women of reproductive age, poor housing conditions leading to respiratory diseases is high. Ninety-five percent of the households in Uganda use a solid type of fuel for cooking, with wood being predominant (69%); 25% of households use charcoal.

The disease burden is multi-sectoral, but the current response is mainly in the health sector. Table 3 summarizes Uganda's performance on the non-health sector UHC tracer indicators.

| Tracer Indicators | UHC Index Score | Ideal score |
|--|-----------------|-------------|
| Improved source of drinking water (%) | 78 | >90 |
| Households appropriately treating water (%) | 52 | >90 |
| Improved toilet coverage (%) | 19 | >90 |
| Hand washing with soap and water (%) | 34 | >90 |
| Use of clean energy (access to electricity) (%) | 29 | >90 |
| Use a solid type of fuel for cooking (%) | 95 | <10 |
| Annual Number of deaths and injuries due to road traffic accidents | 2,348 | <100 |
| (per 100,000 population) | | |
| Child stunting (%) | 29 | <5 |
| Child Wasting rate (%) | 4 | 0 |
| Child underweight rate (%) | 10 | 1 |
| Anaemia Prevalence in Children (%) | 53 | <5 |
| Anaemia Prevalence in Adults (women/men) (%) | W = 32 / M = 16 | <5 |
| Vitamin A Deficiency in Children (%) | 9 | <1 |
| Undernourishment (population) (%) | 40 | <5 |
| Housing floors made of cement screed (%) | 52 | >90 |
| Alcohol abuse | 5.8 | <1 |

Table 3: Uganda's Current Performance on the Non-Health Sector UHC Tracer Indicators

Source: WHO & WB, 2017

1.3 The Health Financing Dimension for UHC

The government's contribution to health financing is through general tax revenues. The level of funding generally remains low for scaling up UHC. While the total Government budget has grown over the years, growth in the health sector budget has not been commensurable. The allocation as a percentage of the total Government budget has steadily dropped from 8.9% in 2010/2011 to 6.7% in 2017/18 and slightly increasing to 7.2% in 2018/19 (see table 4). This is much lower than the Abuja Declaration target of 15% for African Governments. This decline has taken place amidst rising health care demands, high costs due to rapid population growth, the ever-rising disease burden and a rapid epidemiological transition from communicable to NCDs.

| Table 4: Health budget as a proportion of | f total Government budget |
|---|---------------------------|
|---|---------------------------|

| Year | Health Sector Allocation | | Total Governme | Share of Health | |
|---------|--------------------------|------------|----------------|-----------------|------------------------|
| | Amount (Bns) | Growth (%) | Amount (Bns) | Growth (%) | in total Budget (%) |
| 2010/11 | 660 | | 7,377 | | 8.9 |
| 2011/12 | 799 | 21% | 9,630 | 31% | 8.3 |
| 2012/13 | 829 | 4% | 10,711 | 11% | 7.7 |
| 2013/14 | 1,128 | 36% | 13,065 | 22% | 8.6 |
| 2014/15 | 1,281 | 14% | 14,986 | 15% | 8.5 |
| 2015/16 | 1,271 | -1% | 18,311 | 22% | 6.9 |
| 2016/17 | 1,828 | 44% | 20,431 | 12% | 8.9% |
| 2017/18 | 1,950 | 6.7% | 29,000 | 42% | 6.7% |
| 2018/19 | 2,373 | 18% | 32,700 | 13% | 7.2% |

Source: MoH AHSPR, 2018/19

While Uganda has a wide and expansive essential package of health services, government financing is lagging. The essential health care package is still funded mostly by donors (42%) and out-of-pocket (OOP) payments (41%) creating issues for both sustainability and equity. World Health Organization (WHO) also provides a government spending benchmark for low-income countries like Uganda of an estimated \$34 per capita as the minimum for a generic essential package, although GoU spends approximately \$11 - 15 per capita, implying a major gap in domestic financing of health programs. Major large-scale priorities like childhood vaccination, HIV/AIDS, malaria and TB have also been supported for the most part by international donors, which is not sustainable, especially with the dwindling of donor aid to several recipient countries. Indeed, per capita, net development assistance to Uganda sharply decreased from \$54 to \$between 2008 and 2015, before slightly picking up to reach \$in 2017⁸.

Table 5 indicates Uganda's aggregate performance on the UHC financial protection target, as measured by WHO and the WB (2017). The proportion of the population with large household expenditure on health as a share of total household expenditure or income remains high. At 10% of household total consumption or income, the incidence of catastrophic expenditure is at 12% and 2.57% at 25% of household total consumption or income. Consequently, the incidence of impoverishment due to OOP health spending at a poverty line of US\$1.90-a-day in 2011 was 2.68%.

| SDG-UHC indicator 3.8.2, most recently available estimate (year) | dicator 3.8.2,latest year: incidence of catastrophic expenditureimpoverishment due to out- of-pocket health spending (%) | | Poverty gap due to out- of-pocket health spending expressed in cents of international dollars at 2011 PPP factors | | | |
|--|---|---|---|--|---|--|
| | At 10% of household total consumption or income | At 25% of household total consumption or income | Poverty line: at 2011 PPP \$1.90-a-day | Poverty line: at 2011 PPP \$3.10- a-day | Poverty line: at 2011 PPP \$1.90-a- day | Poverty line: at 2011 PPP \$3.10-a-day |
| 2002 | 12.01% | 2.57% | 2.68 | 1.48 | 3.39 | 5.71 |

Table 5: Uganda's Current Values of UHC Financial Protection Indicators

Source: WHO &WB, 2017.

In addition, the Total Health Expenditure (THE) as a percentage of GDP is only 1.3% against the target of 4%. These statistics reveal that Uganda still lags in realizing the UHC financing targets, thus calling for health financing reforms while considering the limited fiscal space.

The public health funding gap has undermined the intention of public health facilities as safety nets for the poor. This is reflected in the high OOP spending, which exacerbates inequities in access to quality healthcare. It has resulted in a chronic shortage of EMHS, low worker availability and poor organizational efficacy.

The high OOP expenditure for Uganda is also explained by the rapid growth of private health providers. To date, about 50% of health services are delivered by the private sector. While the sector plays an important role in supplementing Government efforts in health service provision, the costs of services are highly constraining access by those who cannot afford them. While

⁸ World Bank (<u>https://data.worldbank.org/indicator/DT.ODA.ODAT.PC.ZS?locations=UG&start=2008</u>)

Government provides subsidies to PNFP health service providers to reduce costs of care to the served population, it's insufficient to cause a significant impact. Likewise, private insurance companies have been established to serve but a few corporate sector employees.

1.4 Policy foundations for UHC in Uganda

A number of reforms have been instituted across sectors to help advance Uganda towards UHC. Past health financing reforms included introducing free services in public hospitals in 2001 and providing a Primary Health Care (PHC) grant to PNFP health providers in 1997 in order to lower the fees paid by their clients. The government plans to introduce a National Health Insurance Scheme (NHIS) as a mechanism for financing health care in Uganda, to facilitate the provision of efficient, equitable, accessible, affordable, and quality health care to all residents⁹. Additionally, a set of other formative policies and strategies can support a foundation for coordinated and multisectoral movement towards UHC. These include the National Vision 2040; the second National Development Plan (NDP II) and the upcoming NDP III, which is under development, the HSDP, and the Presidential Economic Policy Paper (PEC) on UHC.

According to the National Vision 2040, Uganda aspires to have a transformed society from peasantry to a modern and prosperous country within 30 years. This entails economic growth to a level of the middle-income country with an average Gross Domestic Product (GDP) per capita of \$1,040 by 2040 from the estimated current \$717 GDP (2018). The annual GDP growth has ranged from 4.5 to 6.4% growth per annum. Vision 2040 recognizes that increasing the coverage for preventive and promotive services, investing in curative services, and empowering communities to take charge of their health would support the health and productivity of Ugandans. It has provided the main strategic shifts to improve the health and productivity of Ugandans, including acceleration of coverage for preventive and promotive services and interventions. In line with a long history of investments in curative services, Vision 2040 also recognized the shift to communities are in this respect expected to mobilize their efforts and assets to contribute to health-promoting behaviors such as hygiene, sanitation, and positive lifestyle that mitigate tobacco smoking, domestic violence, alcohol, hand-washing and similar behaviors.

The NDP II focuses on empowering communities to take charge of their health, increased publicprivate partnerships in health service delivery, and multisectoral collaboration across Ministries Departments and Agencies (MDAs) towards a common vision of a healthy Uganda, while the third draft NDP emphasizes the importance of social safety nets such as National Health Insurance, harnessing the demographic dividend, and improving quality and governance in the health and other sectors, amongst other priorities. The NDP II also envisions a structural change to improve the quality of services provided to the population and paradigm shifts from 1) facility-based to community-based delivery systems that empower communities to take control of their health especially through health promotion and prevention actions, 2) dominantly public provision to public-private cooperation in service delivery; and 3) from siloed sector plans to more collaboration among relevant MDAs for collective action goals¹⁰.

The HSDP 2015 – 2020 discusses investment in health governance and partnerships, making the essential package flexible to adapt to the changing health contexts and needs, having dedicated

⁹ National Health Insurance Bill May 2019

¹⁰ NPA, Vision 2040 (2010)

budgets for disease conditions with the highest increase in burden, sustained political commitment to UHC, and investments in health infrastructure as a set of essential actions. Additionally, the HSDP emphasizes the mobilization of multi-sectoral support for health involving all different stakeholders, with a focus on areas like food security, nutrition, safe water, sanitation and health literacy. The government acknowledges the vital role that the private sector plays in the health system, which goes beyond direct health service provision to include the supply of medicines and medical equipment, manufacturing, information systems, as well as training of the workforce. The vision for the health sector is to contribute to a healthy and productive population, economic growth and national development. The sector goal is directly related to UHC-accelerating movement toward UHC with essential health and related services needed for the promotion of a healthy and productive life¹¹.

Finally, the PEC paper on UHC defines UHC as a process through which households are empowered to equitably create health and access a full range of quality health services (Health promotion, prevention, treatment, rehabilitative and palliative care) without financial hardships. UHC is also portrayed as a system built on a multi-sectoral approach with crosscutting sub-programs along with the identified determinants of health¹². The MoH has adopted the UHC definition that extends beyond the provision of medical services – to include the contribution of other interventions that address the determinants of health and wellbeing. The Ugandan definition is *"all persons in Uganda have equitable access to comprehensive quality health and related services without financial constraints – all delivered through a multi-sectoral approach"*. This definition is strong in realizing the competencies, asserts and mandates that need to bear on the UHC agenda but outside of the realm of the health sector governance and mandates.

1.5 Process of developing the UHC Roadmap

Uganda has developed policies and strategies to guide the country through the process of moving towards UHC. Beyond this, the government has begun to set a pathway aimed at meeting its UHC commitments, including a research agenda for UHC, conducting a UHC situation analysis, and developing a PEC paper to guide the implementation of UHC.

As a next step, the Uganda MoH, with support from USAID through the African Collaborative for Health Financing Solution (ACS), the World Bank, and WHO commissioned 2 Consultants to develop a UHC roadmap that would guide the implementation of UHC-related policies and strategies in Uganda coherently in a manner that moves towards UHC and ensure long term success.

The roadmap development process was steered by a Core Committee with membership from MoH, USAID, WHO and the World Bank, and a Multi-sectoral Committee. The Core Committee was charged with oversight of the roadmap development process, while input from the Multi-sectoral Committee ensured that multisectoral actions and perspectives were included in the roadmap. The Multi-sectoral Committee membership constituted local, regional and global experts, including those from the civil society, private sector and academia. This process was participatory, consultative and collaborative, and was informed by the context analysis for UHC

¹¹ MoH, Health Sector Development Plan 2015 - 20

¹² NPA, (2018) Towards Universal Health Coverage in Uganda: Building on Successes and Ensuring Health Systems Resilience, Draft PEC Paper, National Planning Authority, Government of Uganda

developments in Uganda and globally.¹³ The 2 Consultants conducted a situational analysis, reviewed relevant global and national literature including information from existing health surveys, the HSDP 2015 – 2020 mid-term evaluation report, and other sector policy documents across the MDAs in Uganda, to understand their roles and readiness to contribute to achieving UHC and gather insights on best practices from regional and global levels.

The document review process was supplemented by group interviews and stakeholder workshops within the framework of the Multi-sectoral Committee on the UHC Roadmap and targeted key informant interviews of experts in the health and other sectors to explore and validate the information and increasing buy-in especially for the innovations necessary to work across sectors for UHC roadmap. Through the UHC Roadmap Core Committee, multisectoral workshops were organized and facilitated to deliberate on the UHC roadmap, using as inputs synthesized versions of the roadmap scenarios.

The scenario analysis used aimed to provide for the starting points and optional intermediate paths to UHC in Uganda. It also aimed to provide stakeholders the opportunity to make informed choices of the pathway and examine the major uncertainties and implications for the different pathways to UHC. The main strategic actions trade-offs for the consideration of the roadmap arise from which public policy goals to optimize at the start of the roadmap and which ones to address later, given the fiscal space projections, system capacity and uncertain factors. Four main questions arise for the strategic action choices:

- 1. As coverage expands, how is financial risk protection getting adjusted to optimize health status improvements?
- 2. Given the financial constraints, which service packages should be prioritized in the early phase and which ones to add in the medium term as the fiscal space improves?
- 3. Before universal coverage is attained, how can vulnerable and poor groups be identified to benefit early in the roadmap?
- 4. How can complementary sectors become more deliberate in their investments in actions that improve the underlying determinants of health?

1.6 Theoretical underpinnings to the UHC roadmap

The conceptualization of this roadmap was guided by three main frameworks, the WHO dimensions of UHC, the determinants of health, and the key variables from the political economy framework.

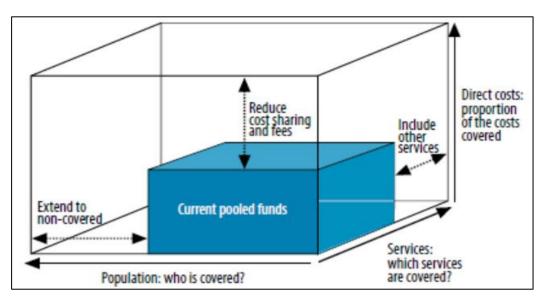
1. WHO UHC Dimensions and Health Systems Strengthening

For the analysis of the health sector, the three UHC dimensions framework for UHC was used (see figure 2)¹⁴ mostly to assess the thematic dimensions of a) Mitigating the financial burden of paying for health by the government, communities and individuals; b) expanding the service package of good quality in accordance to major healthcare needs of the population and c) expanding coverage of eligible populations with the service packages fairly and equitably. These dimensions were complemented with thinking on health system strengthening (HSS) to ensure resilience and development of the health system as the coverage of interventions is expanded.

¹³ Ssengooba et al (2018) Universal health coverage in Uganda, Looking Back and Forward to Speed Up the Progress, Makerere University, Kampala, Uganda.

¹⁴ WHO (2015) Health financing for universal coverage: Universal coverage- three dimensions. [August 8, 2015].].]. <u>http://www.who.int/health_financing/strategy/dimensions/en</u>.





2. Determinants of Health

The determinants of the health framework were used to broaden the scope for synergic actions across sectors to improve health and wellbeing. As illustrated below (see figure 3),¹⁵ the framework has the population and various biological factors at its center, which are then moderated by personal choices, lifestyle, social and community interactions/networks. Other factors include food production, nutrition, education and working conditions, living conditions, economic engagements, water, sanitation and housing. Current and future capabilities and investments in these areas will also form an addition set of key actions in the UHC roadmap.



Figure 3: Framework for health determinants

¹⁵ Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.

3. Political economy

Given the centrality of governance factors especially in situations demanding greater coordination of a multitude of stakeholders, a political economy lens was used to identify interests, organizations, groups and agendas at global, national and subnational levels that have the power to influence the UHC development in Uganda. This lens also enabled us to examine potential institutional arrangements and entry points for the UHC roadmap.

1.7 Objectives of the UHC roadmap

1.7.1 Main Objective

The main objective of the UHC roadmap is to define a critical path by providing **clarity on the strategic actions and sequencing** for the main interventions and **milestones** to the attainment of UHC in Uganda by 2030.

1.7.2 Specific Objectives

The specific objectives are;

- 1. To ensure alignment of UHC aspirations with **global and regional best practices on UHC** as well as Uganda's Vision 2040 and its priorities.
- 2. To highlight measures and mechanisms to secure political commitment at the **highest level** to enable the success of the UHC agenda.
- 3. To clearly define the key investments both within and beyond the health sector to influence other determinants of health outside of (SDG) 3.
- 4. To define **conditions** that can lead to the necessary change, political will and commitment from a multi-sectoral perspective.

2. Strategic Actions for UHC advancement

No country has achieved UHC overnight, movement towards this laudable goal will take time, coordination and planning between multiple parties. To meet the objectives outlined above, the priority for the UHC roadmap is to determine a clear set of strategic actions that can help guide movement towards UHC in Uganda. In order to do so, six strategic actions have been outlined in this section highlighting the considerations and opportunities for successful implementation.

2.1 Strategic Action 1: Expand community-level health promotion and prevention (cHPP) programs

Health promotion programs will be emphasized as a way to mitigate behaviors, attitudes and environmental factors that affect the health status of communities. Reversible individual-related factors associated with poor health will be targeted. Uganda is also home to over one million refugees who require basic services but are poorly integrated into communities and without proper planning, can deplete the system. Investing in impactful community levels strategies such as access to safe water, sanitation and environmental hygiene, reduction in teenage pregnancy and promoting child spacing. Other programs will include improved nutrition, mitigation of domestic violence and reduction of road injuries and Non-communicable diseases (NCDs) by promotion of healthy lifestyle while prioritizing coverage of interventions like contraception, vaccination, control of malaria, TB and HIV of the next 5-10 years. Community-level health promotion can lower the financial burden on the system while contributing to the health and social protection goals.

These priority cHPP interventions offer great opportunities in the early phases of the UHC roadmap. Indeed, community-based programs offer the opportunity for the greatest impact and hold significant job opportunities especially for the under-employed youth across the country. Supportive programs, grants, contracts and training are vital to stimulate community-level self-help and non-government actions for health promotion programs.

Strides towards UHC in Uganda will be possible if systematic interventions are implemented to mitigate the individuals' behaviors leading to ill-health. The ultimate goal of cHPP interventions is to reduce negative practices contributing to non-healthy living styles in Ugandan households. Both the private sector and communities can be engaged to further this goal. cHPP interventions will be approached with deep community participation and engagement in order that they can be contextualized to both needs and the social economic and cultural setting. Efforts will be made to mobilize communities and associations representatives, religious and traditional leaders, and community health workers and volunteers, and to include their perspective in a way that includes and feeds back to broader communities. For the private sector, investments and innovations in programs around health promotion, safety and regulation, and public awareness will be explored.

1.7.3 Considerations for Successful Expansion of the cHHP Program

- 1. **Ownership and Participation** effective community programs should inculcate a sense of personal responsibility to one's health through individual and communal practices. Programs should apply a community perspective in designing actions to be implemented taking into consideration local capacities and resources.
- 2. Input and Feedback Mechanisms effective programs embed mechanisms to ensure priority health needs are taken into consideration and provide feedback to the community level on how needs beyond personal and community actions are being addressed.
- 3. Effective Accountability Mechanisms both lateral accountability (communities / and members holding each other accountable for voluntary actions) and vertical accountability to local/national government commitments to improving health outcomes.

1.7.4 Opportunities for Expanding the cHHP Program

The main opportunities offered by this component of the UHC roadmap include:

- 1. Comparatively low-cost and potentially higher return on investment through reducing unnecessary ill-health, loss of productivity and greater financial burden through treatment.
- 2. Community-level health promotion and prevention are recognized both as a key driver to UHC and the core pillar of PHC. Further Uganda's national vision 2040 has provided acceleration of coverage for cHPP as a key strategic shift required to improve the health and productivity of Ugandans.

2.2 Strategic Action 2: Develop and operationalize integrated multisectoral government-wide programs to mitigate health determinants

There are many effective actions on social determinants of health that lie outside of the formal health sector and its mandates. One approach to integrating the multi-sectoral lens at the policy level has been through the Health-in-All Policies (HiAP), which recognizes health as a responsibility of various sectors and actors in government, non-state actors and the community. It also calls for the deliberate mobilization and support for comprehensive coverage of key determinants of health.

Hence, the MoH should focus on stewardship of the UHC agenda while cultivating collaboration, creating synergies with other sectors to effectively address the determinants of health and seeking lessons from successful multi-sectoral initiatives. Additionally, there is an opportunity for the MoH to leverage the resources of non-health private sector actors that invest in the sector through Corporate Social Responsibility Programs in support of the SDG goals. Ultimately, the MoH should seek to create conditions for adaptive learning that allow the integration of best practices into the implementation of UHC-related interventions in Uganda.

Some sectors that are critical to the attainment of UHC include education, agriculture, finance, gender and labor, works and transport, environment and energy among others. Improving health and well-being also require effective operationalization of additional mandates in the various MDAs, funding agencies, LGs as well as in communities.

| Sector | Ideal sectoral contributions | Sector | Ideal sectoral contributions |
|--|---|-------------------------------------|--|
| Water and Sanitation | Universal access to safe water, environment and domestic hygiene, urban and rural sanitation programs | Housing and Urban Development | Universal access to decent housing, environmental sanitation, and pollution reduction. Partnerships to address pro-poor services. Urban health and sanitation programs |
| Transport and road safety | Road safety laws, awareness and enforcement programs. Safe motorable roads. Certified motor conditions and drivers; safe pedestrian walkways | Health | Prevention of Communicable and Non-Communicable Diseases; Family planning and birth control, RMNCAH, health promotion & BCC; Outpatient and Inpatient |
| Labour, Gender and Social Development | Workplace programs for safety and health services; mitigation of domestic and workplace violence and stress; control of child marriages and teenage pregnancy; functional education on health and poverty | | services; Laboratory and diagnostic services; outbreak and epidemic management; health systems strengthening; Nutrition; Mental Health; accident and emergency services |
| Justice, Law and Order | Updating and awareness of laws, rights and obligations; Vital registration and surveillance of vital events; Law enforcement, standards for food and medicines products and regulatory vigilance for health risks. | Education and Sports | Functional life skills – including fertility education; reproductive literacy and healthy behaviors; School health services; Workforce preparation and Health Vocation planning |
| Finance, Planning and | Expansion of the tax base and revenue collections; Allocation | Local Government | Design and coordinate service delivery, orchestrating |

| Sector | Ideal sectoral contributions | Sector | Ideal sectoral contributions |
|-------------|-----------------------------------|--------|------------------------------------|
| Economic | of finances to vital determinants | | partnership and accountability for |
| Development | of health; Better management | | HPP and community development |
| | of external aid for social | | programmes. |
| | programs; Expansion of | | |
| | employment opportunities and | | |
| | markets. | | |

2.2.1 Considerations for successful development and operationalization of integrated multisectoral government-wide programs to mitigate health determinants

- 1. **Stewardship** Multi-sectoral action requires a clear driving entity in a specific sector. For UHC, the stewardship role lies with the health sector. The Multi-sectoral Committee that has guided the development of this UHC roadmap offers a unique platform to support the coordination of multi-sectoral UHC initiatives. This will ensure that different MDAs and sectors work towards a common UHC goal while minimizing the competition for resources.
- 2. Capacity While multi-sectoral programming offers an immense opportunity, given that this is a relatively new way of working, the sector needs to account for the capacities needed to successfully engage with other sectors and MDAs in a meaningful way. This includes the capacity to participate in integrated planning and generate the required evidence to advocate with other sectors for new resources. In addition, there is a need to increase the capacity of LGs to implement the close-to-community actions that complement the health service provision.
- 3. Clarity of mandate Once the entry points for multi-sectoral UHC action have been determined, the health sector will need to negotiate with other sectors and outline clear roles and responsibilities for the selected programming. This clarity will be achieved by empowering subnational governments through decentralization to plan and integrate programs in a manner that addresses the priority UHC goals for the communities while mirroring the central government concerns for UHC and other SDGs. This will allow for the planning and delivery of more synergistic actions is more feasible at the sub-national levels.
- 4. **Multisectoral coordination** Effective health promotion will require input and actions across sectors to address the underlying causes of poor health and mitigate injuries. Coordination with sectors such as Agriculture (food and nutrition security), Water and Environment (Hygiene and Sanitation), and Transport (road safety) will be essential.
- 5. **Monitoring progress** Indicators specific to multi-sectoral programming will be incorporated into the UHC monitoring plan.

2.2.2 Opportunities for development and operationalization of integrated multisectoral government-wide programs to mitigate health determinants

The main opportunities presented by this component of the UHC Roadmap include:

1. Improved focus on determinants of health especially those that have a direct benefit to the well-being of communities while reducing the burden on the health system.

- 2. Opportunity for government to coordinate and collaborate around a few defined common strategies for attaining UHC.
- 3. Implementation of deliberate strategies to finance and implement interventions that promote health in other sectors.
- 4. Re-setting the community norms and values about healthy lifestyles by leveraging other sectors and opinion shapers.
- 5. Build leadership and accountability platforms for close-to-community health programs.
- 6. Greater societal well-being and improved quality of life for citizens through the promotion of health and integration of preventive measures by other sectors.

2.3 Strategic Action 3: Improve the quality, availability and breadth of essential health care services and increasingly specialized services

Service delivery is one of the core building blocks of the health system. The health system should be geared to provide services that address users' needs. The major shift in this program are 1) to reduce the volume of care through effective prevention and health promotion, 2) clarify what services package to be expanded in the "essential health care package", 3) to boost the quality of the services package and 4) mitigate OOP expenditures. The additional shift is to 5) bring the contribution of the private sector (beyond PNFPs) into the mainstream health information system and strategic purchasing arrangements to enable the poor access services.

On the supply side, improving technologies and health inputs including workforce production and performance management systems, while on the demand side, meaningfully including the perspectives of patients and their communities to support accountability, performance management, and other feedback mechanisms that incorporate the perspectives of patients.

Even though a referral hospital system exists for medical care, the poor investments in technology in most hospitals in Uganda preclude the provision of services, pushing Ugandans to seek specialized medical care abroad. Moreover, the quality of essential health services currently provided is among the major concerns from communities and policy makers. Indeed, the poor quality of these services delays recovery and diverts users into higher-cost options such as hospitals and private providers. This roadmap points out a set of strategies that aim to change the current state of affairs on the delivery side. They touch on the early diagnostic services improvement, preparation of the health systems for the provision of the high-end specialized services and establishment of institutional mechanisms to address access constraints (affordability, availability) and the institutionalization of quality assurance systems including accreditation systems and regulatory authority's introduction.

Firstly, this roadmap promotes the interventions that represent good value including a mix of services that address the high burden to the health system – for which the goal is the immediate reduction of the disease burden. The second category represents service packages that already enjoy high coverage but with high population, cohorts to be covered annually, e.g., Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) service package, which would require sustained coverage. The third category is services that require gradual improvement in coverage. Among these are skilled birth attendance and related emergency neonatal and obstetric care (EmNOC). The fourth category represents services that need to be initiated – especially given the impact they have on the population health if not addressed in the medium to long term, e.g., NCDs and most specialized care services such as renal and cardiovascular

diseases. Regarding the quality of health services, the roadmap recognizes interventions both on the supply side (technologies, health inputs, accreditation system led by an integrated authority in charge of quality assurance and regulatory control systems across public and private providers) and the demand side (meaningfully including the perspectives of patients and their communities).

This strategic action is based on a twofold rationale. First, the reinforcement of the service packages with a potential for reducing the service burden to the health system will prepare the gradual expansion of the (specialized) health services. Second, improving the quality of care will contribute to building users' trust in the health services. In case of good quality, citizens are more likely to adopt behavior in favor of early health facilities' attendance. This strategic action pursues the goal of improving the use of services and then, the health outcomes of the citizens and contributing to the cost containment.

This strategic action will benefit from the contribution of a large range of stakeholders, including professional organizations, unions, private providers, normalization authorities, purchasing agencies, etc.

2.3.1 Considerations for increasing essential and specialized health care services

- 1. Benefits package Improving the availability and the quality of health services is threatened by the fact that the health system is under-financed and relies on unstable and short-term financing such as charitable donations as donor aid. The government needs to clarify what is in and out of the big "essential health care package" as currently defined. Using positive or negative lists is vital to communicate entitlements. Given the limited expansion in the fiscal space for domestic health budgets, the quality decisions need to be grounded in the financial and nonfinancial resources available both domestic and external assistance programs. Also, there will be a need to clarify the package of services that are covered by NHI- as outlined in the NHIS Bill and how the uncovered are to be supported for UHC goals (e.g., tax funding). A strategic decision could be to insure for specialized services that attract high catastrophic costs for NHI instead of covering the same services that are provided free of charge through public financing.
- 2. Health needs expansion The high population growth will entail a rapid expansion of health care needs. Also, chronic care and specialized services will require considerable funding. To mitigate this, effective community health promotion, effective multisectoral programs targeting health determinants and meeting the family planning needs are vital. Moreover, recent experiences show that the growth in the health care needs is less guided by a robust system of priority setting or evaluation of the costs and returns in health status improvements. New services also come with additional protocols for medical care technologies, medicines and workforce training to ensure the capacity to provide quality services. Institutional structures to oversee the decisions to expand the package and to assess the implications on the system capacity, fiscal space and benefits to the affected groups will be necessary.
- 3. **Epidemiologic profile** Diseases that make the biggest impact in lost health and productive days remain highly prevalent. Tackling these diseases needs a priority in the short term. Highend specialized care such as renal dialysis, cancer and organ transplant is expensive relative to benefits. A wider market for specialized services can draw patients from outside of Uganda.

2.3.2 Opportunities for increasing essential and specialized health care services

The main opportunities offered by this component of the UHC Roadmap are:

- 1. Health promotion is increasingly recognized as vital to the success of UHC.
- 2. Wide coverage of public health interventions e.g., EPI, malaria, HIV/AIDS and TB control, etc. generates savings in personal care by reducing the incidence of ill-health.
- 3. Public tax revenue can be targeted to public health interventions like vector control, urban sanitation, etc.
- 4. NHI is on the policy agenda. Aid programs and grants are helping the start-up costs.
- 5. Research opportunities to access grants, equipment and experts.

2.4 Strategic Action 4: Support systems improvement in governance, infrastructure, medicines, supplies and vaccines, health workforce expansion, health information, research and technology

With the ambition to continuously attract citizens to government health facilities, this roadmap recommends intensifying efforts on some game changers that lay out a territory or network of health facilities where the bulk of health needs can be addressed. Suggested strategies include the improvement in governance, the numbers, skills-mix and equitable deployment of the health care workforce, the provision of sufficient funds for inputs, logistics systems and regulation.

The interventions required to build a strong facility backbone call out for a meaningful partnership with the private sector for a mix of complementary investments in the medical centers of excellence as well as close coordination to realize an optimal geographic coverage. Regarding the workforce distribution, the roadmap emphasizes the need to update staffing norms for both clinical and community-level promotion and prevention activities, to promote healthcare-related vocations in schools, and to incentive staff who work in areas of low coverage and high morbidity. In addition, as medicine is central to the patients' treatment and represents a huge cost post of the health expenditures, the roadmap urges the uptake of regulation measures that prevent the medicines and products' counterfeit whilst increasing the financial allocation for medicines to a reasonable level according to the WHO recommendations.

However, the above interventions won't prosper and lead to concrete advancements in absence of sound governance mechanisms. Incentives and mechanisms for effective coordination and governance at the national level are major factors for success. Where coordination of central ministries has yielded results, the coordinating entity is usually highly placed and assigned the "convening powers" of the Presidency. Potential policy decisions may be needed to assign UHC coordination to coordinate government (central and local MDAs) and other sub-sectors (private and civil society) to address health improvement.

It's envisioned that decisions made within governance structures be informed by data extracted from the health information system and global evidence. This roadmap supports the expansion and implementation of the UHC research agenda that the MoH has developed through the SPEED project in 2016. Its findings will provide the health system decision-makers with continuous up-to-date knowledge on technical and non-technical solutions that could be adopted or contextualized for the realization of UHC ambition.

The rationale behind this strategic action is to consider health facilities as part of the structural investments that will enable Uganda to spur economic growth in line with the NDP framework. The health provision network will be deployed alongside the railway, water, roads, air infrastructures that are promoted by the national infrastructure development program. This strategic action pursues the goal of putting in place a reliable network of health facilities that can care for health needs of the entire population.

Tight dialogue with professional organizations, unions, private providers will be critical to ensure equitable distribution of health facilities and workforce required to provide services that are relative to Ugandans' needs. The coordination among regulation authorities will be another great catalyzer to make sure medicines, supplies and vaccines used within the delivery system meet standards that Uganda people deserve.

2.4.1 Considerations to support systems improvement

- 1. Coordination of Partners Effort to better coordinate donor aid especially should be given priority through fragmentation reduction by creating a joined-up aid pool (like UHC fund). This will help to lessen the burden of transaction costs on the part of central and LGs. In the short term, external aid programs should be directed towards community-level health promotion and PHC programs that represent good value in expanding coverage of essential services at this level and reducing preventable ill-health and related service costs. Moving forward, the development aid should be coordinated to increase the pool of funds to assist expand the service options and investments to aid the institutionalization of social health insurance and to enhance quality improvements.
- 2. Coordination of providers The coordination across public, private and civic sectors is a prerequisite for success. Without clear role distribution, mutual exchange among providers, alignment in strategies implementation among the providers' network, it won't be possible to run the delivery system effectively. Regulatory systems by enforcing health behaviors and practices will underpin all these coordination efforts.
- **3. Specialized service infrastructure revamp** Uganda's health system needs a push to make specialized service infrastructure/buildings functional. But recurrent/operations cost control should remain a permanent concern. Furthermore, accreditation expansion to specialized services should be considered as a uphold to improve quality standards.
- **4.** Leveraging multisectoral human resources There is a need to pool community-level workforce for integrated support to community development e.g., Extension workers from agriculture, community development, religious groups and LG. All these resources are great additional hands that can and should be mobilized for the benefit of human resources for health.

2.4.2 Opportunities to support systems improvement

The main opportunities presented by this component of the UHC roadmap lie in:

 The new NDP III (2020/21 – 2024/25) emphasizes the need to "improve access and quality of social services including the delivery of Specialized Medical Care investment in health" as one of the strategies to achieve its strategic objective 3 that is increasing productivity, Inclusiveness and wellbeing of the population. The political commitment put on the NDP at the highest level of the State of Uganda is going to attract all attention that will guide development actions soon. 2. Ongoing infrastructure that is being built like Uganda Cancer Centre of Excellence, Mulago Specialized Hospital, Mulago Specialised Women and Neonatal Hospital, will reinforce the health system capacity to provide high-class specialized health services. Undoubtedly, these facility's reinforcement program is a cornerstone intervention and represents a strong signal that indicates the direction through which Uganda is expecting investments in the health delivery system.

2.5 Strategic Action 5: Develop the right mix of financing sources to increase public expenditures on health and social protection programs to expand financial risk protection for the population

Protecting the most vulnerable is a cross-cutting action that requires additional financial flows particularly in a resource-constrained context. It also necessitates establishing institutional mechanisms that remove the financial barriers for universal and equitable access to healthcare services. Uganda is also at a juncture point for its move towards UHC. The country can't afford the considerable donor aid reduction that is likely to happen in the future without finding compensatory resources for health. It's important to prepare the health system to deal with such a more than probable situation mostly as Uganda will realize its ambition to be a middle-income country by 2040. This roadmap indicates three strategies to explore to change the current pattern through more domestic tax revenues generation, progressive deployment of NHI and institutional mechanisms to address the financing functions for health and its determinants.

Providing financial risk projects from ill-health is one of the major pillars for UHC. The goal of this strategic action is to reduce the OOP proportion of total health expenditures. This ambition is attainable if Uganda succeeds to raise additional financial resources for health insurance through prepayment and reallocate strategically other MDA health-related funding to health priorities. The two main sources of prepayment systems are public tax revenue allocated for health care and health insurance. In this respect, the road map aims to reduce the dependence of health financing on OOP payments that are known to represent a burden to the households, especially for high-cost medical care.

The use of some of the National Social Security Fund (NSSF) savings, motor third-party insurance for health, and reallocation from debt repayment are recommended to generate more financial resources for health. Recommended actions in line with the NHIS Bill as well as an examination of other options to cover communities are suggested below, including subsidies and grants provided to PNFPs and private providers, the expansion of Results-Based Financing (RBF) and community voucher systems or other schemes. In addition, there is the opportunity for the sector to bridge initial funding gaps by leveraging private sector philanthropic capital from the corporate sector in Uganda. One of the institutional challenges for the expansion of private sector provision of healthcare is the lack of affordable financing. Therefore, supporting initiatives such as the recently launched Medical Credit Scheme that has investment and support from across different MDAs will expand the availability of affordable services for the population.

Discussions with the MoFPED will be paramount to secure long-term engagement for allocating public subsidies necessary to this strategic action implementation.

2.5.1 Considerations for expanding financial risk protection for the population

1. Private sector provision may grow faster as the NHIS provides an opportunity for a stable provider payment system. Legislative agenda to make public sector providers effective in NHI

will need prioritizing. The prior existence of free services is a major complicating factor for NHI in Uganda.

- 2. In the short-term Government, financing needs to markedly increase to address the quality and coverage gaps in the essential package and the majority (80% informal sector) are unlikely to get into NHI in the short term. Pressure on public funds to cover the uninsured may generate political risks for the government.
- 3. Investments and reforms required to establish NHI may divert the attention of health reformers, sector leadership and policy elites in society for a long time.
- 4. OOP remains high for the majority of uninsured persons, raising equity concerns and increasing political pressure to use tax funds to provide insurance for non-insured.
- 5. Mobilization and social advocacy to push public expenditures towards specialized services packages is a likely outcome. This may negatively affect priorities accorded to public health interventions that are required to prevent illness and promote well-being thus delaying the progress towards UHC goals.
- 6. Put in place mechanisms for controlling costs and mitigating collusion and potential for corruption in negotiating NHI contracts and billing systems and provider payments.
- 7. Strengthen regulatory systems to curb fraud, control costs, optimize quality in the public and private sectors.
- 8. Design institutional arrangement for health financing to build on established institutional arranges such as decentralization, PNFP bureaus and organized networks in the communities.

2.5.2 Opportunities for expanding financial risk protection for the population

The main opportunities offered by this component of the UHC Roadmap are:

- Draft NHIS Bill 2019 approved by Cabinet for submission to Parliament.
- Positive pressure for accreditation may improve the quality of services and access across public and private facilities.
- Community groups may provide pressure to improve coverage for the indigents and poor vulnerable groups.

2.6 Strategic Action 6: Strengthen the decentralized delivery of health services

This roadmap grants great importance to strategies that promote the strengthening of decentralized units as a driver of multi-sectoral action and the systematic learning from successful multi-sectoral initiatives. Although the health budget accords priority to LG allocations, the resource trend shows that grants like PHC grant – the main vehicle for health services operations and allocation for medicines are stagnant despite increases in population, costs, and a number of service provision entities at LG. LG does receive variable financial and capacity building from central government and off-budget funding arrangements – such as project monies from UN agencies like UNICEF, UNFPA, etc and from fund holders for global health initiatives like PEPFAR and the Global Fund. The main challenge is the poor coherence, coverage and sustainability of most off-budget programs. The major delays in the disbursement of funds are widespread and responsible for uncertainty in the implementation of planned activities and untimely accountability of funds.

Recent studies show limited room by LGs to negotiate local priorities with donor agencies. The concept of decentralization and its ideals in responding to local needs is getting eclipsed by vertical (top-down) programming and funding streams. Most Development Partners tend to

select a sample of "project districts" and implement different health programs (or program elements) with variable geographic coverage in selected districts. This results in a "patchwork" of national coverage for programs and their outcomes. Short-term support for most of the off-budget support is another challenge that does not aid continuity and or sustainability.

The health sector should develop a comprehensive program to provide technical support to LGs thus enabling them to integrate health prevention and promotion activities into their priority initiatives.

2.6.1 Considerations to strengthen the decentralized delivery of health services

- 1) **Empowerment:** The UHC agenda, requires that decentralization of service delivery is well empowered to create the aggregate coverage goals for SDGs. This requires that capacity building and resourcing of LGs are aligned with the service delivery obligations.
- **2) Integration:** More operational integration across government and non-government sectors needs to be deliberately designed to use the resources that flow to the LGs level. This can be through adoption of the program-based budgeting.
- 3) Multi-sectoral collaboration: There is a potential workforce (salaried positions) in several departments of LGs that can form a pool of extension workers to deliver on health and related programs. These teams can work with religious and cultural leaders, associations, institutions, CBOs to support and coordinate community programs.

2.6.2 Opportunities to strengthen the decentralized delivery of health and social protection services

The main opportunities offered by this component of the UHC Roadmap are:

- Decentralization empowers LGs to plan and implement context-specific interventions.
- The parish level provides the nucleus for bottom-up planning and can be used to promote HIAPs.
- The community extension workforce at LGs can be pooled to address a comprehensive set of programs (both health and non-health) and leverage operational funds at the community rather than working in a siloed manner.

2.6.3 Indicators for strengthening the decentralized delivery of health and social protection services

- % of LGs with community development programs including cHPP.
- % of the GoU budget allocated to LGs for health service delivery.
- % of non-state actors providing health promotion and social protection services.

3. Priority Interventions for the Uganda UHC Roadmap 2020 – 2030

oversight from Government for overall governance and implementation. More detailed 5 year and annual plans aligned to the National Planning framework will follow, with actions charged to responsible parties, and timeframe as Short Term (1 - 2 years), Medium-term (2 – 5 years) and Long-term (5 – 10 years) as well as the responsible parties and key outputs. This section elaborates the priority interventions for each of the strategic actions for the UHC roadmap as foreseen in the implementation

| Strategic Action | Interventions | Short- | Medium- | Long- Term | Lead in | Partners | Key Output |
|-----------------------|----------------------------------|-----------|---------|-----------------|---------|---------------|----------------------------|
| | | (1-2 yrs) | yrs) | (5 – 10 Yrs) | | | |
| 1. Expand community- | Operationalize the community | Х | | | MoH | | Community-level health |
| level health | health programming to scale up | | | | | | promotion and prevention |
| promotion and | coverage – actions such as | | | | | | plan developed |
| - (cf | mapping community health | | | | | | |
| and social protection | structures, identifying gaps and | | | | | | |
| programs | developing an | | | | | | |
| | implementation/expansion | | | | | | |
| | plan. | | | | | | |
| | Strengthen Health education | × | × | × | MoH | LGs, Partners | Increased health literacy |
| | and promotion to improve | | | | | | |
| | health literacy and facilitate | | | | | | |
| | informed decisions about health | | | | | | |
| | care, behaviors and more | | | | | | |
| | effective engagement with | | | | | | |
| | health providers | | | | | | |
| | Strengthen Integrated Disease | × | × | | MoH | LGs | Weekly Integrated Disease |
| | Surveillance & Response System | | | | | | Surveillance and reporting |
| | | | | | | | done by public and private |
| | | | | | | | health facilities |

Table 7: Interventions for the Uganda UHC Roadmap 2020 – 2030

| X X MOH The private sector engaged in the provision of health promotion and health education X X X LGs LGs X X X LGs planning, monitoring and holding accountability fora holding accountability fora health promotion and health promotion and health health promotion and holding accountability fora health promotion and health promotion |
|--|
| мон Gs |
| |
| The private sector in the provision of promotion and education LGs using bo planning, moniton holding accountab Frontline workfo health promotic |
| The private sector in the provision of promotion and education LGs using bo planning, monitor holding accountab Frontline workfor health promotic |
| The private sector in the provision of promotion and education LGs using bo planning, moniton holding accountab Frontline workfo health promotio |
| |

| Term (L2 yrs) Term (s) (s) Term (s) Term (s) Govt (s) Conduct integrated community education and behavior change campaigns with other sectors focussed on health education health promotion around key topics such as nutrition, healthy/lifextyles. X LGs Revtalize urban) improvement. X X MoH LGs Expand the number of urban) improvement. X X MoH LGs Expand the number of groups such as civil society, development partnerships developed with accolerate WASH (tural and urban) improvement. X X MoH LGs Strengthen resources for UHC. X X MoH LGs Homent cool private sectors into Uganda's taxation policies. X MoH Parliament cool private sectors into Uganda's taxation policies. X MoH Parliament cool private sectors into Uganda's taxation policies. X MoH Cool private sectors into Uganda's taxation policies. X MoH Coil private sectors into Uganda's taxation policies. X X <td< th=""><th>Strategic Action</th><th>Interventions</th><th>Short-</th><th>Medium-</th><th>long-</th><th>Lead in</th><th>Partners</th><th>Key Output</th></td<> | Strategic Action | Interventions | Short- | Medium- | long- | Lead in | Partners | Key Output |
|--|------------------|--|-------------------|--------------------|-------------------------|---------|------------|----------------------------|
| t1 integrated community X LGs Integrated community cion and behavior change gris with other sectors ad on health education alth promotion around ppics such as nutrition, X X MoH LGs education education and campaigns were held and conducted in urban rural areas ize public health X X MoH LGs public health inspo conducted in urban rural areas ize public health X X MoH LGs public health inspo conducted in urban rural areas ize public health X X MoH LGs public health inspo conducted in urban rural areas it ne number of X MoH LGs public health inspa conducted in urban rural areas it the number of X MoH LGs public health inspa conducted in urban rural areas it the number of X MoH Partnerships deve with non-state actors, other sectors, and sector and constate actors, allocation for UH-res it the allocation for UH-res allocation for UH-res it x X MoH Parliament HDPs interventions at interventions at policies interventions X X X LGs | C | | Term (1-2 yrs) | Term (3- 5 yrs) | Term (5 – 10 Yrs) | Gov't | | |
| igns with other sectors campaigns were held. ad on health education aelth promotion around pics such as nutriton, //lfestyles. X X MoH LGS Public health inspi- conducted in urban nural areas ize public health X X MoH LGS Public health inspi- conducted in urban nural areas inther MDA at all levels to arate WASH (rural and improvement. X X MoH LGS public health inspi- conducted in urban nural areas inthe number of then advocacy with sector. X X MoH LGS public health inspi- conducted in urban nural areas is allocate more cestor UHC. X MoH Parliament Increased interventions at national and LG level. is actions integrate UHC sectors to integrate UHC sectors to integrate UHC sectors integrate UHC sectors to integrate UHC sectors for the Public X X MoH Parliament UHC strategic all integrated into ta policies g and domestic ion, road safety, food X X LGs LGs enforcing the I Health Act | | Conduct integrated community education and behavior change | | х | | LGs | | and |
| aelth promotion around apics such as nutrition, //ifestyles. X X MOH LGs Public health inspector public health inspector conducted in urban ize public health X X MOH LGs public health inspector ize public health X X MOH LGs public health inspector ize public health X X MOH LGs conducted in urban improvement. X MOH MOH Partnerships develot from other sectors from such as civil society, prestor. X MOH Partnerships develot b to allocate more cestor UHC. X MOH Partnerships develot interventions and X MOH Partnerships develot isector. allocate more cestor UHC. X MOH Parliament Increased reso interventions into Uganda's in cations into Uganda's in policies X X MOH UHC strategic act ion, road safety, food X X X LGs LGs enforcing the P environmental X X X LGs Health Act | | campaigns with other sectors | | | | | | campaigns were held. |
| pics such as nutrition, X X MoH LGs Public health inspection ize public health X X MoH LGs conducted in urban ize ordination X X MoH LGs conducted in urban ize manber of X X MoH LGs conducted in urban improvement. X X MoH LGs conducted in urban rural areas such as civil society, someth X MoH MoH Partnerships developed with non-state actors for other sectors. sector. partnerships developed with non-state actors for other sectors. such as civil society, society, society, sector. X MoH Partnerships developed with non-state actors for other sectors. sector. allocate more X MoH Partnerships developed with non-state actors for allocation for UHC-relice at actors for interventions and LG eveloced into trace actors. allocation for UHC-relice act not sectors into Uganda's nobicies act not sectors into Uganda's nobicies act not sector integrate urbor of the Public X MoH Partnerships developed into traxe policies act not sector into traxe | | focussed on health education | | | | | | |
| Interstyles. NoH LGs Public health inspection ize public health X X MoH LGs conducted in urban ion and collaboration X X MoH LGs conducted in urban improvement: are X MoH LGs conducted in urban such as civil society, sectors from X MoH Partnerships developed with from other sectors from X MoH Partnerships developed with non-state actors for such as civil society, prinent partners and X MoH Parliament increased reso such as civil society, sector. allocate more X MoH Parliament allocation for UHC-relices. sector. allocate more X MoH Parliament allocation for UHC-relices at national and LG level. sectors into Uganda's x X MoH ES integrated into tract act into tract into tract act intot into act into tract act into tract act intot into act in | | and health promotion around | | | | | | |
| Infrestyles. X X X MoH LGs Public health inspection ion and collaboration ther MDA at all levels to ate WASH (rural and improvement. X X MoH LGs conducted in urban rural areas improvement. X X MoH LGs conducted in urban rural areas stips developed with from other sectors from such as civil society, pment partners and sector. X MoH Partnerships develop b to allocate more cs for UHC. X MoH Parliament Increased reso allocation for UHC-rela cs for UHC. X MoH Parliament Increased reso allocation for UHC-rela cs for UHC. X MoH Parliament Increased reso allocation for UHC-rela cast for UHC. X MoH Parliament Increased reso allocation for UHC-rela cast for UHC. X MoH Parliament Increased reso allocation for UHC-rela cast for UHC. X MoH Parliament Increased interventions at interventions at policies and cd genetic X X MoH Eds enforcing the P Health Act and cds, for example on g and domestic X X X g and domestic X X LGs LGs envirjonmental X | | key topics such as nutrition, | | | | | | |
| ize public health X X MoH LGs public health inspection inervolution and and X X MoH LGs public health inspection are MASH (rural and X X MoH LGs public health inspection are MASH (rural and X X MoH Partnerships develor are mprovement. X MoH MoH Partnerships develor such as civil society, priment partners and X MoH Parliament increased reso b to <aliocation for="" td="" uhc.<=""> X MoH Parliament increased reso csector. advocacy with X MoH Parliament increased reso csector to integrate UHC X MoH Parliament integrated into tax policies rest or UHC. sintegrate X MoH Parliament integrated into tax is cactors into uganda's national and LG level. NoH UHC strategic act cactors into uganda's X X X LGs LGs enforcing the H</aliocation> | | healthy lifestyles. | | | | | | |
| ion and collaboration conducted in urban inprovement. X MoH rural areas improvement. X MoH Partnerships develop such as civil society, pment partners and sectors from other sectors from X MoH Partnerships develop b to allocate more sectors to integrate UHC. X MoH Parliament Increased reso c actions into Uganda's nonlicies. X MOH Parliament integrate UHC Increased integrate into and LG level. on policies. X MOH Parliament integrate into and LG level. Increased into taxa policies integrate into taxa policies integrate into taxa policies into and LG level. ion, road safety, food X X MOH HDPs Health Act environmental X X MOH HL strategic action into grade into taxa policies into taxa policies into taxa policies into taxa policies into and LG level. Integrate into taxa policies into | | public | × | × | × | MoH | LGs | |
| ther MDA at all levels to rural and rural areas improvement. X MoH Partnerships developed with non-state actors for with non-state actors for other sectors from such as civil society, pment partners and sector. MoH Parliament Partnerships developed with non-state actors for other sectors from such as civil society, pment partners and sector. MoH Parliament Increased reso D to allocate more ces for UHC. X MoH Parliament Increased reso D to allocate more ces for UHC. X MoH Parliament Increased reso prate with MoFPED and sectors to integrate UHC strategic act interventions at net cactions into Uganda's n policies. X MoH UHC strategic act integrated into taxa policies act integrated into taxa policies. andards, for example on g and domestic domestic ion, road safety, food environmental X X MoH USs enforcing the P | | | | | | | | ⊒. |
| ate WASH (rural and improvement. X MoH Partnerships develop with non-state actors for with non-state actors of other sectors such as civil society, pement partners and sector. X MoH Partnerships develop with non-state actors of other sectors. b to allocate more ces for UHC. X MoH Parliament cso Increased biolocation for UHC-reliance cost or integrate UHC X crate with MoFPED and cestors to integrate UHC sectors to integrate UHC is actions into Uganda's nopolicies. X MoH Parliament cost or UHC-reliance interventions at national and LG level. Act (regulatory measures andards, for example on g and addisety, food environmental X X MoH UHC cso UHC integrate dinto taxa policies | | with other MDA at all levels to | | | | | | rural areas |
| improvement. X MoH Partnerships developed 4 the number of X MoH with non-state actors for with non-state actors for other sectors for other sectors. with non-state actors for other sectors. such as civil society, pment partners and sector. X MoH Parliament other sectors. D to allocate more ces for UHC. X MoH Parliament Increased reso sectors to integrate UHC sectors into Uganda's in policies. X MoH Parliament allocation for UHC-reliant interventions at mational and LG level. UHC strategic act policies. allocation for UHC strategic act policies. and domestic ion, road safety, food environmental X X X MoH UHC strategic act policies. integrated into transition upplicities. X X MoH UHC strategic act policies. policies. and domestic ion, road safety, food environmental X X LGs LGs enforcing the PL | | accelerate WASH (rural and | | | | | | |
| i the number of X MoH Partnerships developed rships developed with avterships developed with morstate actors from such as civil society, and x MoH Parliament with non-state actors for b to allocate more x MoH Parliament Increased reso c to allocate more x MoH Parliament allocation for UHC-reliand c x X MoH Parliament Increased reso cations into Uganda's x X MoH UHC strategic act in policies. x X MoH UHC strategic act and domestic x X MoH UHC strategic act in, road safety, food x X LGs Inforcing the Puelic environmental x X X LGs Health Act | | urban) improvement. | | | | | | |
| rships developed with with non-state actors f from other sectors from such as civil society, pment partners and X sector. X then advocacy with X D to allocate more SO cs for UHC. NoH prate with MoFPED and X sectors to integrate UHC NoH cic actions into Uganda's NoH npolicies. X andards, for example on X g and domestic X environ, road safety, food X environmental X | | the number | | × | | MoH | | |
| from other sectors from such as civil society, pment partners and sector. X MoH Parliament Increased reson sector. X MoH Parliament allocation for UHC-relic CSO Increased reson D to allocate more ces for UHC. X MoH Parliament Increased reson Drate with MoFPED and sectors to integrate UHC ic actions into Uganda's in ational and LG level. X MoH UHC strategic act npolicies. X MoH ZSO UHC strategic act interventions at andards, for example on g and domestic environmental X X LGs LGs enforcing the P Health Act LGs LGs enforcing the P Health Act | | | | | | | | with non-state actors from |
| such as civil society, pment partners and X MoH Parliament Increased reso sector. X X MoH Parliament allocation for UHC-reli D to allocate more X MoH Parliament allocation for UHC-reli ces for UHC. X MoH Parliament interventions at orate with MoFPED and X MoH Parliament allocation for UHC-reli sectors to integrate UHC X MoH MoH HDPs interventions at sectors to integrate UHC X MoH UHC strategic act integrated into taxa g and of the Public X X MoH LGs LGs enforcing the PuHealth Act andards, for example on X X LGs LGs enforcing the PuHealth Act Health Act and domestic X X X LGs LGs enforcing the PuHealth Act | | actors from other sectors from | | | | | | other sectors. |
| pment partners and X MoH Parliament Increased reso D to allocate more X MoH CSO interventions at D to allocate MoH X MoH CSO interventions at D to allocation for UHC.relic X MoH CSO interventions at csectors to integrate UHC X MoH MoH UHC strategic act sectors to integrate X X MoH UHC strategic act sectors to integrate X X MoH UHC strategic act sectors to integrate X X MoH UHC strategic act sectors to integrated X X LGs policies policies andards, for example on X X X LGs LGs enforcing the Pu Health Act servironmental X X X LGs Health Act | | groups such as civil society, | | | | | | |
| sector. X MoH Parliament Increased reso D to allocate more X MoH Parliament Increased reso D to allocate more CSO allocation for UHC-relices allocation for UHC-relices cse for UHC. X MoH Parliament Increased reso orate with MoFPED and X MoH HDPs interventions at orate with MoFPED and X MoH MoH UHC strategic act sectors to integrate UHC X MoH UHC strategic act sectors into Uganda's X MoH UHC strategic act in policies. X MoH LGs policies andards, for example on X LGs LGs enforcing the Pu Health Act Health Act Health Act Health Act Health Act Health Act Health Act Health Act | | development partners and | | | | | | |
| thenadvocacywithXMoHParliamentIncreasedresoDtoallocatemoreCSOallocation for UHC-relicCSOinterventionsallocation for UHC-relicces for UHC.XMoHXMoHHDPsinterventionsatpratewithMoFPEDandXMoHUHCstrategicatsectors tointegrateVMoHVUHCstrategicatsectors intoUganda'sXXMoHUHCstrategicatintegratedVXXLGsUHCstrategicatandards, for example onXXXLGsLGs enforcingthePulciesganddomesticXXXLGsLGs enforcingthePulcathHealthActon,roadsafety,foodIIIIIIIIenvironmentalIIIIIIIIIII | | private sector. | | | | | | |
| D to allocate more CSO allocation for UHC-relices ces for UHC. and AC HDPs interventions at national and LG level. orate with MoFPED and sectors to integrate UHC sectors to integrate UHC sectors to untegrate untegrate act untegrate into taxa policies. UHC sectors to taxa policies andards, for example on g and domestic ion, road safety, food environmental X X LGs LGs enforcing the PL Health Act Health Act | | advocacy | | × | | MoH | Parliament | |
| ces for UHC. HDPs interventions at national and LG level. orate with MoFPED and sectors to integrate UHC sectors to integrate UHC sectors to integrate UHC sectors to the Public X MoH UHC strategic act integrated into taxa policies. n policies. X MoH LGs LGs enforcing the Public and and LG level. Act (regulatory measures and ards, for example on g and domestic ion, road safety, food environmental X X LGs LGs Health Act Health Act and the policies into taxa policies. | | to allocate | | | | | CSO | allocation for UHC-related |
| vrate with MoFPED and sectors to integrate UHC ic actions into Uganda's n policies.XMoHUHC strategic integrated into policies n policiesement of the Public Act (regulatory measures andards, for example on g and domestic ion, road safety, food environmentalXXLGsLGsLGs enforcing the Health Act Health Act | | resources for UHC. | | | | | HDPs | |
| sectors to integrate UHC integrated into jic actions into Uganda's integrated into n policies. X X LGs policies ament of the Public X X LGs LGs enforcing the Act (regulatory measures Act (regulatory measures LGs LGs Health Act andards, for example on g and domestic Health Act ion, road safety, food LG Health Act Health Act | | | | | × | Мон | | strategic |
| ic actions into Uganda's policies policies n policies. n policies X X LGs LGs enforcing the Act (regulatory measures andards, for example on g and domestic ion, road safety, food environmental | | other sectors to integrate UHC | | | | | | into |
| n policies. In policies. In policies. It is a series of the Public of the Public on the Act (regulatory measures on and a domestic on, road safety, food environmental of the public on the transmission of transmissi | | strategic actions into Uganda's | | | | | | policies |
| ement of the Public X X LGs LGs LGs Health Act Act (regulatory measures andards, for example on and domestic Health Act Health Act g and domestic and andards, for example on Health Act ion, road safety, food and and and Image: Act of the environmental of the envitenvironmental of the environmental of the environmental of | | taxation policies. | | | | | | |
| Act (regulatory measures andards, for example on g and domestic ion, road safety, food environmental | | of the | | × | × | LGs | | enforcing the |
| and standards, for example on housing and domestic sanitation, road safety, food safety, environmental log log | | Health Act (regulatory measures | | | | | | Health Act |
| g and ion, road safe envir | | and standards, for example on | | | | | | |
| ion, road e | | and | | | | | | |
| | | ion, road | | | | | | |
| | | | | | | | | |

| Establish e protocols for c they become advanced | Manage the c of ill-health community approaches. | Expand vaccina major disease effective technologies. | Strengthen refe between public sector providers. | Define set the func provision. | | availability and study for Uganda breadth of essential Define/revise t health care services health care packa and increasingly | sanitation, polluti substance abuse). 3. Improve the quality, Conduct a Burde | Strategic Action Interventions |
|---|---|---|--|---|---|---|--|----------------------------------|
| Establish effective care protocols for conditions before they become complicated or advanced | Manage the commonest causes of ill-health close to the community using the PHC approaches. | vaccinations to cover disease burden with e vaccination ogies. | Strengthen referral protocols between public and private sector providers. | Define sets of inputs to expand the functionality of service provision. | Implementation of the revised Essential Health Care Package with a focus on high-impact intervention packages for each life stage using a multi-sectoral approach. | study for Uganda Define/revise the essential health care package for Uganda | sanitation, pollution, alcohol & substance abuse). Conduct a Burden of Disease | tions |
| × | × | × | × | × | × | × | × | Short- Term (1-2 yrs) |
| | × | × | | | × | | | Medium- Term (3- 5 yrs) |
| | × | × | | | × | | | Long- Term (5 – 10 Yrs) |
| МоН | Мон | Мон | Мон | Мон | | Мон | Мон | Lead in Gov't |
| | | | | | | | | Partners |
| Uganda Clinical Guidelines updated and disseminated | Population accessing PHC services | Vaccination coverage for the priority diseases in the country | Referral protocols in place and utilized | Revised Service Standards | Health facilities implemented the defined package for the level. | Essential health care package for Uganda revised | BOD study conducted | Key Output |

| Strategic Action | Interventions | Short- | Medium- | Long- | Lead in | Partners | Key Output |
|------------------|---|-------------------|--------------------|-------------------------|---------|----------|---|
| | | Term (1-2 yrs) | Term (3- 5 yrs) | Term (5 – 10 Yrs) | Gov't | | |
| | Strengthen screening and early identification or diagnostic capacity of NCDs at all levels of | × | × | × | Мон | | Population screened for selected NCDs (cancers, SCD, Diabetes, HT, etc) |
| | | | | | | | |
| | Expand the functionality of service provision especially for | × | × | × | Мон | | HC IVs providing CEmNOC |
| | Establish an integrated authority | | × | | Мон | | Health Professional |
| | to improve quality assurance | | | | | | ity estat |
| | and regulatory control systems | | | | | | |
| | across public and private | | | | | | |
| | | | < | | | | |
| | | | > | | | | |
| | ne priority setting | | | | | | e on th |
| | feasibility analyses for | | | | | | setting and feasibility |
| | innovations, technologies and | | | | | | analyses for innovations, |
| | protocols (Potential to align to | | | | | | technologies and protocols |
| | Health Technology Assessment | | | | | | |
| | (HTA) actions) | | | | | | |
| | Establish partnerships with | | × | | МоН | | Partnerships established |
| | centers of excellence abroad to | | | | | | |
| | support the skills and technology | | | | | | |
| | transfer to Uganda. | | | | | | |
| | Increase health facilities | × | × | × | МоН | | Health facility coverage by |
| | network, including through | | | | | | level |
| | partnerships with the private | | | | | | |
| | sector, to ensure effective | | | | | | |
| | referral and timely access to | | | | | | |
| | services and treatment. | | | | | | |

| Strategic Action | Interventions | Short- | Medium- | Long- | Lead in | Partners | Kev Output |
|----------------------|-----------------------------------|-------------------|--------------------|-------------------------|---------|---------------------|-------------------------------|
| c | | Term (1-2 yrs) | Term (3- 5 yrs) | Term (5 – 10 Yrs) | Gov't | | |
| | Expand provision for specialized | × | × | × | МоН | | Specialized and referral |
| | and referral service packages | | | | | | services packages expanded |
| | Strengthen the National referral | | × | × | MoH | | Referral network for |
| | networks for specialized care | | | | | | specialized care functional |
| | services | | | | | | |
| | Develop a plan for investments | | × | | | | Investment Plan for |
| | in the medical centers of | | | | | | medical centers of |
| | excellence including public- | | | | | | excellence developed |
| | private partnerships. | | | | | | |
| | Establish a regular accreditation | | | × | MoH | | Accreditation system |
| | health care services and | | | | | | |
| | ed services | | | | | | |
| | appropriate incentives and | | | | | | |
| | sanctions. | | | | | | |
| | Link accreditation and quality | | × | × | MoH | MoFPED | Health financing linked to |
| | improvement programs to | | | | | | performance |
| | health financing through | | | | | | |
| | mechanisms such as | | | | | | |
| | performance-based incentives. | | | | | | |
| 4. Support systems | Provide leadership structure for | × | | | OPM | MoLG | Coordination structure for |
| improvement in | coordination of UHC-related | | | | | | UHC related programs in |
| governance, | programs across sectors. | | | | | | place |
| infrastructure, | Develop a multi-sectoral | × | | | MoH | LGs, Private Sector | Multi-sectoral framework |
| medicines, supplies | framework for UHC with clear | | | | | | developed |
| and vaccines, health | roles for the key actors at all | | | | | | |
| workforce expansion, | levels to include governance | | | | | | |
| health information, | and coordination of actors and | | | | | | |
| research and | actions to improve health from | | | | | | |
| technology | all vital agencies. | | | | | | |

| Term Term <th< th=""><th>Stratogic Action</th><th>http://www.ioso</th><th>Chort</th><th>Modium</th><th></th><th></th><th></th><th>Kou Output</th></th<> | Stratogic Action | http://www.ioso | Chort | Modium | | | | Kou Output |
|--|--------------------|------------------------------------|-------------------|--------|-------------------------|-------|---------------------|---|
| orm X X MoH LGs, Partners All non-state health a mapped and resore tracked at all levels e X X X MOH LGs, Private Sector No. of health mana tracked at all levels ad X X X MOH LGs, Private Sector No. of health mana tracked at all levels id X X X MOH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings and X X MOH LGs Integrated OPL and in the management skills for X X MOH LGs Integrated OPL and integrated OPL and integrated OPL and integrated OPL and integrated opt and integrate and integrate and integrate and int | סוו מנבצור ארווסוו | | Term (1-2 yrs) | yrs) | Term (5 – 10 Yrs) | Gov't | railleis | |
| e No. of health man tracked at all levels at X X X MOH LGs, Private Sector tracked at all levels and X X X MOH LGs, Private Sector standards of practice ings X X X MOH LGs, Private Sector guidelines for health nutrition programs different settings and X X X LGs MOH LGs Integrated OPL and I for X X X LGS LGS MOH LGS h X X X MOH LGS MOH, CSOS Facilities impleme A X X X MOH LGS MOH, CSOS Facilities impleme CAPA or similar approa h All disasters responder within 48 hours | | Develop networked e-platform | × | × | | MoH | LGs, Partners | All non-state health actors |
| e Vitini 48 hours at X X X MOH US, Private Sector Vitale of health mana trained in leadership management skills and X X X X MOH US, Private Sector Standards of practice ings and X X X MOH US, Private Sector Standards of practice ingent Sills and X X X MOH US, Private Sector Standards of practice for A X X X MOH US, Private Sector Standards of practice integrated OPL and I integrated OPL and I manuals Facilities implement All disasters responder within 48 hours | | for mapping, reporting and | | | | | | mapped and resources |
| X X X MOH LGS, Private Sector Investigation id X X X MOH LGS, Private Sector Standards of practice guidelines for health management skills ings X X X MOH LGS, Private Sector Standards of practice guidelines for health management skills unity X X MOH LGS Integrated OPL and I management skills onal- X X MOH LGS Integrated OPL and I management skills onal- X X MOH LGS Integrated OPL and I management skills onal- X X MOH LGS Integrated OPL and I management skills onal- X X MOH LGS Facilities implement skills onal- X X MOH </td <td></td> <td>coordination of all non-state</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>tracked at all levels</td> | | coordination of all non-state | | | | | | tracked at all levels |
| x x x MoH LGs, Private Sector No. of health mane trained in leadership management skills ings X X MOH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings onal- for X X MOH LGs Integrated OPL and I manuals onal- for X X MOH LGs Integrated OPL and I manuals onal- h X X MOH LGs Integrated OPL and I manuals onal- h X X MOH LGs Integrated OPL and I manuals onal- h X X MOH LGs MoH, CSOs within 48 hours | | health actors. | | | | | | |
| at X X MOH LGs, Private Sector Standards of practice management skills ings X X MOH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings onal- X X MOH LGs Integrated OPL and I manuals for X X MOH LGs Integrated OPL and I manuals for X X MOH LGs All disasters responder within 48 hours | | Building health | × | × | | MoH | LGs, Private Sector | of |
| att X X MoH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings and X X MoH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings onal- X X MoH LGs Integrated OPL and I for X X MoH LGs Integrated OPL and I on X X MoH LGs Facilities impleme CAPA or similar approarmality of the set of | | leadership/managerial | | | | | | trained in leadership and |
| ings X X MOH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings urity X X MOH LGs Integrated OPL and I manuals for health nutrition programs different settings onal- X X MOH LGs Integrated OPL and I manuals for health nutrition programs different settings onal- X X MOH LGs Integrated OPL and I manuals for health nutrition programs different settings on X X X MOH LGs Integrated OPL and I manuals for health manuals for healt | | efficiency and effectiveness at | | | | | | management skills |
| Ind X X MOH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings urity X X MOH LGs Integrated OPL and I manuals onal- X X MOH LGs Integrated OPL and I manuals for X X MOH LGs Facilities impleme on X X MOH LGs Facilities impleme on X X X MoH LGs Hoti sasters responder on X X X MoH LGs All disasters responder | | district and hospital/health | | | | | | |
| nd X X X MOH LGs, Private Sector Standards of practice guidelines for health nutrition programs different settings curity 1 X X MOH LGs Integrated OPL and I itional- X X MOH LGs Integrated OPL and I itional- X X MOH LGs Integrated OPL and I itional- X X MOH LGs Facilities impleme ition X X X MOH LGs MoH, CSOs for X X X MOH LGs MoH, CSOs Facilities impleme ition X X X MOH LGs MoH, CSOs Facilities impleme ition X X X MoH LGs MoH, CSOs Facilities impleme ition X X X MoH LGs MoH, CSOs Facilities impleme ition X X X MoH LGs MoH LGs All disasters responder | | facility level | | | | | | |
| tings guidelines for health nutrition programs curity X 1 and ional- ional- X | | Set standards of practice and | Х | × | × | MoH | LGs, Private Sector | |
| curity n and n n nutrition programs iional- X X MoH LGs Integrated OPL and M ifferent settings X X LGs MoH, CSOs Facilities implement th X X LGs MoH, CSOs Facilities implement th X X MoH LGs All disasters responded m X X MoH LGs All disasters responded | | guidelines for different settings | | | | | | guidelines for health and |
| tional- tional- s for th th th th th th th th th th th th th | | (Communities- in training | | | | | | |
| r and h and | | institutions, schools work- | | | | | | different settings |
| n and tional- s for x x x tion th x x x x x x x x LGs MoH LGs MoH, CSOs i i i i i i i i i i i i i i i i i i i | | places, homes, prisons, security | | | | | | |
| tional- sfor X X X MoH LGs MoH, CSOs X X X MoH LGs MoH, CSOs | | institutions, etc.) for health and | | | | | | |
| tional- storr x x then x x x x x x x LGs MoH LGs MoH LGs LGs LGs | | nutrition programs. | | | | | | |
| tion X X X LGs MoH, CSOs X MoH, CSOs | | Develop integrated Operational- | | × | | MoH | LGs | |
| tion X X X LGs MoH, CSOs A MoH, CSOs | | level (OPL) and Mid-level | | | | | | manuals |
| tion X X X LGs MoH, CSOs | | Manager's (MLM) manuals for | | | | | | |
| thon X X X K K K K K K K K K K K K K K K K | | delivery of the UNMHCP | | | | | | |
| tion the more than a second se | | Revitalize Catchment Area | × | × | | LGs | MoH, CSOs | |
| мон | | Mapping, Planning and Action | | | | | | ¹ CAPA or similar approaches |
| X X | | (CAPA) planning at all health | | | | | | |
| мон | | facilities | | | | | | |
| | | Strengthen the Emergency | | × | × | MoH | | All disasters responded to |
| ensure linkage and use of information generated from other sectors e.g., disaster management, disease outbreaks, pandemics and | | Operation Centre (EOC) to | | | | | | within 48 hours |
| information generated from other sectors e.g., disaster management, disease outbreaks, pandemics and | | ensure linkage and use of | | | | | | |
| other sectors e.g., disaster management, disease outbreaks, pandemics and | | information generated from | | | | | | |
| outbreaks, pandemics and | | other sectors e.g., disaster | | | | | | |
| outbreaks, pandemics and | | management, disease | | | | | | |
| | | outbreaks, pandemics and | | | | | | |

| Term (1-2 yrs) Term (3-5) Term (5-10 Gov/t tof National and Centres for edical Services. X X X MoH centres for edical Services. X X X MoH rage facilities at all equipment X X X MoH city in equipment equipment X X X MoH city in segional equipment X X X MoH city in segional easte Management X X X MoH sease and death notification. X X X MoH scale up a national viders and high- swith internet X X X MoH | Strategic Action | Interventions | Short- | Medium- | long- | Lead in | Dartners | Key Output |
|---|------------------|---|-------------------|--------------------|-------------------------|---------|---------------------|--|
| X X X MoH EMS functional X X X MoH LGs, Private Sector Regional Blood X X X MoH LGs, Private Sector established were lac X X X MoH LGs, Private Sector Public sector healting X X X MoH LGs, Private Sector Public sector healting X X X MoH LGs, Private Sector Public sector healting X X X MoH LGs, Private Sector Public sector healting X X X MoH LGs, Private Sector HCWM system estab X X X MoH NIRA HMIS MIS MoH NIRA HMIS National EMRS estal MIS X X MoH MoSTI, LGs National EMRS estal Migh volume HC IIIs III IIII volume HC IIIs IIII volume HC IIIs | | | Term (1-2 yrs) | Term (3- 5 yrs) | Term (5 – 10 Yrs) | Gov't | | |
| X X MOH LGs, Private Sector Regional Blood X X X MOH LGs, Private Sector HC IVs equipped with X X X MOH LGs, Private Sector Public sector healting X X X MOH LGs, Private Sector Public sector healting X X X MOH LGs, Private Sector HC IVs equipped with X X X MOH LGs, Private Sector HCWN system estab X X X MOH LGs, Private Sector HCWM system estab X X X MOH NIRA ICD coding integrate MIS X X MOH NIRA National EMRS estation MINIS X X MOH MoSTI, LGs National EMRS estation | | Establishment of National and | х | × | | MoH | | EMS functional |
| X X X MOH LGS, Private Sector Regional Blood established were lac HC IVs equipped with storage facilities X X X MOH LGS, Private Sector HC IVs equipped with storage facilities X X X MOH LGS, Private Sector Public sector health houses constructed X X X MOH LGS, Private Sector HCWM system estab X X X MOH LGS, Private Sector HCWM system estab X X X MOH LGS, Private Sector HCWM system estab X X X MOH LGS, Private Sector HCWM system estab X X X MOH MRA ICD coding integrate MINIS MOH MoH MoSTI, LGS on hospitals, HC IV high volume HC IIIs | | Regional Call Centres for | | | | | | |
| X X X MoH LGs, Private Sector Regional Blood X X X MoH LGs, Private Sector HC IVs equipped with storage facilities X X X MoH LGs, Private Sector Public sector health houses constructed X X X MoH LGs, Private Sector HC WM system estab X X X MoH LGs, Private Sector HCWM system estab X X X MoH NIRA ICD coding integrate X X X MoH NIRA HMIS N X X MoH NIRA HMIS No NoH NIRA HMIS National EMRS estal Nigh volume HC IIIs Nigh volume HC IIIs Nigh volume HC IIIs Nigh volume HC IIIs | | Emergency Medical Services. | | | | | | |
| X X X MoH LGs, Private Sector HC IVs equipped with storage facilities X X X MoH LGs, Private Sector Public sector health houses constructed X X X MoH LGs, Private Sector HC IVs equipped with houses constructed X X X MoH LGs, Private Sector HCVM system establic sector X X X MoH LGs, Private Sector HCVM system establic sector X X X MoH MRA ICD coding integrated X X X MoH MoSTI, LGs National EMRS establic on hospitals, HC IVs high volume HC IIIs Integrated Integrated Integrated Integrated | | Establish regional blood banks and blood storage facilities at all | × | × | | Мон | LGs, Private Sector | Regional Blood Banks established were lacking |
| tin coverage of X X X MoH LGs, Private Sector storage facilities in city in equipment X X MoH LGs, Private Sector Public sector health tenance including X X MoH LGs, Private Sector Public sector health tenance including X X MoH LGs, Private Sector REWs retooled tenance including X X MoH LGs, Private Sector HCWM system establic ally sustainable X X X MoH LGs, Private Sector HCWM system establic ally sustainable X X X MoH LGs, Private Sector HCWM system establic ally sustainable X X X MoH LGs, Private Sector HCWM system establic ally sustainable X X X MoH LGs, Private Sector HCWM system establic ally sustainable X X X MoH LGs, Private Sector HCWM system establic all levels X X X MoH NIRA HMIS scale up a national X X X MoH MoSTI, LGs National EMRS establic on hospitals, HC IVs <t< td=""><td></td><td>HC IVs.</td><td></td><td></td><td></td><td></td><td></td><td>HC IVs equipped with blood</td></t<> | | HC IVs. | | | | | | HC IVs equipped with blood |
| t in coverage of X X X MoH LGs, Private Sector Public sector hoults constructed houses constructed icity in equipment X X MoH LGs, Private Sector REWs retooled terance including he Regional X X MoH LGs, Private Sector HCWM system establi Equipment X X MOH LGs, Private Sector HCWM system establi site Management X X MOH LGs, Private Sector HCWM system establi ally sustainable X X MOH LGs, Private Sector HCWM system establi ally sustainable X X MOH NRA HCWM system establi ally sustainable X X MOH NRA HCWM system establi ally sustainable X X MOH NIRA HCUM system establi interact X X MOH NIRA HMIS scale up a national X X X MOH NoSTI, LGs National EMRS estable alcial Records X X X X MoH MoSTI, LGs National EMRS estable vib and high- swith internet X X X X MoH MoH <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>storage facilities</td> | | | | | | | | storage facilities |
| acity in equipment X X MoH tenance including he Regional Equipment X X MoH Equipment X X MoH Equipment X X MoH Instructionable X X MoH ally sustainable X X MoH Instructionable X X MoH Instructionable X X MoH Instructionable X MoH LGs, Private Sector ally sustainable X X MoH Instructionable X MoH NIRA sease and death X X MoH I notification. X X MoH scale up a national X X X sdical Records X X MoH public and private X X MoH IVs and high- X X MoH | | Improvement in coverage of staff housing. | × | × | × | МоН | LGs, Private Sector | |
| t X X X MOH LGs, Private Sector X X X MOH LGs, Private Sector X X X MOH NIRA X X X MOH NIRA | | Improve capacity in equipment | × | × | | МоН | | retooled |
| t X X MOH LGs, Private Sector | | use and maintenance including | | | | | | functional |
| t X X X MOH LGs, Private Sector | | retooling of the Regional | | | | | | |
| t X X X MOH LGs, Private Sector | | Maintenance Equipment | | | | | | |
| al S t t X X X MOH NIRA MOH NIRA | | Establish an efficient safe and | | × | × | MoH | I Ge Drivate Sector | HCWM system established |
| I X X MOH NIRA X X X MOH NIRA X X MOH MOSTI, LGs | | environmentally sustainable | | | | | | |
| al X X MOH NIRA | | Healthcare Waste Management | | | | | | |
| al X X MOH NIRA | | System. | | | | | | |
| al X X X MoH MoSTI, LGs | | Capacity building in ICD coding | × | | | MoH | NIRA | ICD coding integrated into |
| I X X X MoH MoSTI, LGs | | for health providers at all levels | | | | | | HMIS |
| al X X X MOH MOSTI, LGs | | to improve disease and death | | | | | | |
| | | Fatablish and nouncation. | < | < | < | | | |
| | | Electronic Medical Records | > | > | > | | | on hospitals, HC IVs and, |
| hospitals, HC IVs and high- volume HC IIIs with internet access. | | System in all public and private | | | | | | high volume HC IIIs |
| volume HC IIIs with internet access. | | hospitals, HC IVs and high- | | | | | | |
| access. | | volume HC IIIs with internet | | | | | | |
| | | access. | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | (| Strategic Action |
|---------------------------|------------------------|---------------------------|---|-----------------------------|--|------------------------------|-------------------|---------------------------------|-------------------------|------------------------------|-------------------------------|----------------------------------|---------------------------|--------------------------------|---------------------|-------------------------|---------------------------------|-------------|-------------------------------|-------------------------------|----------------------------------|--------------------------------|----------------------------|------------------------------|---------------------------|------|-----------|------------|------------------|
| assessments, research and | institutions | Strengthen health sector | development (R&D) strategy and national research priority agenda. | Develop health research and | Assessments for all health facilities. | Conduct routine Data Quality | sector providers. | increase reporting from private | private sector umbrella | Strengthen coordination with | strategic information on UHC. | sectoral information systems for | integrating HIS and other | Strengthen the use of big data | Information System. | of the Community Health | Operationalization and scale-up | CRVS, etc). | NDAMIS, HPRIS, e-Recruitment, | EMRS, WAOS, ERP, RX Solution, | health sector (HMIS, HRIS, CHIS, | information systems within the | integrating the electronic | health information system by | Establish a comprehensive | | | | Interventions |
| | | Х | | × | | × | | | | × | | | | | | | Х | | | | | | | | × | | (1-2 yrs) | Term | Short- |
| | | × | | × | | × | | | | × | | | | × | | | × | | | | | | | | × | | yrs) | Term (3- 5 | Medium- |
| | | × | | × | | × | | | | × | | | | × | | | | | | | | | | | | Yrs) | (5 – 10 | ن Term | Long- |
| | | UNHRO | | UNHRO | | MoH | | | | Мон | | | | HoM | | | МоН | | | | | | | | MoH | | | Gov't | Lead in |
| Partners | cition , | MoSTI, UVRI, | | Academia | | LGs | | | Providers | LGs, Private | | | | | | | LGs, Partners | | | | | | | | MoSTI, LGs | | | | Partners |
| | works and publications | No. of completed research | and agenda | Health research strategy | | Annual DQAs conducted | | טווסב מנופוופט | DHIS3 strengthened | health facili | | | evidence from multi- | Decisions making based on | | linked to HMIS | Community health data | | | | | | Registries established. | Information Exchange | Comprehensive Health | | | | Key Output |

| | | | | | | | | Strategic Action |
|------------------------------|-----------------------------|--|---|--------------------------------------|--|--|---|----------------------------------|
| coverage and high morbidity. | Design incentive schemes to | Review/develop up-to-date schemes of service and standards of practice and job descriptions for all cadres. | Provide competitive wages/salaries for health care workers to improve job commitment and a meaningful vocation. | Recruitment of the health workers | Develop a comprehensive 10- year HRH policy and strategic plan aligned to UHC. | Conduct and publish research for scientific evidence on the safety, efficacy, quality and availability of traditional medicine products. | analyses, jointly with non-health sector programs. Develop PPP investment plans for strengthening research for scientific evidence on the safety, efficacy, quality and availability of traditional medicine products. | Interventions |
| | | × | | | | × | | Short- Term (1-2 yrs) |
| | × | | | × | × | × | × | Medium- Term (3- 5 yrs) |
| | | | × | | | × | | Long- Term (5 – 10 Yrs) |
| | MoPS | Мон | MoFPED | Мон | Мон | UNCRI | UNCRI | Lead in Gov't |
| Sector | L LGs, Private | MoPS, HPCs, LGs | Private Sector | MoPS, LGs, Private Sector | MoPS, LGs | MoSTI, Universities, Partners | Private Sector | Partners |
| workers | zed inc | Up-to-date schemes of service and standards of practice and JDs | Enhanced salaries | Staffing level | HRH Policy and Strategic Plans developed | Research products and publications | Investment plan | Key Output |

| | | | | | | | | Strategic Action |
|--|--|---|--|---|---|---|--|----------------------------------|
| Strengthen the National Pharmacovigilance system at all | Increase the financial allocation for medicines and health supplies to a reasonable level at least \$14 per capita by 2025. | Develop a multi-sectoral plan for training of health workforce inappropriate skills and numbers. | Train expert workforce for specialized services. | for priority skills and cadres in the health system such as Public Health Nurses, anaesthetics, diagnostic and health promotion and specialist workforce. | Develop the Human Resource Development Strategy and annual HR Development Plans | Develop e-personnel performance management, monitoring and reporting system. | Functionalize the existing HRIS and National Health Work Force Accounts to capture information on the entire health workforce in the Country and link it to the DHIS2 platform. | Interventions |
| × | | | | | × | | × | Short- Term (1-2 yrs) |
| × | × | × | × | | × | × | × | Medium- Term (3- 5 yrs) |
| × | × | | × | : | × × | | × | Long- Term (5 – 10 Yrs) |
| NDA | MoFPED | MoES | MoES | | Mores Mores | Мон | Мон | Lead in Gov't |
| MoH, Private Sector | MoH, NMS | MoH, HPCs | Мон | | LGs, Private Sector | LGs, Private Sector | LGs | Partners |
| Functioning national e- Pharmacovigilance system | Per capita budget allocation for medicines and health supplies | Training plan | Specialized health workers trained | eated and priority c onsored | HR Strategy and Annual HRD Plans A scholarshin fund was | Annual personnel performance analysis done | iHRIS functional in all LGs and health institutions | Key Output |

| | Ч | | | | | Str |
|---|--|---|--|--|--|----------------------------------|
| to increase public expenditures on health and social protection programs | Develop the right mix of financing sources | | | | | Strategic Action |
| c Develop a NHIS Institutional n Capacity Development al Framework and implementation s roadmap. | x Establish the NHIS. | Develop a meaningful public- private partnership framework for complementary investments in health infrastructure, medicine and health technologies and devices. | Promote the production and appropriate use of indigenous and complementary medicine products and practices. | Review and harmonize standards for medical laboratory technologies including point of care tests (POCT), home health IT diagnostic devices and, diagnostic and imaging technologies. | levels using information technology. Strengthening the post- marketing surveillance of commodities on the market for both public and private sectors. | Interventions |
| × | | | × | | × | Short- Term (1-2 yrs) |
| | × | × | × | × | × | Medium- Term (3- 5 yrs) |
| | | | × | | × | Long- Term (5 – 10 Yrs) |
| МоН | Мон | Mo H | Мон | Mo H | NDA | Lead in Gov't |
| | Parliament, MoFPED | MoSTI, Private Sector | NDA, Private Sector, UNBS | N D D | MoH, Private Sector | Partners |
| NHIS Framework and Implementation roadmap | NHIS established | PPP Investment plan developed | ICMPs integrated into the national health system | Harmonized Standards for diagnostic technologies | Postmarketing surveillance is done for all commodities | Key Output |

| Description Instruments Stort Term Cover Term Stort Yes O Over Joint annual plans and risk protection for UHC programs. Term Kar X MoH MoFPED Pooled funding methanism risk protection K X X MoH MoFPED Pooled funding methanism Pooled funding methanism Fear Booled funding methanism Fear Science Pooled funding methanism Fear Science Fear Booled funding methanism Fear Fear Science Fear | 2 | induction Andrew | | | | | | | |
|--|---|------------------------|------------------------------------|-------------------|--------------------|-------------------------|--------|-------------|----------------------------|
| to expand financial Align aid agendas to the national strengthening country systems. X X X MoH MoFPED budgets budgets risk protection for coordinated financing of urle programs. X X X MoPPED Protection financing of urle programs. Protection financing of urle programs. X X MoH MoFPED Protection financing of urle programs. Protection financing of urle programs. X X MoH MoFPED Protection financing of urle programs. Protection financing of urle prove protection financing of urle prove age of preparent urle prove financial cash transfers. X X MoH MoFPED. Private urle prove financial s to the private sector urle prove coverage of major urle prove coverage of major urle prove coverage of urle prove coverage of | Ĺ | יו מוב9ור ערווסוו | | Term (1-2 yrs) | Term (3- 5 Yrs) | Term (5 – 10 Yrs) | Gov't | | |
| risk protection for UHC priorities while X MoFPED MoFPED Pooled funding med and for coordinated financing of UHC programs. Pooled funding med re-established Map and track resources from Health Partners. X X MoH MoFPED. DPs Hot re-established Kap and track resources from mechanisms for health care and scale-up pro-poor interventions such as demand-side incentives, including vouchess and conditional rash transfers. X X MoH MoFPED. DPs HDP resources re mechanisms Hamessing the private sector through the private sector mechanisms for health care and scale-up provouchers and including vouchess and conditional rash transfers. X X MoH MoFPED. Private private Coverage of reparamethanisms Improve equity and efficiency in resource utilization through RBF scale up beyond RMNCAH. X X MoH MoFPED. Private provision. Level of financial s sector ontputs sector ontputs Sector, DPs to the private sector mechanisms acros sector ontputs Mint to allocate S60 per capita to improve coverage of monotion and the environmental Health Pregents. X MoH Coverage of mechanisms acros sector ontputs Increased per allocation for health allocation for health allocation for health uncreased roit unandates and roit MoH Los re-orien | | expand | | × | × | × | Мон | MoFPED, DPs | plans |
| the population Strengtheling country systems. X MoFPED Pocled funding mediation Re-establish pooling of external aid for coordinated financing of UHC programs. X X MoFPED Pocled funding mediation Wap and track resources from Health Partners. X X MoH MoFPED. DPs and tracked re-established Expand prepayment scale-up pro-poor interventions such as demand-side incentives, including the private sector X X MoH MoFPED. Private and tracked Coverage of prepa and tracked Including to health care conclusional cash trackers. Interventions and conclusional cash trackers. MoH MoH Coverage of prepa mechanisms Intrologin the private sector functifical gaps in care provision. X X X MoH MoFPED, Private provision. Level of financial s tracker of mechanisms across scale-up beyond RMICAH. X X MoH MoFPED, Private sector outputs Aim to allocate SOP or capita to minore coverage of major provision. X X MoH Evel of financial s sector outputs Strengthen delivery of health and delivery of health and Re orient LGs about the mandates and rol X MoH MoH Coverage sector out | | protection | UHC priorities | | | | | | budgets |
| Re-establish pooling of external aid for coordinated financing of UHC programs. X MoFPED Pooled funding med re-established Map and track resources from Health Partners. X X MoH MoFPED, DPS HoP resources in re-established Expand propagrimet provision X X MOH MoFPED, DPS and tracked re-established Expand propagrimet provision X X MOH MoFPED, DPS and tracked and tracked Including conditional cash transfers. X X MOH MoFPED, Private provision. Coverage of through the provise sector through the provise sector through the provise sector through the provise of and tracked X X MOH MoFPED, Private provision. Level of financial s to fill critical gaps in care provision. X X MOH MoFPED, DPs private sector through the provision of a through the provision of and tracked X X MOH MorpED, DPs provision to the private sector through the provision and the provision and through the provision and the provision and the functioned about the functioned about the functioned about the decentralized X X MoH Coverage of mechanisms across sector outputs sector outputs Increased per increased per increased per increased of through the provisio | | the population | strengthening country systems. | | | | | | |
| Interpretation X X X MoH MoFPED, DPs HDP resultshed Map and track resources from Health Partners. X X MOH MOFPED, DPs HDP resources in Hartshealth care and scale-up pro-poor interventions such as demand-side incentives, including X X MOH MOFPED, DPs HDP resources in and tracked Harnessing the private sector through the provision of a Medical Credit Fund or subsidies to fill critical gaps in care X X MOH MOFPED, Private MoFPED, Private Level of financial is sector, DPs Improve equity and efficiency in resource utilization through RBF scale up beyond RMICAH. X X MOH MOFPED, Private sector outputs Level of financial is sector outputs Min to allocate S60 per capita to improve coverage of major Health Prevention and the funromental Health Programs. X X MOH Coverage of mechanisms acros sector outputs Increased per allocation for health allocation for health the coviented about the functional cash and roles to advance delivery of health and programs vital for SDGs. X MOH LGs re-oriented about mandates and roles to mandates and role sole of mandates and roles to mandates and role sole of mandates and roles to mandates and roles to | | | Re-establish pooling of external | | × | | MoFPED | | Pooled funding mechanism |
| UHC programs. Map and track resources from X X MoH MoFPED, DPS HDP resources mand tracked Expand prepayment X X MoH MoFPED, DPS HDP resources mand tracked Expand prepayment X X MoH MoFPED, DPS HDP resources mand tracked Such as demand-side incentives, including vouchers and coverage of prepayment MoH MoH MoH MoH Coverage of prepayment Coverage of prepayment Coverage of prepayment MoH Sector, DPs to the private sector MoH Sector, DPs MoH MoH MoH MoH MoH Sector, DPs <td< td=""><td></td><td></td><td>aid for coordinated financing of</td><td></td><td></td><td></td><td></td><td></td><td>re-established</td></td<> | | | aid for coordinated financing of | | | | | | re-established |
| Map and track resources from Health Partners. X X X MoH MoFPED, DP5 Hubr resources in and tracked such as demand-side incentives, such as demand-side incentives, uncluding X X MoH MoFPED, health Partners Coverage of prepare mechanisms Harnessing the private sector through the provision of a to fill critical gaps in care provision. X X MoH MoFPED, Private sector, DPs Level of financial s to the private sector Improve equity and efficiency in resource utilization through RBF scale up beyond AMMCAH. X X MoH Coverage of mechanisms across sector outputs Amore traiting theration decentralized delivery of health and uccation for health Promotion and the prove coverage of major Health Programs. X X MoH Coverage of mechanisms across sector outputs Strengthen delivery of health and uccating the proper. X X MoH Coverage of mechanisms across sector outputs Strengthen delivery of health and unctates and role to advance delivery of health and programs vital for SDGs. <t< td=""><td></td><td></td><td>UHC programs.</td><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | UHC programs. | | | | | | |
| Health Partners. X MOH and tracked Expand scale-up pro-poor interventions such as demand-side incentives, including X MOH Coverage of prepa- mechanisms Harnessing the provision of a through the provision of a fill critical gaps in care provision. X X MOH MoFPED, Private Level of financial s sector, DPs Interventions Improve equity and efficiency in rescale up beyond efficiency in rescale up to allocate SdO per capita to improve coverage of mechanisms acros sector outputs rescale up to allocation for health environmental Health Programs. X MoH Coverage mechanisms acros sector outputs allocation for health environmental Health Programs. X MoH Level of inancial s mechanisms acros sector outputs allocation for health uprograms vital for SDGs. | | | Map and track resources from | × | × | × | MoH | MoFPED, DPs | resources |
| Expand prepayment mechanisms for health care and scale-up pro-poor interventions such as demand-side incentives, including X MOH Coverage of mechanisms Coverage of mechanisms Harnessing the private sector through the provision of a Medical Credit Fund or subsidies to fill critical gaps in care provision. X X MOH MoFED, Private MoFED, Private Level of financial s Improve equity and efficiency in resource utilization through RBF scale up beyond RM/CAH. X X MOH MoFED Sector, DPs Coverage of mechanisms across sector outputs Strengthen decentralized delivery of health and programs vital for SDGs. X X MOH MoFED Sector, DPs Level of financial s | | | Health Partners. | | | | | | |
| mechanisms for health care and scale-up pro-poor interventions such as demand-side incentives, including vouchers and conditional cash transfers. X X MOH MoFED, sector, DPs Private to fill critical gaps in care provision. MoH MoFED, sector, DPs Private to fill critical gaps in care provision. Coverage mechanisms of the private sector Improve equity and efficiency in resource utilization through RBF scale up beyond RM/CAH. X X MOH Sector, DPs to the private sector mechanisms across sector outputs Atim to allocate S60 per capita to improve coverage of monotion and promotion and the decentralized delivery of health mandates and roles to the mandates and roles to the programs vital for SDGs. X X MOH Coverage sector outputs Increased allocation for health and the provision | | | | | × | | Мон | | |
| scale-up pro-poor interventions such as demand -side incentives, including wouchers and conditional cash transfers. Molt MoFPED, Private Level of financial s financial s Harnessing the private sector through the provision of a Medical Credit Fund or subsidies to fill critical gaps in care provision. X X MoH MoFPED, Private Level of financial s Improve equity and efficiency in resource utilization through RBF scale up beyond RMNCAH. X X MoH Sector, DPs Coverage of mechanisms across scale up beyond RMNCAH. Aim to allocate S60 per capita to improve coverage of major Health Prevention and Promotion and the Environmental Health Programs. X X MoH Coverage of mechanisms across scale up beyond RMNCAH. Increased per allocation for health allocation for health up ograms vital for SDGs. MoH LGs re-oriented abor mandates and role up ograms vital for SDGs. LGs re-oriented abor mandates and role | | | mechanisms for health care and | | | | | | |
| such as demand-side incentives, including with as demand-side incentives, and conditional cash transfers. Molt MoFPED, Private Level of financial s Harnessing the private sector X X MoH MoFPED, Private Level of financial s Harnessing the private sector X X MoH MoFPED, Private Level of financial s Modical Credit Fund or subsidies X X MoH Sector, DPs to the private sector Improve coverage of miprove X X MoH Sector, DPs to the private sector Improve coverage of major X X MoH Sector, DPs to the private sector Improve coverage of major X X MoH Sector, DPs to the private sector Improve coverage of major X X MoH Sector outputs Sector outputs Alm to allocate S00 per capitat X MoFPED MoFPED Increased per allocation for health Hearth Provention <td></td> <td></td> <td>scale-up pro-poor interventions</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | scale-up pro-poor interventions | | | | | | |
| including vouchers and including volcant | | | such as demand-side incentives, | | | | | | |
| conditional cash transfers.MorrestiveMorrestiveMorrestiveLevel of financial sHarnessing the private sectorXXXMoHMorrestiveLevel of financial sthrough the provisionaXXXMoHSector, DPsto the private sectorImprove ceulity and efficiency in resource utilization through RBFXXXMoHCoverage of mechanisms acrossscale up beyond RMNCAH.Aim to allocate \$60 per capita to improve coverage of major Health PreventionXXMoHCoverage of mechanisms acrossStrengthen decentralizedRe-orient LGs about the mandates and roles to advanceXMoHMorFEDIncreased per allocation for health mechanisms acrossStrengthen delivery of health and programs vital for SDGs.XXMoHMoHLGs re-oriented about mandates and roleUHC advancementyrage otherXXMoHUHC advancement | | | vouchers | | | | | | |
| Harnessing the private sector through the provision of a Medical Credit Fund or subsidies to fill critical gaps in care provision.XXMoHMoFPED, Private Sector, DPsLevel of financial s to the private sectorImprove equity and efficiency in resource utilization through RBF scale up beyond RMNCAH.XXXMoHSector, DPsto the private sectorImprove coverage of improve coverage of Health Prevention decentralizedXXXMoHCoverage of mechanisms across sector outputsStrengthen delivery of health and programs vital for SDGs.RXXMoHCoverage of mechanisms across sector outputsUHC advancement delivery of health and programs vital for SDGs.XXMoHMoFPEDLGs re-oriented abor mandates and role | | | conditional cash transfers. | | | | | | |
| through Medical Credit Fund or subsidies to fill critical gaps in care provision.Sector, DPsSector, DPsto the private sectorImprove equity and efficiency in resource utilization through RBF scale up beyond RMNCAH.XXXMoHCoverageof mechanisms across sector outputsAim to allocate \$60 per capita to improve ecverage of HealthXXXMoHCoverageof mechanisms across sector outputsStrengthen decentralized uelivery of health and programs vital for SDGs.XXMoHLGs re-oriented about mandates and role UHC advancement | | | private | × | × | × | MoH | | Level of financial support |
| Medical Credit Fund or subsidies to fill critical gaps in care provision. MoH Coverage Of mechanisms Improve equity and efficiency in resource utilization through RBF scale up beyond RMNCAH. X X MoH Coverage of mechanisms across sector outputs Aim to allocate \$60 per capita to improve coverage of major Health X X MoFPED Coverage Increased per allocation for health Strengthen the mandates and roles to advance X MoH Coverage Increased per allocation for health and UHC goals alongside other X MoH LGs re-oriented about mandates and role LGs re-oriented about mandates and rol MoH UHC advancement | | | of | | | | | Sector, DPs | to the private sector |
| to fill critical gaps in care provision.tofill critical gaps in care provision.MoltCoverageofImprove equity and efficiency in resource utilization through RBF scale up beyond RMNCAH.XXXMoHCoverageof mechanisms acrossAim to allocate \$60 per capita to improve coverage of major HealthXXXMoFPEDIncreased per allocation for healthStrengthen decentralized delivery of health and programs vital for SDGs.XXMoHCoverageof mechanisms across sector outputsMoHRe-orient LGs about the mandates and roles to advance programs vital for SDGs.XMoHLGs re-oriented about mandates and rol UHC advancement | | | Medical Credit Fund or subsidies | | | | | | |
| provision.mprove equity and efficiency in resource utilization through RBFXXMOHCoverage of mechanisms across sector outputsAim to allocate \$60 per capita to improve coverage of major Health Prevention and Promotion and the Environmental Health Programs.XMoFPEDIncreased per allocation for health allocation for health MOHStrengthen decentralized ull cas alongside other programs vital for SDGs.XMoHCoverage of mechanisms across sector outputsMoH mechanisms mechanisms across mechanisms across sector outputsIncreased per allocation for health allocation for health allocation for health allocation for health allocation for healthMoH delivery of health and programs vital for SDGs.XMoHUHC advancement | | | to fill critical gaps in care | | | | | | |
| Improve equity and efficiency in resource utilization through RBF scale up beyond RMNCAH.XXMoHCoverage of mechanisms acrossAim to allocate \$60 per capita to improve coverage of major Health Prevention and Promotion and the Environmental Health Programs.XMoFPEDIncreased per allocation for health allocation for health allocation for health the UHC goals alongside otherXMoFPEDIncreased per allocation for health allocation for health UHC advancementStrengthen delivery of health and programs vital for SDGs.XMoHLGs re-oriented about mandates and role | | | provision. | | | | | | |
| resource utilization through RBF scale up beyond RMNCAH.mechanisms across sector outputsAim to allocate \$60 per capita to improve coverage of major Health Prevention and Promotion and the Environmental Health Programs.XMoFPEDIncreased per allocation for health allocation for health Allocation for healthStrengthen decentralized delivery of health and programs vital for SDGs.XMoFPEDIncreased per allocation for health Allocation for healthUHC goals alongside other programs vital for SDGs.XMoHLGs re-oriented about mandates and role | | | Improve equity and efficiency in | × | × | × | MoH | | of |
| scale up beyond RMNCAH.scale up beyond RMNCAH.sector outputsAim to allocate \$60 per capita to improve coverage of major Health Prevention and Promotion and the Environmental Health Programs.XMoFPEDIncreased per allocation for health allocation for health Allocation for healthStrengthen decentralized delivery of health and programs vital for SDGs.XMoFPEDIncreased per allocation for health Allocation for healthUHC goals alongside other programs vital for SDGs.XMoHUHC advancement | | | resource utilization through RBF | | | | | | across |
| Aim to allocate \$60 per capita to improve improve coverage of major HealthXMoFPEDIncreased per allocation for healthHealthPrevention and Promotionand the Environmental Health Programs.XMoFPEDallocation for healthStrengthen decentralized delivery of health and programs vital for SDGs.XMoHLGs re-oriented abou mandates and roleLGs re-oriented abou mandates and roleUHC goals alongside other programs vital for SDGs.XMoHLGs re-oriented abou mandates and role | | | scale up beyond RMNCAH. | | | | | | sector outputs |
| improvecoverageofmajorHealthPreventionandPromotionandthePromotionandtheEnvironmental HealthPrograms.StrengthentheRe-orient LGs about the mandates and roles to advancedelivery of health andUHC goals alongside otherMoHprograms vital for SDGs.manual for SDGs.MoH | | | Aim to allocate \$60 per capita to | | | × | MoFPED | | per |
| HealthPreventionandPromotionandthePromotionandtheEnvironmental Health Programs.Environmental Health Programs.MoHdecentralizedmandates and roles to advanceMoHdelivery of health andUHC goals alongside otherMoHprograms vital for SDGs.MoHMoH | | | coverage of | | | | | | allocation for health |
| PromotionandtheEnvironmental Health Programs.StrengthentheRe-orient LGs about theXdecentralizedmandates and roles to advancedelivery of health andUHC goals alongside otherprograms vital for SDGs.Moll | | | Prevention | | | | | | |
| Environmental Health Programs.MoHStrengthentheRe-orient LGs about theXdecentralizedmandates and roles to advanceMoHdelivery of health andUHC goals alongside otherHprograms vital for SDGs.MoH | | | and | | | | | | |
| Strengthen the Re-orient LGs about the X MoH decentralized mandates and roles to advance delivery of health and UHC goals alongside other delivery of health and UHC goals alongside other delivery of health and Image: the state of | | | Environmental Health Programs. | | | | | | |
| mandates and roles to advance alth and UHC goals alongside other programs vital for SDGs. | 6 | Strengthen | | × | | | MoH | | LGs re-oriented about UHC |
| UHC goals alongside other programs vital for SDGs. | | decentralized | | | | | | | mandates and roles for |
| programs vital for SDGs. | | delivery of health and | | | | | | | UHC advancement |
| | | | programs vital for SDGs. | | | | | | |

| surveys undertaken | LO3, MOT | | > | > | | within the LGs and use local evidence to address inequalities | |
|--|----------|------------------|----------------------------------|-------------------------------|-----------------------------|---|-------------------------------|
| Guidelines developed | | Mofped | < | < | × | Develop guidelines for improving alignment and sustainable coverage of health protection programs supported by off-budget funding streams. | |
| Close-to-community non-governmental mobilized | MoGLSD | LGS | × | × | × | Mobilize close-to-community and non-governmental actors to contribute to UHC programs alongside other development programs. | |
| No. of community development programs including cHPP established | | MoLG | | | × | Consolidate the workforce for community levels programs across all departments of LGs to pool resources and experts to guide community development programs including cHPP. | |
| UHC Technical suppor program to LGs developed | | Molg | | | × | Provide guidelines and capacity building for more integrated planning, budgeting and implementation arrangements that enable greater synergy and value for money for health and non-health development programs. | |
| No. of Multi-secti programs implemented | | MoLG | | × | | Strengthen multi-sectoral coordination at LGs level to better embed health priorities at the decentralized level | social protection services |
| Key Output | Partners | Lead in Gov′t | Long- Term (5 – 10 Yrs) | Medium- Term (3- 5 yrs) | Short- Term (1-2 yrs) | Interventions | Strategic Action |

| | | | | | | th promotion. | |
|-----------------------------|---------------|---------|---------|------------|-----------|----------------------------------|-----------------------|
| | | | | | | the health projection and | |
| | | | | | | community assert to improve | |
| sanitation days | | | | | | mobilize self-help and | |
| promotion campaigns e.g., | | | | | | promotion campaigns that | |
| LGs implementing health | | LGs | | × | | Implement regular health | |
| | | | | | | and disease prevention. | |
| LGs | | | | | | workers) for health promotion | |
| Workforce formalized in all | | | | | | workforce (community health | |
| Community Health | | MoH | | | × | Formalization of volunteer | |
| health facilities | | | | | | | |
| done by public and private | | | | | | | |
| Surveillance and reporting | | | | | | Surveillance & Response System | |
| Weekly Integrated Disease | LGs | MoH | | × | × | Strengthen Integrated Disease | |
| | | | | | | health providers | |
| | | | | | | effective engagement with | |
| | | | | | | ehaviors and i | |
| | | | | | | informed decisions about health | |
| | | | | | | health literacy and facilitate | |
| | | | | | | and promotion to improve | |
| Increased health literacy | LGs, Partners | MoH | × | × | × | Strengthen Health education | |
| | | | | | | plan. | |
| | | | | | | implementation/expansion | |
| | | | | | | developing an | programs |
| | | | | | | structures, identifying gaps and | and social protection |
| | | | | | | mapping community health | prevention (cHPP), |
| plan developed | | | | | | coverage – actions such as | promotion and |
| promotion and prevention | | | | | | health programming to scale up | level health |
| Community-level health | | MoH | | | × | Operationalize the community | 7. Expand community- |
| | | | | | | their correction. | |
| | | | | | | and appropriate solutions to | |
| | | | Yrs) | | | | |
| | | | (5 – 10 | yrs) | (1-2 yrs) | | |
| | | Gov't | Term | Term (3- 5 | Term | | |
| Key Output | Partners | Lead in | Long- | Medium- | Short- | Interventions | Strategic Action |

| MoH, Partners | and health education to | Promote meaningful X X X LGs client/citizen participation in planning, performance monitoring, and accountability | meaningful X X X participation in performance Id accountability ontline workforce X promotion and | meaningful X X X participation in performance id accountability ontline workforce promotion and tion | | meaningful X X X participation in performance id accountability ontline workforce promotion and ition refugee health effectively into nunities. |
|------------------------------|--|--|---|--|--|---|
| Lead in Pa Gov't Pa Pa | ХМон | | | | | |
| | | ς) Γ | 10 ЗЗ | 10H | | |
| | | education and health education LGs using bottom-up planning, monitoring and holding accountability fora | Frontline workforce for health promotion and health education LGs using bottom-up planning, monitoring and holding accountability fora | Frontline workforce for health education LGs using bottom-up planning, monitoring and holding accountability fora Frontline workforce for health promotion and disease prevention recruited | Frontline workforce for health promotion and health education LGs using bottom-up planning, monitoring and holding accountability fora Frontline workforce for health promotion and disease prevention recruited Refugee health services | education and health education LGs using bottom-up planning, monitoring and holding accountability fora Frontline workforce for health promotion and disease prevention recruited Refugee health services integrated into the district health services |
| | | ig, and accountability | induce inducting account ability oility X kforce X and MoH Frontline workforce health | performance morning accountability countability X MoH Frontline workforce ine workforce X MoH Health promotion motion and Image: State of the state of | х х Мон он | х х Мон И И И И И И И И И И И И И И И И И И И |
| | meaningfulXXXLGsLGsusingparticipationinplanning, moniperformanceholding account | | kforce X MoH Frontline workforce and health promotion | ine workforce X MoH Frontline workforce motion and | х х | х х |
| | X X X X X X MOH MOH K MOH MOH GS | мон | х х | X MOH | X MoH Low-cost | |
| | х X X X X X X X X X X X X X X X X X X X | х х Мон Мон | х х Мон | × MoH | X MoH Low-cost programs introdu | providers, |
| | х X X X X MoH MoH Gs | х х Мон Мон | X X MOH | Х | X MoH Low-cost programs introdu | aceutical and medical manufacturers to |

| | | | | | | | | | | | | | | | determinants | mitigate health | wide programs to | sectoral government- | integrated multi- | operationalize | 8. Develop and | | | | | | | | | Sugregic Action | Stratogic Action |
|---------------------|--|------------------------------|------------------------------|-------------------------------|------------------------------|-------------|---------------------|------------------------------|----------------------------|-------------------------------|---------------------------------|------------------------------|-----------------|-------------------------|-----------------------------|---------------------------|------------------|---------------------------|------------------------|-----------------------------|----------------------------|------------------------|--------------------------------|---------------------------------|----------------------------------|-----------------------|-----------------------|------|-----------|-----------------|------------------|
| healthy lifestyles. | and health promotion around key tonics such as nutrition | focussed on health education | campaigns with other sectors | education and behavior change | Conduct integrated community | leadership. | and other community | undertaken by Local Councils | campaigns (bulungi bwansi) | level coupled with sanitation | and sanitation at the community | Expand access to clean water | implementation. | throughout planning and | collaboration and synergies | Enforce multisectoral | national level. | engagement for UHC at the | towards multi-sectoral | arrangements and modalities | Establish institutional | services as available. | both public and private sector | allow for communities to access | Design financing modalities that | secondary prevention. | programs that support | | | | Interiore |
| | | | | | | | | | | | | × | | | | | | | | | × | | | | | | | | (1-2 yrs) | Term | Chort |
| | | | | | × | | | | | | | × | | | | × | | | | | × | | | | × | | | | yrs) | Term (3- 5 | Modium |
| | | | | | | | | | | | | × | | | | × | | | | | | | | | | | | Yrs) | (5 – 10 | Term | - |
| | | | | | LGs | | | | | | | MoW&E | | | | OPM | | | | | OPM | | | | MoH | | | | | Gov't | |
| | | | | | | | | | | Political Leaders | MoLG | MoH | | | | | | | | | | | | | | | | | | Partiters | |
| | | | campaigns were held. | education and SBCC | Integrated community | | | | Sanitation campaigns held | | water and sanitation | Expanded access to clean | | programs developed | government-wide | Integrated multi-sectoral | | | established. | for multi-sectoral action | The institutional modality | | | for health established | Prepayment mechanisms | | | | | Ney Output | Kou Dutaut |

| | | | | | | health service delivery. | |
|----------------------------------|----------|---------|---------|------------|-----------|-----------------------------------|----------------------|
| SCD, Diabetes, HT, etc) | | | | | | capacity of NCDs at all levels of | |
| selected NCDs | | | | | | identification or diagnostic | |
| Population | | MoH | × | × | × | Strengthen screening and early | |
| | | | | | | advanced | |
| | | | | | | they become complicated or | |
| updated and disseminated | | | | | | protocols for conditions before | |
| Uganda Clinical Guidelines | | MoH | | | × | Establish effective care | |
| | | | | | | approaches. | |
| | | | | | | community using the PHC | |
| services | | | | | | 0 | |
| Population accessing PHC | | MoH | × | × | × | Manage the commonest causes | |
| | | | | | | technologies. | |
| country | | | | | | effective vaccination | |
| the priority diseases in the | | | | | | major disease burden with | |
| Vaccination | | MoH | × | × | × | Expand vaccinations to cover | |
| | | | | | | sector providers. | |
| and utilized | | | | | | between public and private | |
| Referral protocols in place | | MoH | | | × | Strengthen referral protocols | |
| | | | | | | provision. | |
| | | | | | | the functionality of service | |
| Revised Service Standards | | MoH | | | × | Define sets of inputs to expand | |
| | | | | | | approach. | |
| | | | | | | life stage using a multi-sectoral | |
| | | | | | | intervention packages for each | |
| package for the level. | | | | | | with a focus on high-impact | |
| implemented the defined | | | | | | Essential Health Care Package | |
| Health | | | × | × | × | Implementation of the revised | specialized services |
| revised | | | | | | | and increasingly |
| package | | | | | | health care package for Uganda | health care services |
| Essential | | МоН | | | × | Define/revise the essential | breadth of essential |
| | | | Yrs) | | | | |
| | | | (5 – 10 | yrs) | (1-2 yrs) | | |
| | | Gov't | Term | Term (3- 5 | Term | | |
| vey Output | Partners | Lead in | Long- | Medium- | Short- | Interventions | Strategic Action |

| Х Мон |
|---------|
| × |
| |
| |
| |
| |
| |
| |
| х Мон |
| |
| |
| |
| Мон |
| |
| |
| |
| |
| |
| |
| MolCT |
| |
| |
| |
| |
| Мон |
| |
| |
| Х Мон |
| Yrs) |
| (5 – 10 |
| |
| |

| Develop netw for mapping coordination health actors. | intrastructure, Develop a medicines, supplies framework for u and vaccines, health roles for the ke workforce expansion, levels to include g health information, coordination o research and actions to impro technology all vital agencies. | Link accreditation and improvement program health financing t mechanisms such performance-based incer improvement in coordination of UHC governance, programs across sectors. | Develop a plan for i in the medical excellence includii private partnerships. Establish a regular a system for providers health care ser specialized servio appropriate incen sanctions. | Strategic Action |
|---|--|---|---|-------------------------|
| Develop networked e-platform for mapping, reporting and coordination of all non-state health actors. | Develop a multi-sectoral framework for UHC with clear roles for the key actors at all levels to include governance and coordination of actors and actions to improve health from all vital agencies. | Link accreditation and quality improvement programs to health financing through mechanisms such as performance-based incentives. Provide leadership structure for coordination of UHC-related programs across sectors. | Develop a plan for investments in the medical centers of excellence including public- private partnerships. Establish a regular accreditation system for providers of essential health care services and specialized services with appropriate incentives and sanctions. | |
| × | × | × | | Term (1-2 yrs) |
| × | | × | × | yrs) |
| | | × | × | Term (5 – 10 Yrs) |
| МоН | MoH | МоН ОРМ | Мон | Gov't |
| LGs, Partners | LGs, Private Sector | MoFPED MoLG | | raiues |
| All non-state health actors mapped and resources tracked at all levels | Multi-sectoral framework developed | Health financing linked to performance Coordination structure for UHC related programs in place | Investment Plan for medical centers of excellence developed Accreditation system developed | vel Orthor |

| NY NG X NGH LGs, Private Sector X X MOH LGs X X MOH LGs X X MOH LGs X X MOH LGs | Strategic Action | Interventions | Short- Term (1-2 vrs) | Medium- Term (3- 5 vrc) | Long- Term (5 – 10 | Lead in Gov't | Partners | Key Output |
|--|------------------|------------------------------------|-----------------------------|-------------------------------|--------------------------|------------------|---------------------|--------------|
| X X X MoH LGs, Private Sector X X X MoH LGs X X X MoH LGs X X X MoH LGs | | | (1-2 yrs) | yrs) | (5 – 10 Yrs) | | | |
| X X X X X X X X X X X X X X X X X X X | | | × | × | | МоН | LGs, Private Sector | 9f |
| X X X X MOH X X X X MOH X X X X MOH X X X X MOH X X X K MOH LGs MOH, CSOS K MOH K X MOH K K MOH | | nip/managerial | | | | | | trained in |
| X X X MOH LGS, Private Sector X X X MOH LGS, Private Sector X X X MOH LGS X X X MOH LGS X X MOH LGS MOH MOH LGS MOH MOH LGS | | efficiency and effectiveness at | | | | | | managem |
| X X X MoH LGS, Private Sector X X X MoH LGS MoH, CSOS X X MoH LGS MoH, CSOS LGS X X MoH LGS MoH, CSOS LGS X X MoH LGS MoH, CSOS LGS | | district and hospital/health | | | | | | Q |
| X X X X MOH X X X MOH LGs MOH, CSOS MOH GS MOH, CSOS | | vel | | | | | | |
| х Х Х Мон LGs Х Х Мон LGs Мон LGs Мон LGs | | Set standards of practice and | × | × | × | MoH | LGs, Private Sector | Standards |
| х Х Х Мон LGs Х Мон СSOs | | guidelines for different settings | | | | | | guidelines |
| x x x x x x x x x x x K x X K x K K K K <t< td=""><td></td><td>Communities- in training</td><td></td><td></td><td></td><td></td><td></td><td>nutrition</td></t<> | | Communities- in training | | | | | | nutrition |
| X X X X MOH X X MOH K X MOH K K K K K K K K K K K K K K K K K K K | | schools | | | | | | different s |
| х X X MOH LGs X MOH LGs X MOH LGs | | places, homes, prisons, security | | | | | | |
| х Х Х МОН LGs Х Х МОН LGs МОН CSOs | | institutions, etc.) for health and | | | | | | |
| X X X MoH LGs X X X IGs MoH, CSOs X X X MoH IGs X X X MoH IGs | | nutrition programs. | | | | | | |
| X X X MOH X MOH X MOH X MOH | | Develop integrated Operational- | | х | | MoH | LGs | Integrated |
| х Х Х Х Х Х Х Х Х Х Х Х Х Х Х Х Х Х Х Х | | level (OPL) and Mid-level | | | | | | manuals |
| х Х Х К К К К К К К К К К К К К К К К К | | Manager's (MLM) manuals for | | | | | | |
| X X X X X X X X X X X X X X X X X X X | | delivery of the UNMHCP | | | | | | |
| х Х Х Х Х М ОН М ОН И С С С С С С С С С С С С С С С С С С | | Catchment | × | × | | LGs | MoH, CSOs | Facilities |
| × × × | | | | | | | | CAPA or sin |
| × × × × × × × × MoH × | | (CAPA) planning at all health | | | | | | |
| × × × × × × | | facilities | | | | | | |
| × | | the | | × | × | MoH | | All disaster |
| х х м м н | | Centre (EOC) | | | | | | within 48 h |
| х х м М Ч | | and use | | | | | | |
| X X X MOH | | generated | | | | | | |
| х х мон | | e.g., | | | | | | |
| × × × MoH | | | | | | | | |
| X X MoH | | pandemics | | | | | | |
| X X MoH | | emerging global health threats | | | | | | |
| implement a X X X MoH | | for a timely response. | | | | | | |
| n Plan (NAP) for | | and implement | × | × | × | MoH | | NAP for He |
| | | National Action Plan (NAP) for | | | | | | developed |
| | | Health Security | | | | | | implemented |

| yrs) (5 - 10 Yrs) X MoH X MoH MoH LGs, MoSTI, MoEM, MOWE MOH X X X MoH LGs, Private Sector X MoH X MoH MoH LGs, Private Sector X MoH LGs, Private Sector MoH LGs, Private Sector | Strategic Action | Interventions | Short- Term | Medium- Term (3- 5 | Long- Term | Lead in Gov't | Partners | Key Output |
|--|------------------|-------------------------------------|----------------|-----------------------|-----------------|------------------|---------------------|-------------------------|
| bilsh Port Health Services for X X MoH anced surveillance X MoH MoH ate and revise the public X MoH MoH alop a National Master Plan X MoH MoH glop a National Master Plan X MoH MoH establishment, expansion X MoH MoH maintenance of public MoH MoWT, MoEM, MoWT, MoEM, MOWT, MoEM, MOWE MoH truction, rehabilitation and general hospitals X X X MoH asse access to specialized X X X MoH LGs, Private Sector th care services by X X X MOH LGs, Private Sector th care services of general hospitals X X X MoH LGs, Private Sector th care services of general hospitals X X X MoH LGs, Private Sector th care services of general hospitals and Super X X X MoH LGs, Private Sector th care services of lences. X X X MoH LGs, Private Sector th care services of lences. X X X MoH LGs, Private Sector lence. X X <td< th=""><th></th><th></th><th>(1-2 yrs)</th><th>yrs)</th><th>(5 – 10 Yrs)</th><th></th><th></th><th></th></td<> | | | (1-2 yrs) | yrs) | (5 – 10 Yrs) | | | |
| Inced surveillance X MoH aata and revise the public- tale partnerships strategy or to determine baseline X MoH stop a National Master Plan maintenance of public X MoH LGs, MoSTI, MoWT, MoEM, MoWT, MoEM, MoWT, MoEM, MOWE sipp a National Master Plan maintenance of public X X MoH LGs, MoSTI, MoWT, MoEM, MOWE establishment, expansion maintenance of public X X MoH LGs, MoSTI, MoWT, MoEM, MOWE safe access to essential truction, rehabilitation ase access to specialized pping of general hospitals X X MOH LGs, Private Sector truction and rehabilitation perral hospitals and Super failzed hospitals /Centres for gency Medical Services. MOH LGs, Private Sector MOH LGs, Private Sector Lence. bish regional biod banks X X X MOH LGs, Private Sector Lence. bish regional biod banks X X X MOH LGs, Private Sector Lence. bish regional biod banks X X X MOH LGs, Private Sector Lence. bish regional biod banks X X X MOH LGs, Private Sector Lence. | | Establish Port Health Services for | × | × | | МоН | | Port Health facilities |
| Late and revise the public- tre partnerships strategy or to determine baseline X MoH Sions. MoH LGs, MoSTI, MoWT, MoEM, MoWT, MoEM, maintenance of public Isions. MoH LGs, MoSTI, MoWT, MoEM, MOWE establishment, expansion maintenance of public MoH LGs, MoSTI, MOWT, MoEM, MOWE establishment, expansion maintenance of public MoH LGs, Private Sector th infrastructure in the thy linked to overall urban, s and transport, electricity X X MOH water development plans. X X MOH LGs, Private Sector th care services by truction, rehabilitation and rehabilitation aferral hospitals and Super failzed hospitals/Centres of lence. X X X MoH bish regional blood banks X X X MoH LGs, Private Sector bish regional blood banks X X X MoH LGs, Private Sector vision and repailal king X X X MoH LGs, Private Sector | | enhanced surveillance | | | | | | constructed |
| ate partnerships strategy or to determine baseline isions. X X MoH LGs, MoSTI, MoEM, MoWI, MOEM, MOWI, MOUH, MCS, Private Sector the care services of services for rialized hospitals /Centres of rigency Medical Services at all X X MoH LGs, Private Sector MOH LGS, | | Evaluate and revise the public- | × | | | MoH | | PPP strategy evaluat |
| isions. MoH LGs., MoSTI, establishment, expansion maintenance of public MoH LGs., MoWT, MoEN, establishment, expansion x x MoH MoWT, MoWT, MoENT, establishment, expansion x x MoH LGs., MoWT, MoENT, establishment, expansion x x X MoH LGs., MoWT, MoENT, establishment, expansion maintenance of public x X MoH LGs., MoWT, MoENT, establishment, expansion x X X MoH LGs., MoWT, MoENT, sand transport, electricity x X X MoH LGs, PrivateSector sare access to specialized X X X MoH LGs, PrivateSector th care services of X X X MoH LGs, PrivateSector thc.cs. and rehabilitation X X X MoH LGs, PrivateSector taized hospitals /Centres of | | private partnerships strategy or | | | | | | and revised |
| isions. MoH MoH MoH MoSTI, alop a National Master Plan X MoH MoH MoSTI, maintenance of public infrastructure in the MoWT, MoEM, MoWT, MoEM, th infrastructure in the infrastructure in the MoWT, MoWT, MoEM, MOWE MOH LGs, Private Sector MOH LGs, Private Sector MOH Is, Private Sector< | | plan to determine baseline | | | | | | |
| Bop a National Master Plan X MoH LGs, MoSTI, establishment, expansion moWT, MoWT, MoWT, MoWT, MoWT, maintenance of public moWT, MoWT, MoWT, MoWT, MoWE, th infrastructure in the MoWT, MoWE MoWE, MoWE, try linked to overall urban, s and transport, electricity X X X MoH LGs, private Sector water development plans. x X X X MoH LGs, private Sector th care services by x X X MoH LGs, private Sector th care services by x X X MoH LGs, private Sector th care services by x X X MoH LGs, private Sector th care services of x X X MoH LGs, private Sector th care services. x X X MoH LGs, private Sector th care services. x X MoH LGs, private Sector th care services. x X MoH LGs, private Sector tialo | | provisions. | | | | | | |
| establishment, expansionMoWT, MoEM, MOWEmaintenance of public th infrastructure in the thy linked to overall urban, s and transport, electricity water development plans.XXMOWEase access to essential thus care services by thus care services | | Develop a National Master Plan | × | | | MoH | | National Master Plan |
| maintenance of publicMOWEth infrastructure in the try linked to overall urban, s and transport, electricityXXMOHase access to essential ase access to specialized private services by truction, rehabilitation and rehabilitation private services of ialized hospitals and Super ialized hospitals /Centres of illence.XXXMOHLGs, Private SectorIllence.XXXXMOHLGs, Private SectorIllence.XXXMOHLGs, Priv | | establishment, | | | | | | developed |
| X X X MoH LGs, Private Sector General hospitals constructed/ rehabilit X X X MoH LGs, Private Sector Referral hospitals an Super Specialized ho /Centres of Excellence constructed/ rehabilit X X X MoH LGs, Private Sector Referral hospitals an Super Specialized ho /Centres of Excellence constructed/ rehabilit X X X MoH LGs, Private Sector Referral hospitals an Super Specialized ho /Centres of Excellence constructed/ rehabilit X X X MoH LGs, Private Sector Regional Ellood established were lact | | maintenance | | | | | MOWE | |
| X X X MoH LGs, Private Sector General hospitals constructed/ rehabilit X X X MoH LGs, Private Sector Referral hospitals and Super Specialized hospitals and Centres of Excellence constructed/ rehabilit X X X MoH LGs, Private Sector Referral hospitals and Centres of Excellence constructed/ rehabilities of Excellence constr | | health infrastructure in the | | | | | | |
| X X X MoH LGs, Private Sector General hospitals constructed/ rehabilities constructed/ rehabil | | country linked to overall urban, | | | | | | |
| X X X X MoH LGs, Private Sector General hospitals constructed/ rehabilitities constructed/ rehabilities c | | roads and transport, electricity | | | | | | |
| X X X X MoH LGs, Private Sector General hospitals constructed/rehabilit X X X X MoH LGs, Private Sector Referral hospitals and Super Specialized hospitals and Super Spec | | and water development plans. | | | | | | |
| X X X X X MoH LGs, Private Sector Referral hos X X X MoH LGs, Private Sector Referral hos X X X MoH LGs, Private Sector Referral hos X X X MoH LGs, Private Sector Referral hos X X X MoH LGs, Private Sector Reform tructed/ & equipped X X X MoH LGs, Private Sector Regional established | | access to | × | × | × | Мон | LGs, Private Sector | General hospitals |
| X X X X MoH LGs, Private Sector Referral hospitals and Super Specialized hospitals and Super Speciali | | care services | | | | | | constructed/ rehabiliti |
| X X X X MoH LGs, Private Sector Referral hospitals and Super Specialized ho /Centres of Excellence constructed/ rehabilitities X X X MoH LGs, Private Sector Super Specialized ho /Centres of Excellence constructed/ rehabilities X X X MoH LGs, Private Sector EMS functional X X X MoH LGs, Private Sector Regional Blood established were laci | | construction, rehabilitation and | | | | | | & equipped |
| X X X MoH LGs, Private Sector Referral hospitals and Super Specialized hospitals and | | equipping of general hospitals | | | | | | |
| X X X MOH LGs, Private Sector Referral hospitals and Super Specialized ho /Centres of Excellenc constructed/ rehabilit & equipped X X X X MOH LGs, Private Sector Regional Blood established were lac | | and HCs. | | | | | | |
| X X X X MoH EMS functional X X X MoH LGs, Private Sector Regional Blood established were lack MoH LGs, Private Sector Regional Blood | | access | × | × | × | MoH | LGs, Private Sector | Referral hospitals and |
| X X X MoH LGs, Private Sector Regional Blood established were lac | | care services | | | | | | Super Specialized ho |
| X X X X Kequipped X X X MoH EMS functional X X X MoH LGs, Private Sector Regional Blood established were lacl Kerelacl Kerelacl Kerelacl Kerelacl Kerelacl | | construction and rehabilitation | | | | | | /Centres of Excellence |
| X X X X X X X X X X X X X X X X X X X | | of referral hospitals and Super | | | | | | constructed/ rehabilit |
| X X X MoH LGs, Private Sector | | Specialized hospitals /Centres of | | | | | | & equipped |
| X X X MoH LGs, Private Sector | | Excellence. | | | | | | |
| X X X MoH LGs, Private Sector | | Establishment of National and | × | × | | MoH | | EMS functional |
| X X X MoH LGs, Private Sector Regional Blood established were lack | | Call Centres | | | | | | |
| X X MoH LGs, Private Sector Regional Blood established were lack | | Emergency Medical Services. | | | | | | |
| | | Establish regional blood banks | × | × | | MoH | LGs, Private Sector | Blood |
| HC IVs. | | and blood storage facilities at all | | | | | | established were lack |
| | | HC IVs. | | | | | | |

| Term Term Staff Term Staff HC IV's equipped with staff housing HC IV's equipped with staff housing HC IV's equipped with biodis stage Improve neart in coverage of staff housing X X MOH LGs, Private Sector Policities biolis staff Improve nearts in cluding interconing of the Regional Maintenance X X MOH LGs, Private Sector Policities biolis staff Capacity building in ICD coding to improve diseas and death to improve diseas and levels to improve diseas and death to improve diseas and levels to improve disease and death to improve disease and death system. X X MOH NRA ICD coling integrated into thouses constructed system. ICD coling integrated into to improve disease and death to improve disease in the system in all policit and private hospitals. HC IVS and, high volume HC IIIs with internet access X X MOH NRA ICD coling integrated into integrating the electronic information system by integrating the electronic information systems within the health information systems by integrating the electronic information systems by integrating the electronic information system is babilished. X X MOH MOSTI, LGS Comprehensive information system is babilished. EMABS, MAOS, | Strategic Action | Interventions | Short- | Medium- | Long- | Lead in | Partners | Key Output |
|--|------------------|------------------------------------|-------------------|--------------------|-------------------------|---------|---------------------|---|
| X X X MOH LGs, Private Sector X X X MOH LGs, Private Sector X X X MOH LGs, Private Sector X X X MOH NIRA X X X MOH NIRA X X X MOH MoSTI, LGs X X X MOH MoSTI, LGs | | | Term (1-2 yrs) | Term (3- 5 yrs) | Term (5 – 10 Yrs) | Gov't | | |
| X X X MoH LGs, Private Sector X X MoH Image: Sector X X X MoH MoSTI, Image: Sector X X X MoH MoSTI, Image: Sector X X X MoH MoSTI, Image: Sector | | | | | | | | HC IVs equipped with blood storage facilities |
| X X X MoH X X MoH LGs, Private Sector X X X MoH NIRA X X X MoH NIRA X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs | | in coverage | Х | × | × | Мон | LGs, Private Sector | Public sector health staff houses constructed |
| X X X MoH LGs, Private Sector X X MoH NIRA X X X MoH NIRA X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs | | Improve capacity in equipment | × | × | | МоН | | retooled |
| X X X MoH LGs, Private Sector X X MoH NIRA X X X MoH NIRA X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs | | use and maintenance including | | | | | | |
| X X MoH LGs, Private Sector X X MoH NIRA X X X MoH NIRA X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs | | retooling of the Regional | | | | | | |
| X X X MoH LGs, Private Sector X X MoH NIRA X X X MoH NIRA X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs | | | | | | | | |
| X X X MoH LGs, Private Sector X X X X MoH NIRA X X X X MoH MoSTI, LGs X X X MoH MoSTI, LGs MoH MoSTI, LGs | | Workshops. | | | | | | |
| X X MOH NIRA X X X MOH NIRA X X X MOH MOSTI, LGS X X MOH MOSTI, LGS | | Establish an efficient, safe and | | × | × | MoH | LGs, Private Sector | HCWM system established |
| X X X MOH NIRA X X X X MOH MOSTI, LGS MOH MOSTI, LGS | | environmentally sustainable | | | | | | |
| X X X MOH NIRA X X X MOH MOSTI, LGS X X X MOH MOSTI, LGS MOH MOSTI, LGS | | System. | | | | | | |
| X X X MOH MOSTI, LGS X X X MOH MOSTI, LGS | | Capacity building in ICD coding | × | | | Мон | NIRA | ICD coding integrated into |
| X X X MoH MoSTI, LGs National EMRS es X X X MoH MoSTI, LGs on hospitals, HC X X X MoH MoSTI, LGs high volume HC II National EMRS MoH MoSTI, LGs Information Registries establis MoH MoSTI, LGs Information | | for health providers at all levels | | | | | | SIMH |
| X X X MoH MoSTI, LGs National EMRS es X X X MoH MoSTI, LGs on hospitals, HC X X X MoH MoSTI, LGs high volume HC II X X X MoH MoSTI, LGs Comprehensive Information Registries establis Registries establis Registries establis | | to improve disease and death | | | | | | |
| X X X MOH MOSTI, LGS National EMRS es on hospitals, HC high volume HC II X X X MOH MOSTI, LGS Comprehensive Information Registries establis | | reporting and notification. | | | | | | |
| X X X MoH MoSTI, LGs Information Registries establis | | Establish and scale up a national | × | × | × | MoH | MoSTI, LGs | National EMRS established |
| X X X MoH MoSTI, LGs Comprehensive Information Registries establis | | Electronic Medical Records | | | | | | high volume HC IIIs |
| HC IIIs with internet X X MoH MoSTI, LGs Comprehensive information system by information system by tring the electronic systems within the sector (HMIS, HRIS, CHIS, Sector (HMIS, HRIS, CHIS, Solution, Sector (HMIS, ERP, RX Solution, Sector (H | | hospitals, HC IVs and high- | | | | | | Q |
| in a comprehensive X MoH MoSTI, LGs Comprehensive information system by X MoH MoSTI, LGs Information ting the electronic Information Information Registries establis ation systems within the sector (HMIS, HRIS, CHIS, Information Registries establis wAOS, ERP, RX Solution, Information Information Information | | volume HC IIIs with internet | | | | | | |
| a comprehensive X X MoH MoSTI, LGs Comprehensive iformation system by Information information systems within the Systems within the Comprehensive ctor (HMIS, HRIS, CHIS, C | | access. | | | | | | |
| Information Registries establis | | ۵ | × | × | | MoH | MoSTI, LGs | |
| | | health information system by | | | | | | Information Exchange |
| Information systems within the health sector (HMIS, HRIS, CHIS, EMRS, WAOS, ERP, RX Solution, | | integrating the electronic | | | | | | Registries established. |
| health sector (HMIS, HRIS, CHIS, EMRS, WAOS, ERP, RX Solution, | | information systems within the | | | | | | |
| EMRS, WAOS, ERP, RX Solution, | | health sector (HMIS, HRIS, CHIS, | | | | | | |
| | | EMRS, WAOS, ERP, RX Solution, | | | | | | |

| (1-2 yrs) yrs) (5 - 10 MOH LGs, Partners Community heal X X X X MOH LGs, Partners Iniked to HMIs X X X X MOH LGs, Partners Decisions making I X X X X MOH LGs, Private Decisions making I X X X X MOH LGs, Private Decisions making I X X X X MOH LGs, Private Private health reoviders X X X X MOH LGs Private health research X X X X MOH LGs Annual DQAs cond X X X X MOH LGs Annual DQAs cond X X X X MOH LGs Annual DQAs cond VICRI VICRI UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, Works and publicat and agenda and agenda and agenda X X X UNCRI UNCRI inversities, LGs, partners Investment plan </th <th>Strategic Action</th> <th>Interventions</th> <th>Short- Term</th> <th>Medium- Term (3- 5</th> <th>Long- Term</th> <th>Lead in Gov't</th> <th>Partners</th> <th>Key Output</th> | Strategic Action | Interventions | Short- Term | Medium- Term (3- 5 | Long- Term | Lead in Gov't | Partners | Key Output |
|---|------------------|------------------------------------|----------------|-----------------------|-----------------|------------------|--------------------|--------------------------|
| e-Recruitment, X X MOH LGS, Partners an, and scale-up am. X X MOH LGS, Partners am, other am, order to ion systems for tion on UHC. X X MOH LGS, Private rdination with an order to ig from private X X MOH LGS, Private r umbrella r order to ig from private X X MOH LGS, Private vall health X X MOH LGS, Private vall health X X MOH LGS, Providers vall health X X MOH LGS, Private vall health X X MOH LGS, Private vall health X X X MOH vall health X X X MOH vall health X X MOH LGS, Private vall health X X X MOH LGS, Private vall health X X X MOH LGS, Partners vall health X X VINRO Academia Providers vall health X X VINRO MoSTI, UNCRI, Varies, LGS, Partners vall health X X VINRO | | | (1-2 yrs) | yrs) | (5 – 10 Yrs) | 907 L | | |
| in and scale-up X X MoH LGs, Partners em. and other X X MoH LGs, Private ion systems for X X MoH LGs, Private ion order to X X MoH LGs, Private providers X X MoH LGs, Cs, Private providers X X MoH LGs, Cs, Cs, UNRI, UNRI, UNRI, UNCRI, Universities, LGs, Partners provider | | NDAMIS, HPRIS, e-Recruitment, | | | | | | |
| In and scale-up X X MoH LGs, Partners nunity Health X X MoH LGs, Partners ion systems for X X MoH LGs, Private ion systems for X X MoH LGs, Private ion order to X X MoH LGs, Private or umbrella X X MoH LGs, Private or order to X X MoH LGs, Private or umbrella X X X MoH research and X X X MoH research priority X X X MoH research priority X X X UNHRO search priority X X X UNHRO search priority X X X UNCRI, UVRI, UVRI, UNRI, UNCRI, UNCR | | CRVS, etc). | | | | | | |
| numity Health X X MoH Image: Constraint of the sector sevence he safety, or the | | Operationalization and scale-up | × | × | | MoH | LGs, Partners | Community hea |
| ann. x X MoH Jse of big data X X MoH Ition on UHC. X X MoH LGs, Private or umbrella X X X MoH LGs, providers X X X MoH LGs, providers X X X MoH LGs, Providers X X VNRO Academia vestreit priority X X VNRO MoSTI, UVRI, UNRI, Separtners vestreit plans < | | Community | | | | | | linked to HMIS |
| Jase of big data X X MoH and other X X MoH ion systems for X X MoH criination with X X MoH providers to X MoH LGs, Private providers to X X MoH LGs, Private search priority X X X MoH LGs, Private search priority X X X MoH LGs, Private search priority X X X UNHRO Academia search priority X X X UNRI, UVRI, UVRI, UNRI, | | Information System. | | | | | | |
| tion on UHC. ion systems for tion on UHC. redination with X X X MOH LGs, Private pr umbrella n order to ig from private Data Quality X X X X MOH research and X X X MOH LGs research priority search priority search priority titutions to alth impact research and with non-health X X X X X UNHRO Academia CRC, UNCRI, UCRI, titutions research for g research for h MoH LGs MOH LGs MOH LGs MOH LGs MOH LGs MOH LGs MOH LGs MOH LGs MOH LGs MOH LGs MOH, UNCRI, UCRI, UNCRI, UCRI, UNCRI, UCRI, UNCRI, UCRI, UNCRI, UCRI, Partners Partners Partners Partners | | Strengthen the use of big data | | Х | Х | Мон | | Decisions making |
| ion systems for tion on UHC.XXXMoHLGs, PrivatePrivateor or umbrella n or der to ig from privateXXMoHLGs, ProvidersProvidersor or g from privateXXXMoHLGs, ProvidersProvidersv g from privateXXXMoHLGs, ProvidersProvidersv g from privateXXXMoHLGsv g from privateXXXUNHROAcademiav search priorityXXXUNHROAcademiasearch priorityXXXUNHROMoSTI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, PartnersUNCRI, PartnersUNCRIvestment plans g research for e on the safety,XXUNCRIPrivate Sector | | integrating HIS and other | | | | | | evidence from |
| tion on UHC.XXXMOHLGS, PrivateorumbrellaXXMOHLGS, Providersoror der to ig from privateXXXMOHLGS, Providersig from privateXXXMOHLGSig from privateXXXMOHLGSig from privateXXXMOHLGSig from privateXXXUNHROAcademiaig from privateXXXUNHROAcademiaig research and with non-healthXXXUNHROMoSTI, UNCRI, UNCRI, UNCRI, Partnersig research for g research for e on the safety,XXUNCRIPrivate Sector | | sectoral information systems for | | | | | | sectoral data |
| rdination with or umbrella n order to g from privateXXXMoHLGs, ProvidersPrivate ProvidersvData Quality research and QD) strategy search priorityXXXMoHLGsresearch and QD) strategy search priorityXXXMoHLGsresearch and QD) strategy search priorityXXXUNHROAcademiaresearch priorityXXXUNHROMoSTI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, PartnersUNCRI, Partners Partnersresearch for g research for e on the safety,XXUNCRIPrivate Sector | | strategic information on UHC. | | | | | | |
| or umbrella Providers in order to ig from private X X is participation X UNCRI is partners Yester UNCRI is partners Yester is partners Yester | | Strengthen coordination with | Х | × | х | НоМ | | |
| n order to x x X MoH LGs research and x x x X MoH LGs research and x x x X NoH LGs research and x x x X UNHRO Academia search priority x x X UNHRO Academia search priority x x X UNHRO Academia search priority x x X UNHRO MoSTI, UVRI, UVRI, UVRI, UVRI, UVRI, UVRI, UVRI, UCRI, UNCRI, UCRI, UNCRI, UCRI, UNCRI, UCRI, UNCRI, UCRI, UNCRI, | | private sector umbrella | | | | | Providers | |
| Ig from privateXXXMoHLGsI Data QualityXXXMoHLGsI Data QualityXXXMoHLGsI Data QualityXXXMoHLGsI Data QualityXXXUNHROAcademiaI Data QualityXXXUNHROAcademiaI Data ConstrategyXXXUNHROAcademiaI RobertXXXUNHROMoSTI, UVRI,I utilitionsXXXUNHROMoSTI, UVRI,ealthImpactXXUNHROMoSTI, UVRI,i utilitionsXXUNHROMoSTI, UCRI,UCRI,esearch andXXXUNCRI,Partnersresearch forXXUNCRIPrivate Sectorg research forXXUNCRIPrivate Sectore on the safety,XXUNCRIPrivate Sector | | ⊒. | | | | | | DHIS2 strengthened |
| Pata QualityXXXMoHLGsresearch andXXXMoHLGsresearch andXXXUNHROAcademia&D) strategyXXXUNHROAcademia&D) strategyXXXUNHROAcademia&D) strategyXXXUNHROMoSTI, UVRI,earch priorityXXXUNHROMoSTI, UVRI,earch andXXXUNHROMoSTI, UVRI,earch andXXXUNHROMoSTI, UVRI,earch andXXUNCRI, JCRC,Universities, LGs,research forXXUNCRIPartnersresearch forXUNCRIPrivate Sectorg research forXUNCRIPrivate Sector | | increase reporting from private | | | | | | |
| Pata Quality X X X MoH LGs research and X X X MoH LGs research and X X X UNHRO Academia x&D) strategy X X X UNHRO Academia x&D) strategy X X X UNHRO Academia x&D) strategy X X UNHRO Academia x&D X X UNHRO MoSTI, UVRI, search priority X X UNHRO MoSTI, UVRI, search and X X UNHRO MoSTI, UVRI, itutions to X X UNHRO MoSTI, UVRI, itutions X X UNURI UNCRI, JCRC, UNCRI, UNCRI, Partners vith non-health X X UNCRI Private Sector Private Sector g research for X X UNCRI Private Sector e on the safety, X UNCRI Private Sector | | sector providers. | | | | | | |
| or all healthXXXUNHROAcademiaresearch and &CD strategy search priorityXXVUNHROAcademia&CD strategy &&CD strategy search priorityXXXUNHROAcademia&CD strategy &&CD strategy search priorityXXXUNHROAcademia&CD strategy &XXXUNHROMoSTI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, UNCRI, PartnersUNCRI, Partnerseon the safety,XUNCRIPrivate Sector | | Data | × | × | × | MoH | LGs | Annual DQAs conducted |
| research and &D) strategy &AD) strategy search priorityXXXUNHROAcademia&D) strategy search priorityXXUNHROAcademia&AD) strategy search priorityXXUNHROAcademiaalth sector itutions titutions alth impact research and with non-healthXXUNHROMoSTI, UNCRI, UNCRI, UNCRI, Partnersvestment plans g research for e on the safety,XUNCRIUNCRIPrivate Sector | | for all | | | | | | |
| research and X X X VINHRO Academia R&D) strategy search priority search priority ealth sector X X X VINHRO MoSTI, UVRI, titutions to alth impact research and research and xestment plans X X VINHRO MoSTI, UVRI, ittu non-health itth non-health xestment plans X VINHRO Partners g research for g research for g research for g research for g | | facilities. | | | | | | |
| QLD) strategy search priority search priority ealth sector X X UNHRO MoSTI, UVRI, titutions to X X UNHRO MoSTI, UVRI, itutions to X X UNHRO MoSTI, UVRI, itutions to X UNHRO MoSTI, UVRI, JCRC, itutions to X Partners Partners research and X UNCRI Partners vith non-health X UNCRI Private Sector g research for X UNCRI Private Sector e on the safety, X UNCRI Private Sector | | Develop health research and | × | × | × | UNHRO | Academia | Health research strategy |
| search priority X X X UNHRO MoSTI, UVRI, ealth sector X X UNHRO MoSTI, UVRI, titutions to X X UNHRO UNCRI, JCRC, alth impact X UNCRI, JCRC, Universities, LGs, research and X UNCRI Partners Partners with non-health X UNCRI Private Sector g research for X UNCRI g research for X UNCRI Private Sector g rotate Sector g rotate Sector | | development (R&D) strategy | | | | | | and agenda |
| ealthsectorXXXUNHROMoSTI,UVRI,titutionstoXXUNHROMoSTI,UVRI,althimpactXUNUCRI,JCRC,althandXValuePartnersresearchandXUNCRIPartnersvith non-healthXUNCRIPrivate Sectorg research forXUNCRIPrivate Sectorg research forXUNCRIPrivate Sector | | and national research priority | | | | | | |
| ealthsectorXXXUNHROMoSTI,UVRI,LitutionstoUNCRI,JCRC,Litutionsuniversities,LGs,researchanduniversities,LGs,researchanduniversities,LGs,researchanduniversities,LGs,researchuniversities,LGs,vith non-healthuniversities,LGs,researchuniversities,LGs,researchuniversities,LGs,g researchtotog researchtotog researchtotog researchtotog researchtotog researchtotog researchtotog researchtotog researchtog researchto </td <td></td> <td>agenda.</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | agenda. | | | | | | |
| titutions to UNCRI, JCRC, alth impact Universities, LGs, research and Partners vith non-health X UNCRI Partners /estment plans X UNCRI Private Sector g research for VINCRI Private Sector | | health | × | × | × | UNHRO | | No. of completed |
| alth impact Universities, LGs, research and Partners vith non-health X UNCRI vestment plans X g research for g research private Sector g on the safety, impact | | institutions | | | | | | works and publicat |
| research and Partners with non-health //estment plans X UNCRI Private Sector g research for g research for e on the safety, | | health | | | | | Universities, LGs, | |
| with non-health VINCRI /estment plans X g research for g research for e on the safety, | | , research | | | | | Partners | |
| vestment plans X UNCRI Private Sector g research for and the safety, and the safety, be on the safety, | | analyses, jointly with non-health | | | | | | |
| X UNCRI Private Sector | | sector programs. | | | | | | |
| for strengthening research for scientific evidence on the safety, | | Develop PPP investment plans | | × | | UNCRI | Private Sector | Investment plan |
| scientific evidence on the safety, | | for strengthening research for | | | | | | |
| | | scientific evidence on the safety, | | | | | | |

| Strategic Action | Interventions | Short- Term (1-2 yrs) | Medium- Term (3- 5 yrs) | Long- Term (5 – 10 Yrs) | Lead in Gov't | Partners | Key Output |
|------------------|--|-----------------------------|-------------------------------|----------------------------------|------------------|-----------------|-----------------------------|
| | efficacy, quality and availability of traditional medicine products. | | | | | | |
| | Conduct and publish research | × | × | × | UNCRI | MoSTI, | Research products and |
| | for scientific evidence on the | | | | | Universities, | publications |
| | safety, efficacy, quality and | | | | | Partners | |
| | availability of traditional | | | | | | |
| | medicine products. | | | | | | |
| | Develop a comprehensive 10- | | × | | MoH | MoPS, LGs | HRH Policy and Strategic |
| | year HRH policy and strategic | | | | | | Plans developed |
| | Recruitment of the health | | × | | MoH | MoPS. LGs. | Staffing level |
| | | | | | | Private Sector | |
| | Provide competitive | | | Х | MoFPED | Private Sector | Enhanced salaries |
| | wages/salaries for health care | | | | | | |
| | workers to improve job | | | | | | |
| | commitment and a meaningful | | | | | | |
| | vocation. | | | | | | |
| | Review/develop up-to-date | × | | | MoH | MoPS, HPCs, LGs | Up-to-date schemes of |
| | schemes of service and | | | | | | service and standards of |
| | standards of practice and job | | | | | | practice and JDs |
| | descriptions for all cadres. | | | | | | |
| | Design incentive schemes to | | × | | MoPS | L LGs, Private | Harmonized incentive |
| | improve staffing in areas of low | | | | | Sector | schemes for health |
| | coverage and high morbidity. | | | | | | workers |
| | Functionalize the existing HRIS | × | × | × | MoH | LGs | iHRIS functional in all LGs |
| | and National Health Work Force | | | | | | and health institutions |
| | Accounts to capture information | | | | | | |
| | on the entire health workforce in | | | | | | |
| | the Country and link it to the | | | | | | |
| | DHIS2 platform. | | | | | | |
| | | | | | | | |

| | | 2 | : | · | | | |
|-----------------|--|-----------------------------|------|----------------------------------|--------|---------------------|--|
| כת שרפאר ארווסע | Interventions | Snort- Term (1-2 yrs) | yrs) | Long- Term (5 – 10 Yrs) | Gov't | rathers | Ney Output |
| | Develop e-personnel performance management, | | × | | Мон | LGs, Private Sector | Annual personnel performance analysis done |
| | anc | | | | | | |
| | Develop the Human Resource | × | × | × | MoH | LGs, Private Sector | HR Strategy and Annual |
| | Development Strategy and annual HR Development Plans | | | | | | HRD Plans |
| | Create a special scholarship fund | | | × | MoES | MoFPED, MoH, | A scholarship fund created |
| | for priority skills and cadres in | | | | | LGs | and priority cadres |
| | the health system such as Public | | | | | | sponsored |
| | Health Nurses, anaesthetics, | | | | | | |
| | and specialist workforce. | | | | | | |
| | Train expert workforce for | | × | Х | MoES | MoH | Specialized health workers |
| | specialized services. | | | | | | trained |
| | Develop a multi-sectoral plan for | | × | | MoES | MoH, HPCs | Training plan |
| | training of health workforce in | | | | | | |
| | Increase the financial allocation | | × | × | MoFPED | MoH, NMS | Per capita budget |
| | for medicines and health | | | | | | allocation for medicines |
| | supplies to a reasonable level at least \$14 ner canita by 2025. | | | | | | and health supplies |
| | Strengthen the National | × | × | × | NDA | MoH, Private | Functioning national e- |
| | igilance syst | | | | | Sector | Pharmacovigilance system |
| | levels using information | | | | | | |
| | technology. | | | | | | |
| | Strengthening the post- | × | × | × | NDA | MoH, Private | Postmarketing surveillance |
| | marketing surveillance of | | | | | Sector | is done for all commodities |
| | commodities on the market for | | | | | | |
| | both public and private sectors. | | | | | | |

| aid for coordinated financing of UHC programs. |
|--|
| strengthening country systems. Re-establish pooling of external aid for coordinated financing of |
| Align aid agendas to the national X UHC priorities while |
| Capacity Development Capacity Development Framework and implementation roadmap. |
| |
| |
| health |
| for complementary investments in health infrastructure. |
| private partnership framework |
| Develop a meaningful public- |
| |
| appropriate use of indigenous and complementary medical |
| the production and X |
| c |
| imaging |
| r diamontic devices and |
| technologies including point of |
| standards for medical laboratory |
| harmonize |
| |
| rs) |
| |
| Short- Medium- |

| through the provision of a Medical Credit Fund or subsidies to fill critical gaps in care provision.XImprove equity and efficiency in resource utilization through RBF scale up beyond RMNCAH.XAim to allocate \$60 per capita to improve coverage of major Health Prevention and Prevention and the Environmental Health Programs.XRe-orient LGs about the mandates and roles to advance UHC goals alongside other programs vital for SDGs.XStrengthen multi-sectoral coordination at LGs level to better embed health priorities at the decentralized levelX |
|--|
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| |
| <u>ه ی م</u> |
| re s a |
| es a |
| ۵ |
| |
| sector X |
| |
| and |
| such as demand-side incentives, |
| scale-up pro-poor interventions |
| mechanisms for health care and |
| prepayment |
| |
| (1-2 yrs) yrs) |
| |
| |
| |

| Mobilize close-to-community and non-governmental actors to contribute to UHC programs alongside other development | that enable greater synergy and value for money for health and non-health development programs. Consolidate the workforce for community levels programs across all departments of LGs to pool resources and experts to guide community development programs including cHPP. Mobilize close-to-community and non-governmental actors to contribute to UHC programs alongside other development | Strategic Action Interventions |
|--|--|----------------------------------|
| close-to-community overnmental actors to to UHC programs | greater synergy and oney for health and development the workforce for levels programs partments of LGs to ces and experts to runity development cluding cHPP. close-to-community rernmental actors to to UHC programs | |
| × | × × | Short- Term (1-2 yrs) |
| × | × | Medium- Term (3- 5 yrs) |
| × | × | Long- Term (5 – 10 Yrs) |
| LGs | Les More | Lead in Gov∕t |
| MoGLSD | MoGLSD | Partners |
| Close-to-community and non-governmental actors | if commu ient progr cHPP establis community rnmental ac | Key Output |

4. Monitoring and Evaluation of the UHC Roadmap

Monitoring and evaluation (M&E) processes are essential functions to ensure that priority strategic interventions outlined in the UHC Roadmap are implemented as planned. The evidence gathered through the M&E framework will be used to:

- Guide decision making in the sector by characterizing the implications of progress (or lack of it) being made by the sector;
- o Guide implementation of plans by providing information on progress and results;
- Guide the information dissemination and use by the sector stakeholders and the public; and
- Provide a unified approach to monitoring progress by all stakeholders in the sector subnational/regional, districts, programs, government agencies, and others.

An integrated and comprehensive approach for monitoring national health strategies will measure progress towards the health-related SDGs, UHC and other national commitments. The M&E system will respond to the growing interest and demand for quality data for decision-making, measurement, learning, accountability and policy dialogue. For this plan, the M&E will:

- 1) Inform formulation of sound policy, improved institutional environment, enhanced multistakeholder coordination mechanisms.
- 2) Ensure well-functioning data sources (civil registration and vital statistics CRVS) systems, population-based surveys, routine facility information systems, facility surveys, administrative data sources disease and public health surveillance, research studies).
- 3) Ensure strong institutional capacity for data collection with unified data architecture, management, analysis, use and dissemination.
- 4) Effective multi-sectoral mechanisms for data and performance review.

| 19. | 18. | 1/. | 16. | 15. | 14. | 13. | 12. | 11. | 10. | 9. | 8. | : | L | 6. | | | | 4. | .ω | 2. | 1. | | No. |
|---|---|--|---|--|---|--|--------------------------------------|--|------------------------------|--|--------------------------------------|--------------|--|------------------------------------|-----------------------------------|-----------------------------|-------------------------------|--|----------------------------|------------------------|--------------------|----------------|----------------|
| Fertility Rate (adolescents) (children per 1000 Adolescent women)/ Adolescent Birth rate | Fertility Rate (All) Children per woman | Family Planning demand satisfied with modern methods in women aged 15 – 49 years who are married or in a union (%) | Women of childbearing age receiving modern FP (%) (mCPR) | Use a solid type of fuel for cooking (%) | Use of clean energy (access to electricity) (%) | Households with access to basic sanitation (%) | Hand washing with soap and water (%) | Population with access to safe water (%) | Exclusive breastfeeding rate | Under-five Vitamin A second dose coverage (%) | Vitamin A Deficiency in Children (%) | (70) | Anaemia Prevalence in Adults (women/men) | Anaemia Prevalence in Children (%) | Undernourishment (population) (%) | Obesity among adult men 18+ | Obesity among adult women 18+ | Overweight among children under five years | Child underweight rate (%) | Child wasting rate (%) | Child stunting (%) | | Indicator |
| 132 | 5.4 | 40 | 35 | 95 | 29 | 19 | 34 | 78 | 66 | 30 | 9 | / IVI- 16 | W = 32 | 53 | 40 | 1.2 | 7.2 | 7.5 | 10 | 4 | 29 | Value | |
| 2016 | 2016 | 9T07 | 2016 | 2016 | 2016 | 2016 | 2019 | 2016 | 2016 | 2019 | 2016 | | 2016 | 2016 | 2016 | 2016 | 2016 | 2016 | 2016 | 2016 | 2016 | Year | Baseline |
| 130 | л | υ u | 40 | Na | Na | 50 | 50 | 74 | 69 | 35 | 8.2 | | Na | Na | 36 | 1.0 | 6.8 | 6.5 | 12 | 3.8 | 27.2 | | 2020/21 |
| 130 | б | ō | 40 | Na | Na | 55 | 38 | 78 | 72 | 38 | 7.4 | | Na | Na | 32 | 0.8 | 6.5 | 5.7 | 10 | 3.6 | 25.4 | | 2021/22 |
| 130 | б | ٥ | 40 | Na | Na | 61 | 42 | 80 | 75 | 42 | 6.7 | | Na | Na | 28 | 0.7 | 6.1 | 4.9 | 9 | 3.4 | 23.6 | | 2022/23 |
| 130 | 4.5 | 73 | 40 | Na | Na | 68 | 46 | 82 | 78 | 46 | 6.1 | | Na | Na | 24 | 0.6 | 5.8 | 4.3 | 7 | 3.2 | 21.8 | | 2023/24 |
| 125 | 4.5 | č | 50 | Na | Na | 75 | 75 | 85 | >80 | 50 | 5.5 | | Na | Na | 20 | 0.5 | 5.5 | 3.7 | л | ш | 20 | | 2024/25 |
| Na | Na | 06< | a Na | <10 | >90 | >90 | >90 | >90 | NA | Na | 4 | | ç | ر | ĉ | <0.4 | <5.2 | NA | 1 | 0 | <20 | Target 2030 | UHC |
| UDHS | UDHS | UDHS | UDHS | HHS | HHS | HHS | HHS | HHS | UDHS | HMIS | UDHS | | UDHS | UDHS | UDHS | UDHS | UDHS | UDHS | UDHS | UDHS | UDHS | | Source of data |

Table 8: The UHC Roadmap M&E Framework

| | | | | | | | 31. | 30. | 23. | 00 | 28. | 0 0 | 27. | 1 | 26. | | | 25. | | | | 24. | | 23. | 22. | 21. | | 20. | 20 | | No. |
|---------------------|----------------|---------|---------|---------------|---------|-----|--|--|---|---|--|--|---------------------|--|-----------------|--------------------------------|-----------------------------------|--|---------------------------|-------------------|-----------|--------------------------------------|---------------------------|--|---------------------------------|--|--|--|--------|--------|----------------|
| f) Meacles-Rinhella | e) Rotavirus 2 | d) IPV | c) HPV2 | b) DPTHibHeb3 | a) BCG | (%) | Immunization coverage rate, by the vaccine | Housing floors made of cement screed (%) | road traffic accidents (Per 100,000 population) | Mortality rates attributed to Injuries due to | sanitation, hygiene (Per 100,000 population) | Mortality rates attributed to unsafe water | 100,000 population) | Mortality rates attributed to Air pollution (Per | Alcohol use (%) | (schistosomiasis and trachoma) | against NTDs per 1,000 population | Number of people requiring interventions | c) Children under 5 years | b) Pregnant women | a) All | Insecticide-treated bed nets use (%) | with in 24 hours- Mother) | Postpartum care coverage (%) (Attendance | Deliveries in health facilities | Proportion of births attended by skilled attendants (%) | during their most recent pregnancy (%) | Women who attended tour or more antenatal care visits with a skilled health professional | | | Indicator |
| 85.5 | 88.7 | 87.4 | 39.9 | 90.7 | 86 | | | 52 | | 2,348 | | 54 | | 156 | 5.8 | | | 276 | 60 | 65 | 59 | | | 54 | 73 | 74 | | 48 | 2 | Value | |
| 2019/20 | 2019/20 | 2019/20 | 2019/20 | 2019/20 | 2019/20 | | | 2016 | | 2016 | | 2016 | | 2016 | 2016 | | | 2018 | 2018/2019 | 2018/2019 | 2018/2019 | | | 2016 | 2016 | 2016 | | 2016 | 2020 | Year | Baseline |
| 68 | 96 | 96 | 70 | 96 | 68 | | | 54 | | 2,066 | | 53 | | Na | 5.6 | | 196 | | 70 | 70 | 70 | | | 56 | 77 | 77 | | 46 | 40 | | 2020/21 |
| 91 | 97 | 97 | 75 | 97 | 91 | | | 55 | | 2,000 | | 50 | | Na | 5.4 | | 139 | | 75 | 75 | 75 | | | 58 | 79 | 79 | | 50 | 1 D | | 2021/22 |
| 92 | 97 | 97 | 75 | 97 | 92 | | | 56 | | 1,950 | | 48 | | Na | 5.2 | | 66 | | 80 | 80 | 80 | | | 60 | 82 | 82 | | 52 | T O | | 2022/23 |
| 94 | 86 | 86 | 76 | 86 | 94 | | | 57 | | 1,750 | | 45 | | Na | 5.0 | | 70 | | 85 | 85 | 85 | | | 62 | 84 | 84 | | 54 | 1 | | 2023/24 |
| 95 | 98 | 86 | 78 | 86 | 95 | | | 58 | | 1,500 | | 43 | | Na | 4.8 | | 50 | | 06 | 90 | 06 | | | 64 | 85 | 85 | | 95 | 7 | | 2024/25 |
| >=95 | >=98 | >=98 | >=78 | 86=< | >=95 | | | >90 | | <100 | | Na | | | <1 | | | | >90 | >90 | >90 | | | >90 | >90 | >90 | | 06< | . 00 | Target | UHC |
| HMIS | HMIS | HMIS | HMIS | HMIS | HMIS | | | HHS | estimates | IHME | | | | МНО | STEPS Survey | | | Survey | SIM | SIM | SIM | | | UDHS | UDHS | UDHS | | UDHS | 5 | | Source of data |

| 51. / s | 50. F | 49. E | 48. (| 47. (| 46. <i>I</i> | 45. (| 44. 9 | 43. H | 42. N | 41. [| 40. F | 39. N | 38. / | 37. / | t | | | | | 32. 0 | i) | - | 6 | | No. I |
|--|--|--|---|--|------------------------------|--|----------------------------------|-----------------------|--------------------------------------|-------------------|---|-----------------------------|----------------------------|------------------------|-------------|--|-------------------------|--------------------------------------|----------------------------|--|-----------------------|------------|----------|----------------|----------------|
| Adults aged at least 15 years who had not smoked tobacco in the previous 30 days (%) | Prostate cancer screening in men above 40 years (%) | Breast cancer screening in women aged 30-49 years (%) | Cervical cancer screening in women aged 30- 49 years (%) | Cancer proportional mortality rate (%) | Annual cancer incident cases | Cardiovascular proportional mortality rate (%) | % with normal blood pressure (%) | Hypertension rate (%) | Mean fasting plasma glucose (mmol/L) | Diabetic rate (%) | Facility based malaria morbidity per 1,000 persons per year | Malaria prevalence rate (%) | ART Viral suppression rate | ART Retention rate (%) | therapy (%) | Deeple with HIV receiving antiretrovical | HIV Browslongo Bato (%) | TB offortive troot most coverage (%) | TB Case Detection Bate (%) | Care-seeking behaviour for children with |) TT2+ Pregnant Women | h) Polio 3 | g) PCV 3 | | Indicator |
| 06 | 2 | 7 | 7 | л | 80,000 | 9 | 73 | 3.2 | 5.22 | 2.5 | 198 | 9.1 | 68 | 79 | 05 | ٥ <u>٥</u> | (J | 7.7 | 34 | 79 | 63.8 | 89.6 | 90.3 | Value | |
| 2016 | 2019 | 2019 | 2019 | 2016 | 2016 | 2016 | 2016 | 2016 | 2016 | 2016 | 2018 | 2018/2019 | 2018/2019 | 2016/17 | | 21/310C | 21/31/UC | 010C | 0100 | 2016 | 2019/20 | 2019/20 | 2019/20 | Year | Baseline |
| 91 | 16 | 12 | 16 | 4.6 | 73,972 | 6.5 | 75 | 3.0 | 5.28 | 2.0 | 150 | 8 | 06 | 82 | 90 | on 4.0 | 100 | 00 | 00 | 80 | 68 | 96 | 96 | | 2020/21 |
| 92 | 24 | 21 | 24 | 4.2 | 68,399 | 6.1 | 76 | 2.8 | 5.34 | 1.8 | 114 | 7 | 91 | 87 | 22 | ده د.۲ | υл | 00 | 80 | 81 | 68 | 97 | 97 | | 2021/22 |
| 93 | 33 | 31 | 33 | 3.9 | 63,246 | 5.8 | 77 | 2.6 | 5.41 | 1.5 | 87 | 6 | 93 | 06 | C C | 0.0 | 70 | 00 00 | 00 | 83 | 69 | 97 | 97 | | 2022/23 |
| 94 | 41 | 40 | 41 | 3.6 | 58,480 | 5.4 | 78 | 2.5 | 5.47 | 1.3 | 66 | б | 94 | 06 | J. | 05 | с л | C0 / OT | 107 | 84 | 69 | 86 | 98 | | 2023/24 |
| 95 | 50 | 50 | 50 | 3.3 | 54,074 | 5.1 | 79 | 2.4 | 5.53 | 1.0 | 50 | 4 | 95 | 06 | 55 | 05 | 0 0 | 05 101 | 107 | 85 | 70 | 86 | 98 | | 2024/25 |
| 06< | Na | Na | Na | \$ | <50,000 | 5 | >90 | 19 | <5.6 | 0.4 | Na | 2 | >95 | >95 | 202 | | | DE TOO | 100 | >90 | >=70 | 86=< | >=98 | Target 2030 | UHC |
| STEP Survey | HMIS | HMIS | HMIS | CRVS | Cancer Registry | CRVS | STEPS Survey | NCD Survey | STEPS Survey | STEPS Survey | HMIS | SIM | HMIS | NMIS | | | | | | UDHS | HMIS | HMIS | HMIS | | Source of data |

| 72. | 71. | 70. | 69. | 68. | 67. | 66. | 65. | 64. | 63. | 62. | 61. | 60. | | 59. | | | 58. | 57. | 56. | 55. | 54. | 53. | 52. | | No. |
|---|---|---------------------------------------|--|----------------------------|------------------------------------|--|--|---------------------------------|--------------------------------------|---------------------------------|--|--|-------------------|---|-----------------------|------------------------------------|--|-------------------------------------|--|--|--|---|---|----------------|----------------|
| % of population covered by health insurance | National budget allocated for health research (%) | Coverage of IDSR surveillance systems | Hospitals using correct International Classification of Diseases (ICD) coding (%) | Integrated data repository | Coverage of death registration (%) | Coverage of birth registration under 5 (%) | Number of health workers (doctors, midwives, nurses) per 10,000 population | Physicians per 1,000 population | Psychiatrists per 100,000 population | Surgeons per 100,000 population | Approved posts filled by skilled personnel (%) | Health facilities reporting no stock out of the 41 tracer medicines/supplies (%) | 10,000 population | Hospital bed density and distribution per | Management Boards (%) | structures i.e. HUMCs and Hospital | Service units with functional governance | Clients satisfied with services (%) | Service availability and readiness index (%) | Health security threats detected on time (%) | International Health Regulations core capacity index (%) | Health Centre IIIs providing BEmNOC (%) | Health Centre IVs providing CEmNOC - Both C/S+BT (%) | | Indicator |
| 2 | 0.026 | 100 | 0 | 0 | 1 | 7 | 18 | 0.1 | <0.05 | 0.6 | 74 | 79 | | 5 | | | Na | 25.6 | 17 | 100% | 73 | 95 | 47 | Value | |
| 2019 | 2018/19 | 2019 | 2019 | 2019 | 2018/19 | 2018/19 | 2018 | 2016 | 2016 | 2016 | 2017/18 | 2019/20 | | 2016 | | | 2018 | 2018 | 2018 | 2019 | 2016 | 2019/20 | 2018/19 | Year | Baseline |
| 3 | 0.02 | 100 | 14 | 0 | 2% | 10 | 20 | 0.54 | 0.5 | 0.68 | 75 | 83 | | 5.6 | | | 100 | 05 | 22 | 100 | 75 | 100 | 56 | | 2020/21 |
| 4 | 0.03 | 100 | 20 | 1 | 5% | 50 | 21 | 0.98 | 0.6 | 0.76 | 80 | 86 | | 6.3 | | | 100 | 35 | 22 | 100 | 78 | 100 | 64 | | 2021/22 |
| 7 | 0.02 | 100 | 25 | 1 | 7% | 60 | 22 | 1.42 | 0.7 | 0.84 | 85 | 68 | | 7.1 | | | 100 | 40 | 36 | 100 | 80 | 100 | 70 | | 2022/23 |
| 8 | 0.02 | 100 | 30 | 1 | 10% | 65 | 24 | 1.86 | 0.8 | 0.92 | 90 | 92 | | 7.9 | | | 100 | 45 | 36 | 100 | 82 | 100 | 72 | | 2023/24 |
| 12 | 0.02 | 100 | 35 | 1 | 15% | 70 | 25 | 2.3 | 0.9 | 1 | 95 | 95 | | 6.8 | | | 100 | 50 | 60 | 100 | 85 | 100 | 75 | | 2024/25 |
| 46 | 0.02 | 100 | 40 | 1 | 20% | 75 | 20 | 2.3 | 0.1 | 1 | 100 | 95 | 1 | 30 | | | 100 | 75 | 06 | 100 | >90 | 100 | 06< | Target 2030 | ИНС |
| HHS | Budget Estimates | SIMH | Reports | Reports | CRVS | CRVS | Register | Register | Register | Register | HRIS | AHSPR | | SIMH | | Assessments | Facility | Survey | SARA Survey | SIMH | Assessments | EMONC assessment | AHSPR | | Source of data |

| No. | Indicator | | Baseline | 2020/21 | 2021/22 | 2022/23 | 2023/24 2024/25 | 2024/25 | UHC | UHC Source of data |
|-----|---|-------|----------|---------|---------|---------|-----------------|---------|----------------|--------------------|
| | | Value | Year | | | | | | Target 2030 | |
| 73. | OOP Health expenditure as % of current | 37 | 2015/16 | 36 | 33 | 30 | 27 | 24 | 18 | 18 NHA |
| | expenditure on health | | | | | | | | | |
| 74. | Total current expenditure on health (% of | 4.1 | 2018/19 | 3.08 | 3.25 | 4.34 | 5.27 | 5.65 | 15 | 15 MTEF |
| | gross domestic product) | | | | | | | | | |
| 75. | Government expenditure of health as % of | 15 | 2018/19 | 31 | 33 | 27 | 24 | 23 | 20 | 20 NHA |
| | total current expenditure | | | | | | | | | |
| 76. | % of PHC budget allocated to health | 30 | 2019/20 | 30 | 30 | 35 | 35 | 35 | NA | NA Budget |
| | promotion and community health (%) | | | | | | | | | Guidelines |

5. Implementation Arrangements

5.1 Governance Framework

The UHC Roadmap implementation will follow the current sector-wide governance structures and mechanisms to foster agreement on common procedures for consultation and decision– making. These will include annual planning, procurement and disbursement mechanisms, M&E, audits, financial management and the exchange of information (communication). Improvements will be implemented as the need arises through the three oversight structures:

- The internal MoH coordination and management structure that guide implementation of sector interventions and activities at the different levels.
- The formal governance structures that steer the different levels and act as accountability platforms; and
- The partnerships governance structures and platforms guide the external coordination of all stakeholders at the respective levels of service delivery.

5.1.1 National Level Governance

The governance structures for coordination of the sector will continue to be strengthened and will guide the sector in implementing the UHC Roadmap. The Top Management, HPAC, SMC and TWGs will continue their roles within the governance structure of the sector at the national level. In the course of implementing the roadmap, especially with a focus on health promotion and disease prevention, new ways to bring cross-sector partners together across levels, new forums will likely emerge.

5.1.2 District/Urban Authority Level Governance

At LG level, City Health Management Teams (CHMTs) and District Health Management Teams (DHMTs) shall continue to plan, implement and review service delivery as well as take responsibility for the population health. The CHMTs/DHMTs will explore opportunities to collaborate with private and community sectors to achieve the UHC goal. There are many ways they can work together on this, building networks and coordinated, cooperative and collaborative partnerships.

This UHC Roadmap will also promote integrated planning at the decentralized level. Through the use of existing planning processes, i.e., the 5-year district strategic plan and the annual operational plans, the MoH in collaboration with the MoLG and the MoFPED will promote partner participation at the district level and require demonstrated evidence of this participation.

5.1.3 The Health Unit Management Committees (HUMCs) or Hospital Management Boards (HMBs)

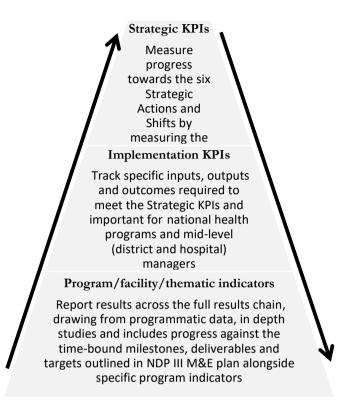
The HUMCs or HMBs in the public and private health facilities will continue to ensure community participation and involvement in health service delivery with the refocus towards health promotion and disease prevention, community feedback and accountability. With the refocus towards health promotion and disease prevention, the HUMCs and HMBs will further commit to looking beyond the walls of their health facilities and address the root causes of poor health that are situated in the community and have a strong focus on improving the places where people live and work and where children learn and play.

5.2 Performance Management

5.2.1 UHC Roadmap Performance Management Framework

The UHC Roadmap performance management framework is designed to track all parts of the strategic framework. It is not designed to measure all aspects of performance. Rather, it sets out how a cross-section of performance across key priority areas will be measured in order to form a holistic assessment of performance towards the UHC strategic actions and interventions. Performance measurement is intended to enable the national health sector strategies and priorities to be translated into management and operational objectives, to provide a focus on results, and to enhance accountability. All disease and program-specific M&E Plans will use the same technical framework and M&E platform defined in the NDP III

M&E Framework.



IDP III Figure 4: UHC Roadmap Performance Framework

This framework is designed to ensure that information to inform high-level strategic governance can be drilled down to the lowest operational levels required to inform course correction. To achieve this, the sector prioritizes action towards three critical areas:

- i. Strengthening performance management capacity at national, district, facility, and community levels. To enable decisions by the health governance structures to be made closer to service users, thus enabling services to be more responsive
- ii. **Developing the use of performance data** based on defined performance standards towards the UHC Roadmap objectives and measured through implementation KPIs.
- iii. Coordinating performance measurement across the entire health system as one. This will be strengthened by functionalizing the MoH M&E section and strengthening the Division of HIM towards reducing duplication, coordinating the development of universal measures, standardizing data requirements for different systems, and improving analysis and presentation for different users.

5.2.2 The Performance Review Management

The MoH and LGs have a responsibility to ensure that the delivery of healthcare services in Uganda is consistent with these strategic directions and priorities of this roadmap. To continually develop a health system that works effectively across levels, programs and departments and is well-positioned to create a sustainable health system, the sector will seek to identify measures of performance that support the delivery of the strategic directions, priority outcomes and derive the best value from the health budget. The KPIs will be

presented as a dashboard to help communicate progress made on reducing disease burden, UHC, and system performance. The core elements of the performance review process are:

- Production of a monthly performance report by each Directorate, department, LG and facility detailing performance against the performance measures.
- Scheduled Quarterly Performance Review Meetings including a mid-year and end-of-year review, but more frequent meetings may be scheduled if performance concerns require this.
- Analysis and confirmation of a performance issue when identified, including determination of the appropriate action to be taken to address the issue.
- Regular performance summary presentations, including identified key issues, are provided through the established health sector governance structures and mechanisms.