

A STUDY OF HEALTH SECTOR REFORMS IN UGANDA:

LESSONS FOR THE HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN (HSSIP)

2010/2015

For The
MINISTRY OF HEALTH

By



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Plot 13B, Acacia Avenue, Kololo
P.O. Box 9974 Kampala, Uganda.

Tel: +256 (0) 41 423 7225
Fax: +256 (0) 41 423 7226
Web: www.achest.org

[A study to provide an insight into the wide range of reforms that Uganda has undertaken in the health sector, in particular since 1978 and spanning the period there-between up to 2010, just prior to the beginning of the NHP and HSSIP (2011 – 2015). The Study draws lessons for government, policy-makers, civil society, the private sector and development partners, which can be applied to improve the performance of the health sector.]

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Plot 13 B Babiha Avenue (formerly Acacia Avenue), Kololo, P.O Box 9974, Kampala, Uganda. **Tel:** +256 414 237225, **E-mail:** info@achest.org

FOREWORD

The evolution of health services in Uganda during the colonial and post-colonial period presents a mixed picture. Prior to the upheavals that rocked the country during the 1970 to early 1980s, Uganda had one of the best performing health systems and best health indices in the region. The period of governance and economic collapse did not spare the health sector and resulted in neglect, looting of equipment and exodus of health workers to other countries and out of the public health sector.

The advent of the NRM leadership in 1986 ushered in a new phase with a new effort and new thinking across all sectors of government. The Poverty Eradication Action Plan (PEAP) provided for improvement in the quality of life of the population through improved services delivery. Accordingly, all sectors were required to adopt Sector Wide Approaches (SWAPS) to development and the health sector in Uganda was one of the early adopters with a new National Health Policy (NHP1) Health Sector Strategic Plan (HSSP1) launched in 2000 through a wide consultative process that lasted three years.

The implementation of NHP1 and HSSP1 under decentralization resulted in rapid improvements in a number of areas such as the utilization and increase in physical access to public health services, immunization coverage, and the increased numbers of health workers recruited at central and district level. There was however slow progress with utilization of maternal health services and in the growth of the health sector budget.

The reforms across government including decentralization to the districts of responsibility for services delivery including health workforce management and the transfer of health training institutions to the Ministry of Education and Sports have presented new challenges that need to be discussed. The population growth rates have remained high at 3.2% yet budgetary allocations have fluctuated over the years. The NHP II and HSSIP II have been developed and were launched in 2010. However, there are issues with the implementation of the new NHP II and HSSIP II with questions being raised. The recommendations of the mid-term and final review of NHP I and HSSP II were not considered in the new policy and plan. There are also concerns in the media and general population and in Parliament regarding the current status of health services in the country.

It is against this background that the Ministry of Health welcomes this study. It is my hope that the study can be used by government and the general public to engage in an open debate by all stakeholders such as parliament, professional associations, academia, civil society, development partners and the media that will lead to a national consensus on the most practical approaches for responding to the current and future health needs of the people of Uganda in today's globalization world.

Finally, I want to thank the USAID for providing the resources for this study and the African Center for Global Health and Social Transformation (ACHEST) for conducting the study and producing this report.

A handwritten signature in blue ink, appearing to read "Ondo", with a stylized, looping initial.

Hon. Dr. Christine J.D. Ondo
MINISTER OF HEALTH

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2 ACKNOWLEDGEMENTS

Health Sector Reforms in Uganda (1978-2010) were aimed at taking services nearer to the people, and in response to the challenges posed by the political and socio-economic dynamics in the country. The Study to document the impact of these reforms on health sector development is therefore commendable.

The Authors would like to acknowledge with appreciation, the encouragement, cooperation and facilitation by the leadership at Ministry of Health, without which the Study could not have taken place.

A special word of appreciation goes to all those who spared time from their very busy schedules to participate in the study as members of the Stakeholders Group, Steering Committee, Key Informants or Grass-root Consumers. It is due to their contributions that the objectives of the Study were met.

The USAID – Uganda is commended, not only for the grant that enabled the study to take place, but also for participating in the study as a member of Donor Countries in the Steering Committee and Stakeholders Group.

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3 ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
AU:	African Union
CBO	Community Based Organization
DHO	District Health Officer
DHSP	District Health Services Project
EDLU	Essential Drug List of Uganda
FHP	First Health Project
GFATM:	Global Fund to fight HIV/AIDS, Tb and Malaria
GOBIFF:	Growth monitoring, oral rehydration, Breastfeeding, Immunization, Family planning, Female education and Food supplementation (for selective PHC)
GoU:	Government of Uganda
HC I, II, III, IV	Health Centre levels 1, 2, 3, 4
HFA	Health for All
HIPC	Highly Indebted Poor Countries
HIV:	Human Immunodeficiency Virus
HSC	Health Service Commission
HSSIP	Health Sector Strategic and Investment Plan
HSSP I, II	Health Sector Strategic Plan 1 and 2
HUMC	Health Unit Management Committee
IMF	International Monetary Fund
IMR:	Infant Mortality Rate
LC I, II, III, IV, V	Local Government levels 1, 2, 3, 4, 5
MDGs:	Millennium Development Goals
MMR:	Maternal Mortality Ratio
MoES	Ministry of Education and Sports
MFPED	Ministry of Finance, Planning and Economic Development
MoH:	Ministry of Health
MoPS	Ministry of Public Service
NAC	National AIDS Commission
NACME	National Advisory Committee on Medical Equipment
NDA	National Drug Authority
NDP:	National Development Plan
NHP	National Health Plan/Policy
NGO	Non-Governmental Organization
NMS	National Medical Stores
PEAP I, II, III	Poverty Eradication Action Plan 1, 2, 3
PHC	Primary Health Care
PMES:	Poverty Monitoring and Evaluation Strategy
PPP	Public Private Partnerships
SWAps:	Sector Wide Approaches
UNICEF	United Nations Children's Fund
UNFPA	United Nations Family Planning Association
UNMHCP	Uganda National Minimum Health Care Package
USAID	U.S. Agency for International Development

WB: World Bank
WHA World Health Assembly
WHO: World Health Organization

4 EXECUTIVE SUMMARY

Introduction

Upon request of the Ministry of Health in Uganda, ACHEST has with support from the country office of USAID conducted a retrospective study to provide insight into the wide range of reforms that Uganda has undertaken in the health sector, since the launching of Primary Health Care (PHC) approach in 1978. The Study draws lessons for government, policy-makers, civil society, the private sector and development partners, which can be applied to improve the performance of the health sector.

Why conduct a study? (Justification)

The need for documentation of these reforms for the purpose of informing further development of the health sector, the country at large and the international community has been discussed for a long time. Uganda's Second National Health Policy (NHP2) and the third Health Sector Strategic and Investment Plan (HSSIP), were launched in October 2010. Opportunities continue to emerge for further input to improve their implementation between 2011 and 2015. While the policy and strategic plan both benefited from the analysis of past reforms in the health sector in particular, as well as overall reforms in the macro-economic policy framework, the timing of their launch coincided with much turmoil in the world economic order. Furthermore, their launch preceded some key socio-political events such as national elections and changes in government. This rapidly changing situation was noted by the Ministry of Health and partners; along with the fact that the rich health policy experience in this country remains largely un-documented despite its well-known value in informing future policy and practice. It is in light of these facts that the long anticipated study to pull together all the policy reform experience of the last 32 years in Uganda has been undertaken. The African Center for Global Health and Social Transformation (ACHEST) was commissioned to carry out the study for the Ministry of Health and partners. The documentation and analysis shall in addition contribute to building the knowledge base for evidence based policy development. It sets precedence for an early initiation of proactive review of implementation constraints of the HSSIP so as to provide a real time model for identifying actions to ensure the implementation of HSSIP is on track.

Scope of the study

The study outlines the key health policy and trends over the last 32 years based upon the PHC approach in Uganda. Global health and economic policy dynamics are shown to have significant influence on country level choices for reform. An understanding of these global policy dynamics and aid architecture is critical for design of mitigating measures of adverse influence upon country level policy reforms. Full mitigation however, is not always possible.

The reform experience

Uganda's post-independence health care system and training institutions were renowned for their productivity in Africa and beyond before the country suffered from civil strife and armed conflicts (1971-1985). The health system deteriorated, infrastructure was destroyed and there were acute shortages of medical commodities, pharmaceuticals as well as great attrition of the human resource base for health services delivery. The initial response was by means of selective PHC reforms using vertical health projects in a situation where no explicit health policies and plans existed. This reform approach did not work well. And the health system was weakened

further accompanied by declining health outcomes. This phase gave way to packaging of vertical programs of priority interventions delivered at a price for users introduced as a user fee through cost sharing policies during macro-economic structural adjustment policy reforms. This approach led to great decline in the use of health facilities and by 2000 the health outcomes and services delivery had sunk to their lowest ebb in recent time. The fight against poverty introduced a more comprehensive approach to health system reforms with the participatory elaboration of a National Health Policy (NHP-I) and Strategic Plan (HSSP-I) that include extensive institutional capacity building measures for oversight and supervision of services, abolished user fees; introduce health financing pool funds through SWAp; Extended the service delivery network country wide and restructure delivery arrangement for closer to client services provision through the establishment of for example Health Centre IV. Reforms were systematically articulated for all health system building blocks for seamless delivery of services. Implementation bore good results and by 2005, health financing envelope had grown substantially, utilization and dramatically shot up and health outcomes had recovered. The parallel re-introduction of vertical programs for priority intervention funded by global health initiatives without appropriate mitigation of adverse impact upon institutional capacities for implementation, begun to erode the successes of comprehensive health system reforms and by 2010, the health financing envelope had fallen, core service indicators were also falling and health outcomes begun to reverse negatively.

Study Recommendations

Introduction:

The following five recommendations are synthesized from the situation analysis that followed extensive literature review, key informant interviews, grass roots district surveys and the guidance from the Steering Committee and two Stakeholder consultations that were held as part of the study. The recommendations address particular aspects of both NHPII and HSSIP and are targeted at improving these documents.

5.1 The health of individuals and communities is a prime concern of all societies. There is abundant evidence to show that countries that have achieved the best health indices at low cost are the ones that have undertaken collective multi-sector and multi-stakeholder national dialogue on population health. Such dialogue is led at the highest political level and results in a social and political compact between the government and the population. In Uganda, while the HSSIP acknowledges the need for a national compact and multi sector action, practical steps for its achievement are not articulated. There is a need for a broad inter-sectoral national dialogue on health and well-being of the people of Uganda. Health is currently viewed as treating and preventing diseases by the Ministry of Health and not as a way of life that is at the centre of the governance of society

It is therefore recommended that a structure under the leadership of the Rt Honorable Prime Minister be created to coordinate national dialogue and actions on the health and well-being of the people of Uganda. Establishment of another structure is recommended at technical level under the leadership of the Head of the Civil Service with the participation of the private sector and civil society. Similar structures should also be considered at district and sub county level.

5.2 The midterm review reports for HSSP-I and HSSP-II as well as information from Key Informant interviews have pointed out the difficulties that have arisen from the current structure of the offices and governance structures at the MOH headquarters. The difficulties experienced include conflicts between officers and departments, overlap of roles and delays in decision making. These have contributed to significant shortcomings in performance over the years. Further, there is evidence to

show that the recommendations and decisions taken during the Restructuring exercise of 1998/99 were not fully implemented with respect to leadership roles in this highly technical ministry. There is a need to stream-line the decision making processes and redefining roles of various offices and organs in the MOH: Offices of PS / DG; Planning / QA; Resource Centre / Disease surveillance; HR development and Personnel; TMC, SMC, HPAC, NHA/JRM for more effective stewardship and governance of the health sector

While both NHP-II and HSSIP have discussed governance of the sector, they are silent regarding the well known issues of sector governance structures. It is therefore recommended that a review is undertaken to streamline roles of the key offices and governance organs at the MoH headquarters.

5.3. There is evidence to show that technical oversight and supervision of services delivery has declined at all levels but more so of the front line health workers. Further, the Annual Health Sector Performance Report of 2009/2010 recommended the revival of consultant outreach program of supervision, and the reactivation of various supervision and QA practices however, these are not explicitly articulated in the HSSIP. There is need for review and institutionalization of a Systems approach for Supervision and oversight of services delivery including the use of continuous performance improvement approaches such as . Quality Assurance tools, leadership and management capacity development, negotiation and communication skills, routine self-assessment etc.

It is therefore recommended that in addition to other measures to strengthen health sector governance, a review is conducted of quality assurance procedures, tools and, supervision manuals already developed by the Ministry, so as to update and institutionalize them for immediate use, as tools for improvement of health services delivery.

5.4. Human Resources for Health are a critical input in all efforts to improve the performance of health systems in all countries. There is unanimity in the reviews of HSSP I and II and Annual Health Sector Performance Reports that the both the health and education systems are facing serious challenges in training and education, recruitment and retention and in incentives provided to the health workforce. At the global level, much attention has been applied to developing global good practice guidelines in health professionals training and management. These span the areas of skill mix planning, education and training that links the education and health systems, rural retention and incentive packages.

It is recommended that Uganda should take full advantage of these global guidelines as they are being used successfully by a number of African countries by undertaking a comprehensive review of health work force issues including education and training; recruitment and retention; HRH information systems and incentives in order to align them with global good practice guidelines.

Whereas the constitution and HSC Act provide a key role for the HSC to manage all aspects of the health work force and in light of persisting health workforce issues noted above, it is recommended that the scope of work of the HSC be evaluated and measures put in place to facilitate HSC to fulfill the broader mandate.

5.5 The midterm reviews and the Joint Assessment of HSSIP have noted that Uganda has , established service standard for delivery of the minimum health care package of services including implementation arrangements. Recommendations were made for development of measures (regulatory/legal framework) for assuring compliance by service providers. While this work was not accomplished as set out under HSSP II, the new HSSIP does not explicitly provide for its' being carried to completion to ensure guidance for oversight of the delivery of services in line with technical standards and public expectations. For example, health centers I, II, III and IV have clearly defined roles yet most have not received the required minimum inputs to enable them to perform in accordance with their defined roles and to meet public expectations. There is need to review and agree service standards by level, mobilize necessary resources for inputs needed for compliance with the standards and establish mechanisms for ensuring that the required capacity is developed for sustainable performance according to the agreed service standard.

It is therefore recommended that a review of health care service standards be conducted with a view to:

- **agree and update existing service standards by level,**
- **develop a health financing strategy to facilitate mobilization of the necessary resources to support delivery of the agreed service packages and in compliance agreed service standards;**
- **establish regulatory or legal mechanisms to facilitate oversight in ensuring compliance and,**
- **Build capacity at all levels for oversight of implementation of the services package and eliminate corruption.**

STUDY ON HEALTH SECTOR REFORMS IN UGANDA:

LESSONS FOR THE HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN (HSSIP) 2010/2015

1 Introduction:

1.1 During the last three decades, Uganda is one of the countries that has undertaken major cross cutting reforms in the governance of the country and in the health sector. The need for documentation of these reforms for the purpose of informing further development of the health sector, the country at large and the international community has been discussed for a long time. Uganda's Second National Health Policy (NHP2)¹ and the third Health Sector Strategic and Investment Plan (HSSIP)², were launched in October 2010. Opportunities continue to emerge for further input to improve their implementation between 2011 and 2015. While the policy and strategic plan both benefited from the analysis of past reforms in the health sector in particular, as well as overall reforms in the macro-economic policy framework, the timing of their launch coincided with much turmoil in the world economic order. Furthermore, their launch preceded some key socio-political events such as national elections and changes in government. This rapidly changing situation was noted by the Ministry of Health and partners; along with the fact that the rich health policy experience in this country remains largely un-documented despite its well-known value in informing future policy and practice. It is in light of these facts that the long anticipated study to pull together all the policy reform experience of the last 32 years in Uganda has been undertaken. The African Center for Global Health and Social Transformation (ACHEST) was commissioned to carry out the study by the Ministry of Health and partners facilitated by a financial grant from the USAID. The documentation and analysis contributes to building the knowledge base for policy development, initiates proactive review of implementation constraints of the HSSIP and provides a real time model for identifying actions to ensure the implementation of HSSIP is on track .

1.2 This study is a retrospective review and analysis of health sector reforms in Uganda from 1978, when the historic Alma Ata Declaration on PHC was adopted, and spans the period between 1978 up to 2010, just prior to the launch of the NHP and HSSIP (2011 – 2015). The Study documents the interventions and experiences, successes and achievements, challenges and lessons of health sector reforms as well as other reforms outside the health sector that impact on the health of the people in Uganda. The expectation is that the findings will contribute to further improvements in the HSSIP 2010-2015 during its implementation and planned review processes.

2 Background:

2.1 Context

2.1.1 Uganda: The Country context

Uganda is classified ³ as a low income, East-African country with one of the fastest growing young, largely agrarian rural based population with relatively poor health indices. The country is in the midst of building a modern democracy following many years of wars and social disruption. A wide range of macroeconomic and social reforms have been undertaken over the past three decades including a new national constitution, decentralization and donor aid management through Swaps among others. The main thrust has been to focus on a Comprehensive Development Framework that promotes private sector led growth through liberalization of the economy and divestiture of public enterprises matched by appropriate fiscal measures to control inflation. Poverty eradication and improvement of the quality of life of the population through provision of universal primary and secondary education and primary health care were among the pillars of the Poverty Eradication Action Plan (PEAP). While significant socio-economic growth and poverty reduction has been registered over the last 20 to 30 years, the current global economic crisis poses a threat that may slow down progress towards better health and well-being of its population. At the same time, there are recent national events, that present an opportunity to respond to the challenges to health policy and strategy development in this rapidly changing environment. A new National Health Policy (NHP II) and Plan (HSSIP) are being rolled out, electoral events have ushered in a new government and a new national health system leadership team has been installed. This setting provides a favorable environment for further reflection upon the past successes and shortcomings with health policy reforms and their implementation. The lessons learnt have the potential for application to inform future reviews and ongoing policy reforms.

"The role of health in Uganda's development was given high priority in the 1960s. This was reflected in the country's planning strategies," "The campaign to develop the economy had "three spearheads: (1) agricultural development, (2) industrialization and (3) expansion and improvement of education and health services."

2.1.2 The Health and Development Background in Uganda

The background to the post-independence health policy trends in Uganda are systematically reviewed by David Dunlop et al., (1973; 1981 and 1985),^{4; 5; 6} the Report of the Health Policy Review Commission (MoH / Owor 1987)⁷ and, by Syngellakis et al. (May 2006)⁸ among others. In the years after independence in 1962-1971, Uganda had the best health indices and the best health care delivery system in the sub-region, but, decades of civil unrest led to their reversal and left the health care system in ruins. Capacity was eroded for health policy and planning for sustaining health system operations and development. To a large part this was consequent upon a massive flight of the health workforce (brain-drain) out of the country that took place owing to disintegration of society and insecurity. In the absence of an explicit national health policy and development agenda, health care provision became highly fragmented and opportunistic up to 1995. In the absence of an explicit national health policy, and lack of resources, numerous vertical intervention based health projects by various development partners were created and welcome to fill the policy vacuum and acute resource gap. The first post-conflict attempt at explicit health policy development stopped at a consensus development stage of a

government White Paper on Health Policy Up-date and Review of 1993⁹. This formed the basis for a national Three Year Health Plan Frame (1993)¹⁰ issued to guide a series of rolling three-year District Health Plans. These plans were used to implement decentralization of health services to local governments with a focus on post-conflict rehabilitation and reconstruction of health services against a background of macro-economic Structural Adjustment Policies (SAP). The first post-conflict comprehensive National Health Policy I (NHP I)¹¹ was negotiated over a four-year period and adopted in 1999, as the framework for implementing Sector Wide Approaches (SWAs) for national health development. It was developed within the Comprehensive Development Framework and the PEAP and implemented through the Health Sector Strategic Plan I - 2000/01 to 2004/05 (HSSP I)¹² and HSSP II (2005/06 – 2009/2010)¹³.

2.1.3 The Policy Framework in Uganda

The NHP II (2010/11 to 2019/20) is to guide health development over a ten year period and, is being implemented through the HSSIP (2010/11 – 2014/15) under the theme of *Promoting People's Health to Enhance Socio-economic Development*. The NHP II aims to contribute towards the overall development goal of the Government of Uganda (GoU), of accelerating economic growth to reduce poverty as stated in the National Development Plan (NDP) 2010/11-2014/15. As was the case in HSSP I and II, the HSSIP identifies a minimum health care package that will be universally accessible to all people in Uganda through the decentralized network of services delivery facilities that are to be upgraded as well as re-equipped for the purpose and funded through general tax revenues. Other measures in the new health policy for strengthening of health system performance include, more efficient use of available health resources, strengthening of public and private partnerships for health and the development of equitable and sustainable financing mechanisms.

2.1.4 Health Service reforms in Uganda

In 1961, in preparation for Uganda's independence from the British, the Ministry of Health (MoH) was created. At that time, there were 27 hospitals. After independence, another 22 rural hospitals were built throughout Uganda. Government hospitals continued to provide service free of charge, while faith-based institutions provided this at low cost. From the 1960s to early 1970s, Uganda had one of the best health care systems in sub Saharan Africa. However, the Military Coup of 1971 and its "Economic War" resulted in two decades of war and political strife. It severely destroyed this health care system; health workers fled the country or could not deliver satisfactory service, infrastructure was destroyed and the provision of other inputs, such as drugs, was severely constrained. Attempts were made to revitalize the health sector, but were generally not successful due to the prevailing political situation.

During this unstable period, NGOs, Faith-based institutions and the private sector both formal and informal gradually took over health care delivery. However, statutory control over health services, especially in the private sector, was not possible. Such a situation resulted in rampant illegal peddling of medicines and other supplies by unqualified persons. A Commission of Inquiry into Medical Services in Uganda submitted its report in 1977. It made recommendations on procurement, storage and distribution of medicines; food shortage; management, deployment and training of staff, among many others. The recommendations were never implemented due to the political and socio-economic situation. It is both interesting and sad to note that the same challenges identified by that report are still faced by the health sector over 30 years later.

In 1986, the present Government came into power and heralded the restoration of the rule of law and reconstruction of health and other systems. , It is at this time that systematic and consistent health sector reforms (HSRs) were initiated and implemented.

2.1.5 The Population and Health Profile in Uganda

Uganda's estimated population is above 30.7 million (UBOS 2010), of whom 56% are below 18 years age (UBOS, 2006). Over 80% of the population lives in the rural areas although the rate of rural to urban migration is high. The population growth rate is very high estimated at 3.2% per annum and 31% of the population is estimated to be living below the poverty line. Uganda's GNI per capita is US \$ 460 (Atlas method) and US \$ 1,190 (Purchasing Power Parity (PPP)) (World Bank 2010). Uganda has also been heavily impacted by conflicts, especially so in the Northern and Eastern parts of the country. This impacted negatively on populations' health and on health sector performance.

Uganda has a decentralized system of government. Of importance, is the fast growing number of districts in the country. In 1999, Uganda had 45 districts, but presently, there are 112 operational districts (end of 2010) together with some new ones which are not yet operational. Uganda has also implemented government wide, non-health sector policy reforms that have impacted on the health sector such as decentralization, public service reforms etc.

While Uganda has registered some progress in some basic health indicators during the recent years, this however, is nowhere near enough, and the health status of communities remains poor and is among the worst in the world: maternal mortality ratio of 435 per 100,000 live births, a high total fertility rate estimated at 6.9 children per woman (GoU 2010), contraceptive prevalence rate of 24%, unmet need of FP of 41%, supervised deliveries 42%, full immunization of 46%, an under five mortality rate of 137 per 1,000 live births, an infant mortality rate of 75 per 1,000 live births and stunted children 38% (GoU 2009) (GoU and UNFPA 2010). Communicable diseases contribute to 50% of disability adjusted life years (DALYs) lost (GoU 2010). After commendable success where HIV prevalence declined from 18% in 1991 to 6.1% in 2002, it stagnated at 6.4 % for almost a decade (GoU and UNFPA 2010).

Lately, Ugandans are more open about expressing their dissatisfaction with the state of health services. They are thus demanding more and better health services and medicines, as well as skilled and committed health workers especially in rural areas and hospitals. At the same time, the health sector faces many challenges that impede delivery of quality services. These challenges relate to financing, workforce, governance and leadership, among others.

2.2 Objectives of the study

2.2.1 The overall objective of this study is to provide an insight into the wide range of reforms in the country that Uganda has undertaken in the health sector, in particular since 1978 and spanning the period there-between up to 2010, just prior to the launch of the NHP2 and HSSIP (2011 – 2015). The Study draws lessons for government, policy-makers, civil society, the private sector and development partners, which can be applied to improve the performance of the health sector.

2.2.2 The specific objectives of the study are:

2.2.2.1 To document a typology of health sector reforms and experiences in Uganda (1978-2010) as an effort of a developing country to establish and sustain a working health system; *(through a comprehensive review of the policy trends and health system performance outcomes over the past 32 years since the launching of the Primary Health Care philosophy at Alma - Ata so as to bridge the*

gaps in the existing incomplete and fragmented documentation on Uganda's health policy development experiences).

2.2.2.2 To identify what worked well and the factors that made these work well, and what did not work and the reasons why; *(so as to build the evidence base for lessons learnt from implementation experiences that can inform health policy adjustments in the medium to long term future on a timely basis during a turbulent period of recurrent global and national economic shocks); and,*

2.2.2.3 To draw lessons and use the lessons to propose improvements in the current health system, make inputs into the ongoing policy and strategy development and address prevailing challenges.

2.3 Analytic framework,

2.3.1. A study period is defined and stratified into three policy development phases characterized by:

- 2.3.1.1. Social political context of the study period phase;
- 2.3.1.2. Character of national Health Policy and its thrust;
- 2.3.1.3. Approaches and typology of health planning or strategy development used to implement health policy objectives.

2.3.2. A combination of policy analytic approaches *(the Stages approach; the policy triangle framework approach and the network frameworks approach)* is applied for health policy process analysis with special attention to stakeholders and their interaction to produce effective health policies within a given policy cycle for health policy content analysis of PHC themes and system building blocks.

2.3.3. Deliverables

- Synthesis report
- Dissemination briefs

2.4 Study methodology and sources of data / information.

2.4.1 This was a retrospective study conducted during 2011 using qualitative research methods. Empirical data was primarily collected through a systematic review of current and historical documents from published and unpublished *(grey)* literature.

2.4.2 Semi structured interviews *(using a combination of questionnaires and verbal interactions)* with key informants supplemented the systematic review of literature. Key informants included past and current policy-makers as well as implementers, professional organizations, the academia, the private sector, development partners, and consumers of health services.

2.4.3 Findings were subjected to a combination of policy analytic approaches for policy process and policy content. Comprehensiveness and quality of methodological processes as well as reality checks and validation of findings all benefitted from broad, regular stakeholder consultations for c Consensus building at various stages of the study.

2.4.4 The outputs of the study are:

2.4.4.1 This synthesis review document on health system reforms and evolution in Uganda over the past 32 years;

2.4.4.2 The synthesis review document shall then form the basis for development of:

- an abridged brief on options for possible improvements of the health system using lessons from policy reform experiences; and,
- a brief, recommending options to consider for possible improvements in the current HSSIP.

2.5 Limitations of Methods and Scope of Analysis

- There are important limitations to the methods applied for data collection and analysis.
- Randomness of sampling and un-structured sample frames limit power of generalization of some findings beyond study sample
- The scope and time frame are ambitious resulting in massive amounts of data that cannot be fully analyzed within the time horizon of the study and implying a need for follow-on work to further add value to findings for future use.

3 The reform environment and process;

3.1 The International, Global Health development perspectives

3.1.1 It has been intimated that Uganda may not attain the MDG targets on time¹⁴; this despite explicit expression by the new NHP and HSSIP¹⁵ to the MDG undertaking. As in previous strategic plans, the expressed commitment to global charters or pronouncements such as the MDGs, is often a result of ratification of international health policy compacts negotiated in a global setting, of asymmetric policy dialogue capacities between north and south stakeholders, with minimal reality checks upon national level implementation arrangements, under the low resource settings in the south. Similarly, the global strategies for attaining these international health policy perspectives often emerge as top down innovations mainstreamed to country strategic plans with generally inadequate contextualization.

3.1.2 The National Development Plan (NDP) sets out the international initiatives to which Uganda is a signatory. These include the Millennium Development Goals (MDGs), the International Conference on Nutrition; the Convention on the Rights of the Child, the UN Convention on the Rights of PWDs, the International Conference on Population and Development, the New Partnership for Africa's Development (NEPAD), the Paris Declaration on Harmonization and Alignment for aid effectiveness, the International Health Partnerships and related initiatives (IHP+) and the Abuja Declaration on HIV and other related infectious diseases among many other initiatives. Uganda in addition renewed her commitment to Primary Health Care (PHC), at the 2008 Ouagadougou (Africa regional) Conference and in May 2008, joined other member states at the World Health Assembly (WHA) to make a commitment to revitalize PHC and to strengthen health systems including efforts to reduce health inequities including action on the social determinants of health. This status has been a result of 30 years of a largely asymmetric global health policy debate from Alma Ata to the current public private international partnerships configuration of the global health policy architecture aiming to accelerate attainment of the MDGs. This global health debate has shaped the health policy trend, strategies and experiences in many low income countries including Uganda.

3.1.3 The rights approach has been at the center of the global health debate of the last 30 years. It arose from dialogue in the 1970s on the provision in the Constitution of the World Health Organization (WHO) which recognizes that health “is one of the fundamental rights of every human being” This right to health has been raised at a number of international summits since being cited in the Universal Declaration of Human Rights in 1947 and has been translated into binding instruments for ratifying countries. In 1977 the 30th WHA ratified the goal of “Health for All by the Year 2000” and it was as a continuation of this policy that, the Alma Ata conference held in the following year (1978), identified Primary Health Care (PHC) as a strategy to achieve this difficult objective. The Declaration of Alma Ata aimed to achieve health for all by the year 2000 through provision of essential health care as an integral part of a country’s health care system but its main aim, however, was “the overall social and economic development” of the community, in a vision based on equity, community participation, a prevention-driven approach, appropriate technology and a cross-sector and holistic approach to development.

3.1.4 The implementation of PHC immediately ran into a host of social, political and economic barriers as a part of a top-down philosophy of Health for All by the year 2000 at a time of growing self-determination of member states and bottom-up planning approaches of countries. Implementation of PHC needed health systems to redirect their policies, strategies and resource allocation requirements towards attainment of equitable universal access to health services through a focus upon rural areas and the most deprived urban ones, basic health care, as well as the primary needs and pathologies of the poorest people at a cost that had not been negotiated at country level prior to ratification of the approach. As a response to the complexity of implementing PHC, a new current of thought called selective PHC developed and has become the more dominant practice. Selective PHC narrowed down the original innovative current of thought and concentrated on the application of selective measures that “should be aimed at preventing and managing those few diseases that cause the greatest mortality and morbidity and for which there are medical interventions of relatively high efficacy” now known as high impact interventions. The postulate is to select these interventions according to cost-effectiveness criteria. Programs to deal with individual diseases or conditions that are identified as cost effective are drawn up at global or central level and then implemented throughout the country (or throughout the world) in the same way, and often with rigidly assigned resources using separate delivery institutions for each program; the programs are organized according to top-down dynamics, (called a vertical approach), using relatively economical, high profile campaigns that conceal the lack of determination needed to overhaul the health system, in contrast with the bottom-up model of PHC, which would involve local communities in decision making. This has up to date resulted in a disease-driven rather than a health-driven approach; an approach that is easier to market and disseminate through the media (e.g. by social marketing).

3.1.5 The reorganization of health care systems into vertical programs (e.g. childhood immunization, family planning, or control of individual diseases, etc.) led to the breakup of public health action in many countries, with an increase in costs and a waste of resources, and isolated health system development from the development in other sectors, such as education and agriculture. At this time of in the early 1980s when a looming debt crisis and attacks on aid policies led to the rise of macroeconomic recipes and Structural Adjustment Programs (SAPs), attention strayed away from health and was concentrating on diseases control that was viewed as being cost effective and cheaper than comprehensive health systems development for PHC.

3.1.6 Through SAPs, the rights based debate on PHC was transformed and absorbed into the SAPs debate towards a fight for eradication or control of poverty; the Poverty Eradication Action Plans (PEAP) based upon PRSPs. The SAPs required the “reduction/removal of direct State intervention in the economy and restructuring of government functions. SAPs conditions for access to international bank lending for development included significant reduction of public expenditure; liberalization, privatization; financial

deregulation including devaluing currency and retrenchment of the public workforce. Privatizations, payment for public health care services, and government decentralization of health care became the new cornerstones for the international debate.

3.1.7 At this stage the way was paved for resurgence in the early 1990s of the selective PHC approach by promoting the introduction of a minimum essential package of services on which public health action for the poor could focus. It promoted health system reforms based on progressive privatization with the transfer of health system costs onto the user with user fees, community financing and health insurance. This effectively overshadowed the smoldering comprehensive PHC inspiration at the Harare (PHC) Conference in 1987 that, raised decentralization as a means of applying PHC, and with districts being promoted as the best way of identifying the underserved as well as for aligning health intervention. Similarly over shadowed were the attempts to sustain progress towards target of Health for All by the Year 2000, through a focus upon inter-sectorial health promotion by the Ottawa Charter, drawn up at First International Conference on Health Promotion in 1986, that introduced the idea of public health policies with health as the objective of all public intervention to help manage social determinant of health. The '*medical poverty trap*' is an expression referring to the resultant effects of the global health system model introduced by the reforms under SAPs which led to soaring private health care costs and impoverishment of families. These reforms were at the center of international health policy debate throughout the 1990s, and contributed to a shift towards the end of the last century from fighting poverty to global vertical health initiatives and globalization.

3.1.8 While increasing interdependence and globalization have posed a challenge to national control of health policy processes and content, progress begun to be recorded with the building of coalitions, trust, and creation of enabling environments through management reforms under the emergence of emergence of sector wide approaches (SWAp), despite continuing disparities in vision and practice between the SWAp practices and the growing trend of global health initiatives (GHI). The continuing growth of an evidence base of the value in stronger health systems and ministries of health (*e.g. from the WHO report Macroeconomics and health: investing in health for economic development; 2008 WHO report on renewal of PHC and from the investment cases to GHI for HSS etc.*) are contributing to a re-awakening to address the institutional capacity gap in health policy dialogue for balanced evidence based health policy decisions to accelerate attainment of better health outcomes especially in low resource settings.

3.2 National Government-wide reforms

3.2.1 Reforms in a period of social upheaval (1978 – 1985)

3.2.1.1 The first of ten guiding principles of the new NHP states that “PHC shall remain the major strategy for the delivery of health services in Uganda, based on the district health system, *and recognizing the role of hospitals as an essential part in a national health system.*”¹⁶ This guidance is a welcome policy reform for the implementation of PHC in Uganda which has over the past 30 years and to the detriment of quality of services oversight, down played the role of hospitals in a health system based upon PHC.

3.2.1.2 At the time of introducing PHC, health policy dialogue in Uganda was almost at its lowest ebb and health planning capacity was accorded little or no priority despite hope and enthusiasm in PHC among activists and the public health community in the country. The introduction of PHC followed the 1977 World Health Assembly (WHA) resolution on Health for All by the year 2000 (HFA2000). In the subsequent year of 1978, the Alma-Ata Declaration emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All.¹⁷

3.2.1.3 Consequently, “although in 1983 the Government adopted Primary Health care as the only practical approach of accelerating the process of making essential health care accessible to households in an affordable and acceptable way,”¹⁸ Uganda had no explicitly articulated national health policy or plan during this period of social upheavals. In this situation, international donor organizations are potentially important influences on the choices made by national policy actors^{19 20} because there are no policies or planned

practice benchmarks to conform to. The global economic setting at this time weighed in favor of selective PHC implementation. This subsequently initiated a fragmented implementation effort through PHC projects, notably for immunization and essential drugs program as well as a handful of disease control projects, leaving all other health system areas grossly under-funded. The approach was neither affordable nor sustainable and although medical treatment in government hospitals and dispensaries was free, facilities had greatly deteriorated under Amin's rule such that following the 1978–79 war of liberation many hospitals were left without staff, medicine or beds. Health care service provision was highly fragmented and opportunistic. Moreover, the continuing social upheaval after Amin's rule, continued to inflict damage and destruction to the health system infrastructure as well as to displace people and health workers out of the system.

3.2.2 Rehabilitation and Reconstruction reform phase in the post conflict period (1986 – 1995)

3.2.2.1. It is said that the health systems of countries recovering from prolonged periods of conflict often carry a double burden: the burden of inheriting an inappropriate and unaffordable health system developed in the pre-conflict era, and the particular burden of long-term destructive effects of conflict on health and health services²¹. This was the case in Uganda for the 1986 to 1995 Rehabilitation and Reconstruction reforms phase.

3.2.2.2. The inherited absence of a clear national health policy framework in 1986 meant that donors could neither conform, nor fail to conform to government goals. The Sector had collapsed and donors came with a free hand. Any help was welcome. The post-conflict National Resistance Movement (NRM) government began a period of reconstruction and rehabilitation. The government's attention was primarily focused upon re-establishing a political and economic environment conducive to growth. The social sector ministries were less of a priority (Macrae et al 1996)²². At the time however, the national rehabilitation and development plan was a compendium of fragmented development projects.

3.2.2.3. The health sector response of government in this situation, was a double pronged approach; on the one hand, quickly act to streamline implementation of health programs through an ad hoc commission of inquiry of the health system as a basis for organising and accepting at that time, the badly needed ad hoc donor-assistance but, on the other hand, to initiate a process for articulation of a health policy to guide planning.

3.2.2.4. The first approach of accepting the ad hoc donor assistance in absence of a health policy framework and planned strategy gave rise to the characteristic feature of Uganda's health policy development typology in the immediate post-conflict period that has in part persisted to date, comprising a tendency for donors not to directly seek to enhance the capacity for systemic policy-making of at government level²³. Instead, they offer financial support to public programs which conform to their special interests and then establish their own interventions outside of the government's institutional sector support to the health system. As a result, donors gained a strong position to influence priorities and resource allocation, while government was in a weaker position to counter donor bids for programs, both because of the overwhelming need for post-war reconstruction inputs and because of the limited institutional capacity to regulate and coordinate aid. Inevitably a proliferation of donor programs occurred, with donor agencies having great control over service program design and management. Needs not identified by donors as priorities received little attention. The relative dominance of donors in health policy development during the post-conflict period had a distortionary effect on the health system due to the weakness of national public health governance institutions.

3.2.2.5. The second approach of initiating a process for articulation of a national health policy was enthusiastically taken forward by the Report and Recommendations of the Health Policy Review Commission, under the Chairmanship of Prof. Raphael Owor, (September 1987). While made in good faith, the Owor Commission report came at a time of intense global health debate favoring selective health care interventions and a smaller role of government in health care delivery as discussed earlier. The government

and partners were not ready at this time to adopt the radical aspects of the health agenda in the Health Policy Review Commission's proposal for a system redesign, choosing instead to implement the reconstruction and of infrastructure and a patchy user fee policy through the First Health Project. In light of the abject poverty conditions under which most rural households lived at the time, the hesitation of government to implement a comprehensive user fee policy across the country is understandable. On the other hand however, the rehabilitation of the health infrastructure requires relatively little one time investment funding and gives quick and tangible results compared with other health problems and especially in comparison to long term institutional capacity development for policy development, planning, and management to sustain health services delivery.

3.2.2.6. In setting of donor dominance of the health policy agenda development, institutional capacity building proposals in the Owor Commission report were neither noticed nor were they welcome being a long term undertaking that was not favored by donors at this time because, as discussed earlier, the donor sights were focused upon quick results, such as those attainable through rehabilitation and reconstruction of health infrastructure using relatively short term donor commitments as were in place then. The agenda for full administrative decentralization gained more consensus than for health care decentralization which occurred as a national imperative following a political position of government. This debate is still active on what aspects of health care are most appropriate to decentralize and how. The decision resulted in the creation of a Health Department or Directorate in the Ministry of Local Government with much duplication functions.

3.2.2.7. Consequently, the government White Paper on Health Policy Up-Date and Review (prepared by the Ministry of Health in October 1993) to be implemented through rolling Three Year Health Plans of decentralized district health administrations, focused the health policy upon two policy objectives from an economic perspective:

- 3.2.2.7.1. Increased Resource Mobilization for the Health Sector from within the budget and from alternative financing mechanisms
- 3.2.2.7.2. More efficient Resource Allocation by focusing upon a set of cost effective interventions as a package;

3.2.3 The planning phase of comprehensive health policy reforms for institutional capacity building and health systems development

“Building coalitions, trust, and creating an enabling environment to conduct health sector reform”

This was a period of intense policy dialogue and negotiation to move from the SAP measures towards more people centred policies for the fight to eradicate poverty:

3.2.2.1. Across government:

- 3.2.2.1.1. A Long term development vision – Vision 2025 was elaborated
- 3.2.2.1.2. New National Constitution becomes effective
- 3.2.2.1.3. The Strategic Poverty Eradication Action Plan (PEAP/PRSP) was finalised and funded through HIPIC funds, PRSC etc. from the World Bank
- 3.2.2.1.4. Public Sector Restructuring and Decentralisation of service delivery were rolled out nation wide
- 3.2.2.1.5. New Public Sector Financial & Procurement Regulations
- 3.2.2.1.6. Other Governance Reforms took place: IGG, Human rights, Environment, Gender

3.2.2.2. Within the health sector

- 3.2.2.2.1. Minimum package of services was agreed
- 3.2.2.2.2. PHC conditional grants established

- 3.2.2.2.3. Grants to NGO service providers established
- 3.2.2.2.4. Service standards were elaborated
- 3.2.2.2.5. Infrastructure standards were established and a basis for expansion of service outlet network agreed;
- 3.2.2.2.6. Standards for equipment, medical commodities and pharmaceuticals were developed along with a regulatory body for their oversight (NDA, NMS and NACME)
- 3.2.2.2.7. Supervision manuals and QA tools were agreed for use and made effective
- 3.2.2.2.8. Sub-national decentralised services were strengthened with HC – IV and Directors of Health Services, District Health Teams and service unit management committees
- 3.2.2.2.9. A Health Service Commission (HSC) was established
- 3.2.2.2.10. Ministry of Health was restructured and all staff re-evaluated through interview before re-appointment as appropriate;
- 3.2.2.2.11. A comprehensive National Health Policy (NHP-I) was agreed and issued 1999
- 3.2.2.2.12. A comprehensive National Health Strategic Plan (NHSSP-I) was articulated to implement NHP-I and became effective 2000/2001
- 3.2.2.2.13. A sector wide approach for health development was agreed for implementation
- 3.2.2.2.14. The international health debate was engaged on aid architecture and influenced the design of the emerging global health funding mechanisms for priority intervention.

3.2.4 Implementation phase 2001 – 2010: (NHP 1 and HSSPI +II) of comprehensive health policy reforms for institutional capacity building and health systems development

2001 – 2010: Implementation of new National Health Policy (NHP-I) and comprehensive Health Sector Strategic Plans (HSSP I & II) were against a background of increasing influence of Global Health Funds that complimented available resources. The initial successes soon gave way to distortions due to the overwhelming influence on the institutional capacity for management and oversight the additional Global funding flows in parallel to the roll out of NHP – I measures. This period however, saw the introduction and roll out of several key technologic interventions for the management of HIV/AIDS (the introduction of free ARVs), new vaccines for childhood immunisation against HepB and meningitis as well as for Malaria and Tb.

4 Individual reforms for Health System performance improvement:

4.1 Leadership and governance of the health system:

There is evidence from round the world to show that leadership and governance of health systems is the single most important determinant of health outcomes in any country. It is about negotiation and power relations within society which places the health and quality of life of the population at the center of governance and development. It entails agreement on policies and implementation arrangements through national dialogue and coalition building. It is this level of consensus that facilitates regulation and enforcement, intelligence gathering through research and information systems and definition of roles and accountability for results. The role of leadership is to ensure that institutional capacity is available and sustained so as to facilitate the attainment of nationally agreed health outcomes. Actual services delivery can be undertaken by government or non government actors.

4.1.1 Health System definition:

There are several definitions of health systems ranging from a simple one such as “the arrangements that society or a country puts into place to take care of the health and well being of the population” (Omaswa and Boufford 2010)²⁵ to that of WHO (2000)²⁴ “A health system consists of all organizations, people and

actions whose *primary intent* is to promote, restore or maintain health”. However a practical definition that will be used in this report defines a health system as consisting of four core elements: *personal health care services, public health (sometimes called population health) services, health research systems and health in all policies*. All these four need to be in place and appropriately supported to assure a balanced strategy for achieving the greatest health result in a country.

Figure 1: Definition of a Health System

Source: *Strong Ministries for Strong Health Systems*²⁵

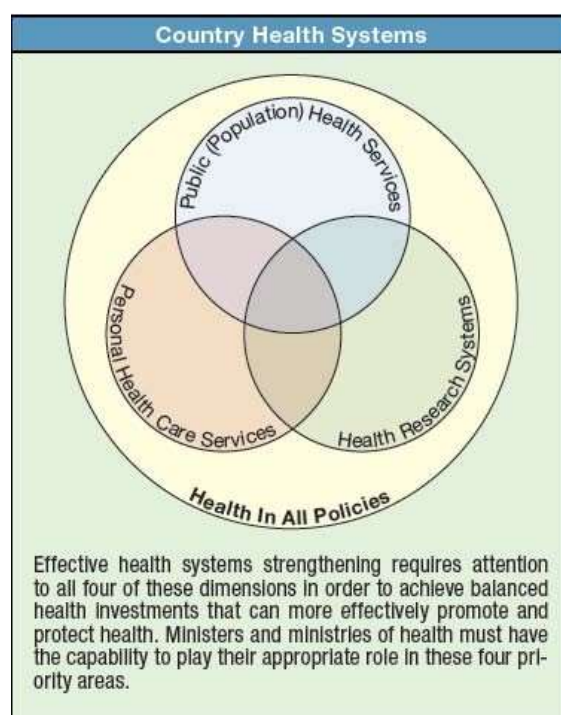
4.1.2 Health System Outputs:

The WHO Alma Ata declaration on PHC laid a sound foundation and outlined a set of guiding principles for population access to essential health services. It has been revalidated and adapted by the various WHO regions during 2008. The PAHO region has identified “a basic package” of public health services—eleven *Essential Public Health Functions* that those ministries of health should be able to provide to assure population level health (www.paho.org). The WHO African Region promulgated the Ouagadougou Declaration in support of the revitalized PHC.(reference)

4.1.3 The central role of governments and MoH:

Governments have certain core roles that cannot be delegated in ensuring that populations enjoy the highest possible standards of health within the limits of available resources. These roles include coordination, regulation ensuring equity and social justice. However, governments alone are not sufficient to achieve the desired population health goals. There are institutions outside government that hold tremendous potential to act as support and accountability agents in maintaining the visibility of the health agenda and identifying through research and advocacy those interventions that promote better population health. These have been referred to as Health Partners Resource Institutions and examples include SCOs, NGOs, Health Professional Organizations, media inter alia (fig 2).

The central role of Ministries of Health in health systems has been repeatedly emphasized: The World Health Report 2000²⁴, *Health Systems: Improving Performance* puts stewardship and governance at the center of diagrams of the variables required for health systems strengthening. Resolutions passed by the World Health Assembly in 1998 (WHA 51.16) cited Assembly actions dating back to the 31st WHA calling on the Director General and country leaders to strengthen ministries of health as key agents for such fundamental government responsibilities as assuring the provision of basic health services, addressing the role of health in development (WHA 50.23), participating in intersectoral action to eradicate poverty; developing public-private partnerships to address health inequalities; achieving MDGs (WHA 58.30). WHA in May of 2009, implementing and evaluating the recommendations of the Commission on Social Determinants of Health and Revitalizing Primary Health Care pointed out that while health determinants are multisectoral, it is the ministries of Health that have the primary responsibility for ensuring that population health goals are visible and are achieved.



The World Bank in the World Development Report 2004: Making Services Work for Poor People²⁶ underlines the important role that government must play in assuring effective services whether as direct provider or through its relationship to private providers as do World Bank Papers #4 and #6 .

Figure 2: MoH Operating Environment - Source: *Strong Ministries for Strong Health Systems*²⁵



4.1.4 Definitions of stewardship, leadership and governance:

4.1.4.1 Stewardship:

According to the Oxford dictionary definition, a *steward* is one who is entrusted with the management of things belonging to another or acts as a supervisor or administrator of the finances, property for another or others. This designates the role of government as protector of the public interest and, in a unique sense not applicable to non-governmental entities, responsible to the public for its actions.

4.1.4.1.1. The ministry of health as a steward must do more than ensure that care is delivered. It must work effectively across government—with ministries of finance for resources; with ministries of education on health professions training and health education in schools with ministries of economic development, water, agriculture, housing and transportation, as well as with those ministries effecting decisions on centralization and decentralization of government and civil service reform and with parliament to gain political support for healthy policies. Ministries in some countries must also relate to specialized parastatal agencies often created to perform government functions such as those that regulate drug quality; conduct and commission research; perform disease surveillance functions; and operate health care services among others.

4.1.4.1.2. In this complex environment, government cannot meet its responsibilities alone, and health ministries must also work effectively with an increasing number of non-governmental actors--

civil society, business, philanthropy, professional associations, academia, donors, academies of medicine and science, the public and with regional and international organizations.

4.1.4.2 Governance:

4.1.4.1.1. The expanded number of actors that must be involved in assuring conditions for health has led to the increasing use of the term “*governance*”. There are multiple definitions of this term but most reflect, at the simplest level, the alignment of multiple actors and interests to promote collective action towards an agreed upon goal. As a good steward, ministries of health must be able to lead and participate in effective systems of governance to assure the best use of resources for health.

4.1.4.1.2. Though there are evolving international standards for effective government, “*governance*” is almost always context specific, because it must reflect the ways in which all stakeholders interact with one another in a particular set of societal circumstances in order to influence the outcomes of public policies. Therefore, of necessity, actions needed to strengthen leadership and management for this increasingly complex role will vary from country to country.

4.1.4.3 Leadership

Leadership entails scanning the environment to create a vision and strategy followed by inspiring and aligning all stakeholders for a common vision and shared action.

4.1.4.4 Management

Management is about getting the work done by making plans and time tables, mobilizing resources for implementation followed by monitoring , evaluating and providing feed back

4.1.5 Situation Analysis of the Leadership functions - (*Achievements, Lessons, Constraints and recommendations for improvement*)

4.1.5.1 Situation analysis of the leadership functions in the period of 1978 – 1985

The study period commences in 1978, the time of the global promulgation and adoption of the Alma Ata Declaration on Health for All by the year 2000 through the Primary Health Care (PHC) approach. Between 1978 – 1985 Uganda is reported to have enthusiastically embraced the PHC principles and a White Paper was published by the MoH in 1982. However, due to the instability in the country at the time, the leadership, both political and technical was not able to implement the recommendations of the White Paper. During this period, the country experienced three civil wars in succession: to dislodge in series, the governments of Idi Amin, Tito Okello and Milton Obote. There was a huge exodus of health professionals and health facilities were destroyed and looted resulting in total collapse of the health services (Cole Dodge ed. 1981)²⁷.

Thirty years down the road, WHO (2008)²⁸ has revalidated PHC principles and has



Figure 3: Policy Reforms for renewal of Primary Health Care

focused on four reform areas namely: Leadership reforms to make the authorities more reliable, service reforms to be people centered public policy reforms to protect the health of populations and universal coverage reforms to promote equity. The participation of the populations themselves in the reforms continues to be central to the reform process. It is helpful at this point to make a distinction between PHC and Primary care. PHC is an approach or a philosophy for achieving health outcomes of a population. Primary Care is the health services provided at the first point of contact between the community and the health system.

4.1.5.1.1. **Achievements:** Publication of the White Paper on PHC

4.1.5.1.2. **Constraints:** Several devastating civil wars, insecurity, massive brain drain, looted health facilities and collapsed health system.

4.1.5.1.3. **Lessons:**
Political stability and leadership are critical to health development
PHC principles remain relevant

4.1.5.1.4 Recommendation:

HSSIP is brief on PHC and it is recommended that a deliberate program of work be developed to undertake analysis of implementation arrangements to ensure that the PHC philosophy and principles are reflected more visibly and operationalized in the NHP and HSSIP.

4.1.5.2 Situation analysis of the leadership functions in the period of 1986 – 1995;

A new government came to power and the leadership created a hopeful environment and provided an opportunity for new thinking and a new effort in all aspects of the country's development. In the stewardship and governance of the health sector, a Health Policy Review Commission under chairmanship of Professor Raphael Owor, was established and deliberated during the period 1987 – 1989. The key governance recommendations are included restructuring of the MOH and separating technical and administrative leadership roles, establishment of the Health Services Commission, village health committees, NDA and NMS among others. Some of these were implemented piece meal over the ensuing years. There were other major reforms across government at this time: a new national constitution was promulgated, roles of the central and local governments were redefined with decentralization of service delivery to district local governments; leaving central ministries with residual roles of policy, standard setting, resource mobilization and supervision. The MoH established the Quality Assurance Program with the primary role of supporting districts to take over decentralized health services. This program worked closely with a decentralization secretariat located in the Ministry of Local Government. It is important to note that this period followed several devastating civil wars that impoverished the whole country. Government had no money; essential commodities were scarce with long queues for everything. Health services were not spared and were equally decimated with damaged and looted health facilities, lacking water, power and suffering a massive brain drain.

Under the circumstances, the international community played a major role in the recovery of the country. Initially government favored leftist partners such Cuba and North Korea espousing barter trade but soon turned round to partner with the West and the Bretton Woods institutions. Without the country's own money, bilateral partners, the World Bank and IMF played leading roles in shaping approaches to health development including the selection of and implementation of the recommendations from the Owor commission of inquiry and PHC principles. Global thinking at the time was also heavily influenced by President Ronald Reagan and Prime Minister Margaret Thatcher where development was looked at primarily through the money lens and the role of government was considered peripheral. It is interesting to note that

the role of the World Health Organization in policy dialogue during this period was not prominent apart from providing a few scholarships for training and providing technical assistance to Makerere University.

There was a high turnover of Ministers of Health with four Ministers serving during this period. This was also the period when the HIV and AIDS epidemic received exceptional attention and leadership from the new government with H E the President himself acting as Chair of the first national HIV committee and the establishment of the first global HIV department in the world. This was so successful that there was a dramatic decline of prevalence from an average of 18% in 1990 to 6% in 1993. This was achieved primarily through a massive national awareness campaign led by H E the President and followed by other leaders, religious, cultural and professional.

It was during this period that important laws governing health professionals were enacted. These included the Medical and Dental Practitioners Act, the Nurses and Midwives Act and the Allied Health Professionals Act. These are the basis for the existence of respective Health Professionals Councils which have key roles to play in the governance and leadership of health professionals and the health system.

4.1.5.2.1 Achievements:

- The Health Policy Review Commission into the health services in Uganda
- Development partners engaged after the wars
- Three year rolling health plans
- Demonstrated leadership on HIV and AIDS
- Introduction of Decentralization of health services delivery
- Establishment of the Quality Assurance Program for supportive supervision and standard setting
- Health Professionals Acts passed and Councils established
- New National Constitutions adopted.

4.1.5.2.2 Constraints:

- Weak human resource and institutional capacity
- Dilapidated infrastructure
- Local governments learning to take over services delivery

4.1.5.2.3 Lessons and Implications for NHPII and HSSIP:

- Strong political leadership contributed to the developments that took place during this period namely: New national constitution, decentralization, the Health Policy Review commission of Inquiry and the success of the HIV/AIDs control. This was also matched by strong technical leadership and translating political direction into technical interventions. It also demonstrates the advantages of broad national dialogue and consensus as opposed to restricted individual disease or issue specific dialogue and interventions.
- The weakened state from a series of wars and without an explicit health policy provided the environment for outside forces to sideline the implementation of the Owor commission report in respect to the implementation of PHC. This influence led to the emphasis on user fees, and vertical disease programs to the detriment of health system development.

4.1.5.2.4 Recommendation:

Health sector reforms work best where there is wide participation and consultation. While HSSIP discusses inter-sectoral collaboration, there are no specific interventions that have been provided for achieving this. It is therefore recommended that a high level structure be established under the leadership of the Rt Hon

Prime Minister to coordinate multi sector engagement in health. An Additional structure at technical level should also be established under the Head of the Civil Service.

4.1.5.3 Situation analysis of the leadership functions in the period of 1996 – 2000:

This period was extremely busy for the health sector and government as a whole. The country started to assert overall policy leadership in respect to development partners and development assistance now moving from rehabilitation and reconstruction to development planning. The provisions of the new national constitution were being rolled out. Constitutional institutions with implications for the health sector were set up such as the IGG, Human Rights Commission, NEMA and districts were learning how to run all decentralized services including health services while central line ministries were being restructured and equally adjusting to play the new roles of policy formulation, standard setting, and supervision and monitoring and resource mobilization for respective sectors. The Ministry of Finance Planning and Economic Development under strong political and technical leadership envisioned a Comprehensive National Development Framework with a document for Vision 2025 and the Poverty Eradication Action Plan (PEAP) to be implemented through Sector Wide Approaches (Swaps) by all sectors. International agencies were also undergoing change. New Global Health Initiatives such UNAIDS and GAVI, Global Stop TB partnership and the Global Fund to Fight Aids TB and Malaria were being negotiated. Uganda was very closely associated with these negotiations and gave leadership to these initiatives. The World Bank continued to of health professionals maintain strong engagement with the Ugandan reforms including the health sector. A new WHO Country Representative had arrived and made an effective contribution as a go between the government and development partners in health. Key reforms are:

The Restructuring of the Public Service: Major restructuring of government ministries was undertaken during this period. Although the MoH was part of this exercise, the outcome was not considered satisfactory by the MoH. An additional internally led restructuring was therefore carried out. It was this overall restructuring exercise that led to the creation of the office of the DGHS in order to fulfill a constitutional requirement for “a technical head of health services” to be in place in the event that the health of the head of state needed to be evaluated within the provision of the constitution. However, there is a cabinet minute to the effect that the Ministry of Health like other technical ministries needed to be headed by a technically qualified individual. In spite of all this a post of Permanent Secretary was created for the MoH separate from that of the DGHS. This later became a source of conflict and remains issues whose implications have been pointed out in the Key Informant interviews report and mid term reviews of HSSP I and II. Experience has also shown that other departments in the MoH are not performing optimally and need a review of their mandates. An example is the management of health information which is fragmented and not streamlined for distribution in a user friendly manner.

The Health Services Commission was one of the Constitutional Commissions that were operationalized through the Health Services Act. Its first job was to appoint the DGHS and to interview and appoint all staff in the MoH Headquarters during the early part of 1999. According to Key informant interviews this Commission has not performed to expectations as it has concentrated more on making appointments and much less determining the conditions of service of health professionals.

NHP 1, HSSP1 and Swaps: Following national elections of 2006, a new Minister of Health was appointed and was in post until 2001. The NHPI and HSSPII and the Swap arrangements were negotiated simultaneously through very wide and laborious consultations that started 1997 leading to the adoption of the NHPI in 1999 and the launch of HSSPI in 2000. Swaps structures and instruments were put into place (Annex...). The overall outcomes of this process was that a clear sector vision for the health sector was achieved and trust had been built between GoU, DPs, NGOs based on openness, mutual respect and patience. Mechanisms for dialogue, monitoring and managing Swaps were established and there was evidence of demonstrated national ownership and commitment (JRM statement Aid memoir). The capacity of districts was growing

around implementing the Planning and Budgeting Process that was transparent bottom-up and consultative for result-oriented and integrated Annual Work plans

4.1.5.3.1 Achievements:

- Swaps working arrangements were successfully negotiated and introduced and were functioning well with strong donor coordination through guidelines developed with MOFEP, - JRM's;
- A clear sector vision was created and trust was built between GoU, DPs, NGOs based on openness, mutual respect and patience;
- Mechanisms for dialogue, monitoring and managing Swaps were in place;
- Ownership status improved;
- Commitment and capacity of districts built for Planning and Budgeting through a transparent and consultative process that was in addition result-oriented with integrated Annual Work plans.
- The HSC was established and new appointments made in the MOH with a new DGHS, and all staff interviewed.

4.1.5.3.2 Constraints:

- the effects of the SAPs characterized by the three year recruitment ban for health workers who were qualifying from publicly sponsored health training institutions and were not being recruited,
- down-sizing of the civil service with retrenchment health workers, removal of allowances etc further demoralized the health workforce.
- The impact was low morale among health workers, massive migration of health workers and increase in vacancy rates in the health services.
- Negotiating NHPI, HSSPI and Swaps was a labour intensive undertaking but provided good preparation for roll out of these tools later.

4.1.5.3.3 Lessons:

- The critical value of strong country leadership in mobilizing intersectoral actors, civil society and DPs for common action in agreeing NHPI, HSSPI and the Swaps.
- Strengthened sector supervision, monitoring and evaluation is possible
- Need to build a critical mass of committed individuals to trigger and champion the reform process.
- In order to build and nurture trust, openness and mutual respect between government officials and DPs is needed.

4.1.5.3.4 Recommendation:

While HSSIP underscores the importance of multisector action, it is silent on practical steps to implement Inter-sectoral collaboration: It is therefore recommended that strong action and leadership is required in order to promote intersectoral action by establishing coordinating structures at various levels i.e. Political/Cabinet under the Rt Hon Prime Minister, Technical under the Head Civil Service, District under the Chief Administrative Officer, Sub county under the Sub county chief.

4.1.5.4 Situation analysis of the leadership functions in the period of 2001 to 2005

This period saw the launch of several Global Health Initiatives in which the country provided leadership and with significant implications for the health sector in Uganda. These included the Global Stop TB Partnership and the Global Fund to Fight Aids TB and Malaria. In the year 2000, H E the President had participated at the Children's Summit in New York. He returned from there and convened a meeting with District LCV Chairpersons to discuss immunization coverage and this resulted in strengthened ownership by district leaders of this program and a rapid improvement in immunization coverage across the country. The Paris Declaration on Aid Effectiveness was negotiated and adopted at the beginning of 2004 and again Uganda

was an active participant in its adoption. Indeed the Uganda development assistance model including Swaps and budget support were used as a foundation for the articles of the Paris declaration.

The roll out of the HSSP I under Swaps arrangements continued to make good progress. Input, process and output indicators were showing rapid and sustained improvements such as immunization coverage, utilization of health facilities, staffing norms and personnel recruitment. Funds transfers to PHC were gradually increasing. One indicator was not improving namely the attendance of skilled health workers during deliveries and this became the subject of a special study commissioned by the MoFPED. The policy to cap funding of hospitals at this time has later proved to have been carried on for too long and has had negative implications.

Table 1: Achievements - Outputs of HSSP-I implementation (Source AHSPR 2005.)²⁹

Achievements - Outputs

Indicator	00/01	01/02	02/03	03/04	04/05	2005 Target
OPD new attendees	0.43	0.60	0.72	0.79	0.9	0.70
DPT 3 coverage	48%	63%	84%	83%	89%	85%
Deliveries in units	22.6%	19%	20.3%	24.4%	25%	35%
Filled staff positions	40%	42%	66%	68%	68%	52%
HIV sero-prevalence	6.1%	6.5%	6.2%	6.2%	6.5%	5.0%

Figure 4: New OPD attendance for HSSP-I (Source AHSPR 2005.)²⁹

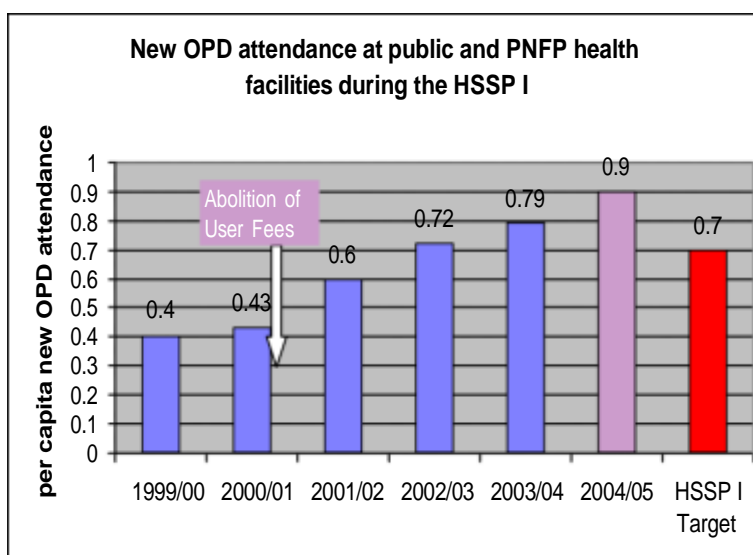


Figure 5: Pentavalent Immunization Coverage for HSSP-I (Source AHSPR 2005.)²⁹

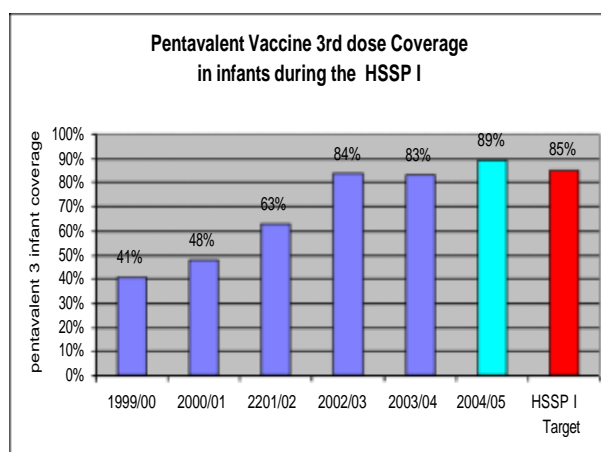
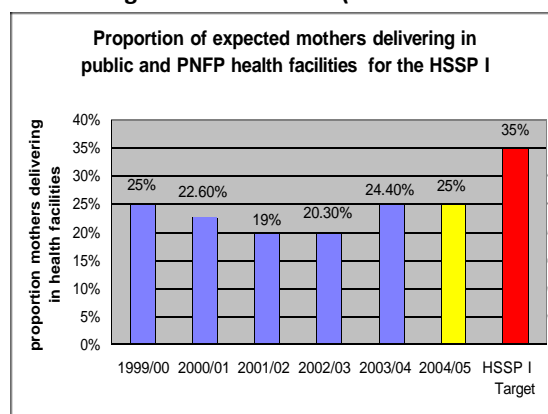


Figure 6: HSSP-I - Expected mothers delivering in health facilities (Source AHSPR 2005.)²⁹



UDHS of 2000/2001 report was released that showed a stagnation in health indices especially, IMR, CMR and MMR. While this was seen as surprise by some development partners, it was easy to explain on account of the negative impact of the SAPs with the recruitment ban, staff attrition resulting in high vacancy and a low morale among health workers that had characterised that period. The MoFPED instituted an investigation which was led from that sector.

The major findings of this investigation were to show that the stagnated health indicators were an expected result of the policies and interventions that preceded the DHS and further that funding for health services was grossly inadequate. Further it made a direct link between health interventions and health indices; a point that is sometimes lost.

Table 2: Health Outcomes in the period 1988 to 2000 (Source UDHS 2000)³⁰

Health Statistics – 1988 to 2000

Indices	1988	1995	2000
IMR	122	97	88
Under 5 Mortality	203	147	152
MMR	550	506	505
Life expectancy	54	48	
Fertility Rate		6.9	6.9
HIV Prevalence	20%		6.1%

4.1.5.4.1 Responding to corruption

The GFATM and GAVI funds scandals occurred at the end of this period. A Commission of inquiry was set up by the President to investigate alleged misuse of the GFATM funds and IGG was instructed to investigate alleged misuse of GAVI funds. In the case of GFATM a government white paper was published that assigned roles and responsibilities to the MoH, the police and the MoFPED in how to handle the findings. Some individuals implicated in the report were exonerated, others have been prosecuted and there are court cases that are still ongoing. In the case of GAVI three Ministers and an employee of the office of the President have been taken to court.

Curbing corruption in the Health Sector in Uganda is bedevilled by many challenges. On the one hand, there are institutions and mechanisms that have already been established across government and within the health sector specifically that should be sufficient to curb corruption. On the other hand there are pressures in the social fabric of the country and in the management of the sector that negate the fight against corruption. The existing mechanisms in the health sector include: Health Unit management committees, the Village Health Teams. At district and hospital levels there are procurement committees, and internal auditors and political leaders at all levels. The negating forces include widespread shortages of commodities and services everywhere a situation that provides raw material for corruption and all this is compounded by the poverty of the population including their leaders as well as the poverty of the health staff and the many dependants that they support.

4.1.5.4.2 Achievements:

- Smooth implementation of Swaps resulting in improved input, process and output indicators.
- Uganda demonstrated global leadership in the development of the GFATM and the Global Stop TB Partnership. Uganda was also active in other international agencies notably UNAIDS and GAVI as well as in the region
- Uganda was a popular destination for study tours by other developing countries from Africa and Asia
- The Uganda reform model was copied in many countries and lessons were shared by WHO, WB and incorporated into aid instruments such as the Paris Declaration on Aid effectiveness and the IHP+

4.1.5.4.3 Constraints:

- The resource envelop remained insufficient to implement the HSSP
- Issues with governance and leadership at the MoH Headquarters. Roles of PS/DGHS, the TMC, SMC, HPAC need streamlining to facilitate efficiency in decision making.
- The health sector was rocked by two scandals involving the alleged misuse of GFATM and GAVI funds at the end of this period.

4.1.5.4.4 Lessons:

- High level leadership and commitment facilitates high performance
- It is possible to build and maintain trust with partners
- Supportive supervision improves performance.

4.1.5.4.5 Recommendations:

- There is need to redefine roles of various organs at the MoH headquarters in line with recommendations of the mid term reviews of HSSPI and HSSPII.

- Regular interventions by the office of the President help in unlocking bottlenecks. It is therefore recommended that H E the President is kept in constant contact with developments in the health sector.

4.1.5.5 Situation analysis of the leadership function in the period of 2006 - 2010

This period saw new leaders being appointed in the health sector; namely three Ministers, the Permanent Secretary, the DGHS, two Directors of Health Services and Under Secretary among others. There were also new appointments at the Health Services Commission. According to the report of the mid term review for HSSP II and statements from respondents to Key Informant interviews, there were strains between the leadership at both political and technical level at the MOH Headquarters. The arrival of a large team of new leaders, the scandals over GFATM and GAVI led to suspicions that adversely affected the performance of the sector. There was a manifest decline in input, process and output indicators during this period ([See Table 3 below](#)).

Table 3: : FALLING CORE PERFORMANCE INDICATORS FOR HSSP II IMPLEMENTATION

Table 1: Performance against the 8 PEAP indicators for the HSSP II Period

Indicator	Baseline FY 2004/05	Achieved FY 2005/06	Achieved FY 2006/07	Achieved FY 2007/08	Achieved FY 2008/09	Achieved FY 2009/10	Target HSSP II (09/10)
Proportion of approved Posts filled by Trained Health workers	68%	75%	88.4% ⁽¹⁾	88.40%	90%	90%	82%
Proportion of Health Facilities without stock-out of 5 major medicines & supplies	10%	27%	35%	38%	40%	41% ⁽²⁾	70%
CDFI Utilization in Govt & PNFP Units	0.9	0.8	0.9	0.8	0.8	0.9	1
Percentage of deliveries taking place in health facilities (Govt and PNFP)	88	78	83	80	84	83	80
Conjugal Years of protection (CYP) ⁽¹⁾	254,239	309,757	357,021	361,089	349,594	400,825	404,988
DPT 3 (Pertussis) vaccine coverage	89%	83%	80%	82%	83%	70%	93%
Household literacy coverage	57%	58%	58.50%	62.40%	67.50%	69.3	70%
National Average HIV Seroprevalence at ANC Surveillance sites	6.20%	6.20%	6.70%	7.00%	5-10% ⁽³⁾	6.5%	4.4%

(1) There was a change in staffing Norms by MOH

(2) This analysis excludes availability of Contraceptives which is procured through the Global Fund

(3) ANC surveillance data 2008

The UDHS of 2005/06 showed improved health indices. This is attributable to the success achieved during the roll out of HSSP I and the demonstrated improvement in input, process and output indicators during HSSPI.

At the international level WHO and the World Bank were signed to implement the International Health Partnership (IHP+) and Uganda became a signatory to an IHP+ compact during the later part of this period. This compact was a reaffirmation of the MoUs that Uganda had signed with the development partners' way back in 2000 at the launch of HSSPI and were indeed largely copied from this MoU.

4.1.5.5.1 Achievements:

- Signing of the IHP+ Compact
- Development and negotiation of NHPII and HSSIP.

4.1.5.5.2 Constraints:

- Internal conflicts among the leadership
- Low resource base due to suspension of GHI funds
- Loss of trust from Partners and community

4.1.5.5.3 Lessons:

- Losing trust is easy but Building and Sustaining trust not easy
- Negative consequences of leadership gaps

4.1.5.5.4 Recommendations:

- In response to the recommendations of mid term reviews of HSSP I and II, and the findings from Key informant interviews, there is need to redefine the roles at all levels for accountability: TMC, PS/DGHS, SMC, HPAC; VHT, HUMC, Regional Tier, RRH oversight of services
- There is need to review NHP II and HSSIP to harmonize & align policy, strategy and investment focus as well as edit Executive Summary to match content of the main document.

4.2 Service delivery reforms;

4.2.1 Definition and analytic approach for service delivery

“Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources” (WHO) ³¹. This definition facilitates conceptualization of a framework for analysis of the service delivery. It helps to distinguish between expected population health benefits and personal health care benefits, so as:

- to identify how services delivered to people could better meet their expectations and needs;
- to identify Service delivery approaches that respond to the needs of people, when and wherever needed in their life cycle;

to articulate ways to effectively link raising funding and payment to health service providers. The above definition and analytic framework for health services delivery is consistent with the five elements for reform adopted by countries for the renewal of PHC philosophy as an approach for the achievement of better health for all (WHO 2008)²⁸. These five elements are:

- organizing health services around people's needs and expectations (service delivery reforms);
- reducing exclusion and social disparities in health (universal coverage reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.

4.2.2 Service Standards

In 1997, Uganda developed guidelines for service standards by level i.e. Community level HCI, Parish level, HCII, Sub-county level, HCIII and County or Health sub district, HCIV and at District Hospital level. A hospital policy was also developed in the mid-2000. These service standards contain the Basic Package of Services for Uganda to be used by health care providers, administrative and political leaders and above all the communities themselves as realistic targets to be achieved. They should form the foundation for planning, financing and monitoring health services and as the tool for ensuring access to the UNMHCP to the population.

4.2.3 Primary Health care (1978 – 1985):

A situation analysis of service delivery policy interventions during a phase of continuing social upheavals) – “The stand alone intervention projects”:

A key strength of the NHP II and HSSIP is their sustained focus upon Primary Health Care (PHC) as the major strategy for the delivery of health services in Uganda and, to be based on the district health system with the added dimension of recognising the role of hospitals as an essential part in a national health system. In light of its “rights-based” approach and focus upon social justice as well as previous experience in Uganda with community based health care approaches such as the Kasangati “Model Health Centre” project in the 1960s, Uganda enthusiastically adopted the PHC approach in 1983 following the government approval of the 1979 White Paper on PHC. The roll out of PHC in Uganda as elsewhere has however run a varied course owing to lack of consensus in the debate regarding the choice between comprehensive implementation approaches in contrast to selective implementation approaches.

4.2.3.1. Achievement:

PHC was the basis of the key policy intervention for services delivery immediately after the Alma Ata declaration. The intervention comprised introduction of stand-alone PHC projects for delivery of identified priority interventions (e.g. childhood immunisation and essential drugs).

4.2.3.2. Constraints

Key constraining factors at the time included the social upheavals and destruction of health services by war at the time of PHC introduction between 1978 and 1985, absence of an explicit national health policy as well as absence of domestic capacity to implement the comprehensive PHC reforms. Consequently, a selective implementation approach of PHC was adopted with establishment of “vertical” intervention based service delivery programs (e.g. for Essential Drugs and for Childhood Immunisation) resulting in further fragmentation of a weakened health system. At this time Government took on a passive role in services delivery and international partners initiated and funded the categorical vertical service programs based upon their interests.

4.2.3.3. Lesson

Absence of an explicit health policy and comprehensive national health plan opens the way to un-coordinated interventions by stakeholders. Apart from definition of interventions there is need for agreed definition of areas of application, The selective PHC reform implementation approach adopted owing to the constraints set out above and the global economic crisis of the early 1980s, not only further weakened the collapsing health system but, was in addition inappropriate because no account was taken of broad health care needs of society as well as social and cultural values at the local level. It fell far short of meeting social and public expectations for health services delivery but in addition had little or no impact on overall health outcomes. It stands out as a lesson on the limitations of the project approach as major means for systems development to achieve better health outcomes.

4.2.3.4. Recommendations:

The application of selective intervention based vertical projects as service delivery models, should be minimised, so as to mitigate its fragmenting effect on the service delivery system. An agreed common statement defining services delivery should be adopted for NHP II and HSSIP.

4.2.4 PHC during National Rehabilitation and Reconstruction (1986 – 1995):

The subsequent phase of PHC implementation between 1986 and 1995 was a period of much hope with emergence of peace in the country between 1986 and 1995. Economic efficiency and reduction of public expenditure were the focus of policy debate. The debate was influenced by the macro-economic global

trend towards Structural Adjustment Policies (SAP) and the introduction of vertical packages based upon cost the effectiveness of interventions on the national burden of disease following the methodology of the WDR of the World Bank in 1993. The strength of the packages was their robust theoretical base however they lacked evidence of implementation feasibility. An alternative comprehensive set of basic services was recommended by the Health Policy Review Commission chaired by Prof. Owor but was considered by the international partners as being unaffordable and as an extra burden but without compelling evidence at the time. Despite lack of feasibility evidence, the 1993 White Paper on Health Policy Review and Update recommended implementation of service packages based upon Burden of Disease cost-effective analysis for delivery through the Three Year Health Plan frame. The essential package was introduced through pilots with the aim of demonstrating cost-effectiveness of clinical and public health interventions. The package was then to be rolled out for implementation along-side other post-war government wide reforms and system-wide rehabilitation of health infrastructure. It was argued that to mitigate the poor quality of services a user fee was required. User-fees were therefore introduced for accessing the essential package. Supervision and quality assurance mechanism were designed for oversight of the pilot implementation of the package and to support districts in taking over services delivery under the new decentralized arrangements.

4.2.3.5. Achievements:

A white paper on health policy was approved by government and a national three year health plan was approved to guide development of services. The infrastructure was extensively rehabilitated and re-equipping initiated. The first package of services based upon BoD studies was established and piloted in decentralised districts. A quality Assurance program was established for oversight of services delivery and development of tools for supervision initiated. User fees were introduced for access by all to the essential package of services.

4.2.3.6. Constraints

Exemption mechanisms for the poor failed to work and utilisation of services plummeted. The health service delivery package program was in essence an amalgamation of new and revitalised vertical health care projects with distinctly separate financing and management arrangements for each project. The services were offered at un-affordable prices and as such the policy was a scale up of a failed reform approach which sustained service delivery weaknesses.

4.2.3.7. Lesson:

The impact of reforms on service delivery should be more rigorously conducted in advance to ensure effective mitigation of their adverse effects. As the assessment of the impact of these reforms on services delivery did not predict the level of decline in services utilisation in advance of implementation, the response to this negative outcome was not adequately prepared for.

4.2.3.8. Recommendation

A continuous, possibly prospective appraisal process, of the likely impact scenarios of proposed reforms (changes) on services delivery in NHP II and HSSIP, should be put in place to act as an early warning mechanism for adverse outcomes of reforms being implemented and as a part of the planned regular review of implementation.

4.2.5 Development of the National Health Policy I and the HSSP-I (1996 – 2000):

Service delivery policy interventions during the phase of policy transformation and planning for the fight against poverty (1996 – 2000):

During the period 1996 – 2000, the project based services and cost sharing policies for accessing essential packages under the economic structural adjustment programs (SAPs), prompted a complete review and re-design of all national health policies and strategic implementation frameworks. The policy dialogue and advocacy for reforms of health policy were labour intensive and very long lasting about 4 years. The GoU through the MOFEP adopted a new approach to donor coordination which was part of the PEAP and Sector Wide Approaches (Swaps) for implementing respective sector priorities. A clear definition of roles between GoU and Development partners and these formed the guidelines for health sector development as well. Institution capacity building was specifically built especially through close on the job peer interaction so as to support the building of trust and confidence between all stakeholders including development partners. This facilitated the building of the evidence base for the debate on service delivery reforms. Support from partners to the health sector for services grew rapidly and external funding accounted for almost 80 percent of the total health budget in 1997/98 (Mukooyo & Wabwire 2003). The key policy shift was to redirect policy focus from SAPs towards a fight against poverty through Poverty Alleviation programs. The World Bank provided debt relief to the poorest countries through the Heavily Indebted Poor Countries (HIPC) Initiative and in Uganda the funding was applied to the implementation of the national program code-named Poverty Eradication and Action Plan (PEAP) and a Poverty Action Fund provided support to district PHC programs. Policy dialogue at sector level intensified with adoption of a sector wide approach to policy development, planning and implementation of service delivery programs. The Uganda National Minimum Health care Package (UNMHP) was a key change/reform as it was articulated to change the amalgamation of vertical project based intervention packages towards an integrated service package defined for each level of care.

4.2.5.1 Restructuring of the MoH:

The Ministry of Health oversight role was strengthened through restructuring and that of district health teams strengthened with introduction of senior leadership for the team by a Director of Medical Services at that level. Collaboration between services provider was enhanced and strengthened through the building of new partnership arrangements with the non-government (NGO) service delivery providers especially the Mission Health Sub-sector. The organization and structure of delivery of care were re-designed to introduce the health sub-district outlet units at county or electoral constituency level with a view to deliver for closer to client higher quality care of skilled service provision as specified in the service standards for the package described above.

4.2.5.2 Expansion of health service outlet network

Extensive expansion and re-equipping were initiated for the infrastructure network of rural health service outlets for both government and non-government provider through non-project, direct PHC grant funds transfer to local governments. Mechanism were developed to encourage and support participation of communities in decision making and planning for health services provision through Village Health Teams (VHTs) and revitalised Health Unit Management Committees (HUMCs). Community Health Departments were established in all government hospitals. Technical oversight and supervision of services delivery were transformed with the roll out of quality assurance tools and practice. The Service Standards for the delivery

of the UNMHP were established including work place operations manuals such as clinical guidelines, planning and management manuals as well as standards for staffing levels, infrastructure, equipment and supplies for the delivery of the UNMHP. The new environment for dialogue on policy exerted ample pressure for government to abolish the user fee policy. These reforms constituted the NHP I (1999) that was implemented through the HSSP I for 2000/2001 – 2004/2005) with access to the UNMHP being free at the time of use.

4.2.5.3 Emerging of Global Health Initiatives

New opportunities also arose through the introduction of the concept and practice of Global Health Initiatives that were actively engaged with success in the national health policy management team gaining key roles of leadership in the global level agenda setting, debate and establishment of Global Health Funding Initiatives. While this development held good prospect for increased financial support for services delivery, it had the constraining aspect of the potential to re-introduce vertical approaches to services delivery for selected interventions. The approach is sound for introduction of innovations but needs clear strategies for institutionalization and exit to ensure sustainability. Actions in this period went a long way towards meeting the criteria set out above in the analytic framework for soundness of service delivery reforms; however, there is a price to policy reform negotiation in terms of implementation down-time. This is reflected in some loss of output and when combined with the constraints of macroeconomic transition between reforms directions, may contribute to reversals in health outcome gains but which are more than compensated by implementation of the reforms.

4.2.5.4 Achievements during the phase of policy development and planning the fight against poverty (1996 – 2000):

- The SWAp was rolled out of minimum health package delivery
- Strengthening of district health teams with a Director was accomplished
- Strengthening of service delivery collaboration with NGOs was initiated
- Health sub-district outlet units were established
- Nation - wide Roll Out of quality Assurance practice of services delivery was undertaken
- Roll out / Establishment of UNMHP
- Roll out / Establishment of Service standards
- Roll out / Establishment of Quality Assurance and standards for supervision of services delivery
- Health sub-district introduced
- Introduction of concept and practice of Global Health Initiatives begun

4.2.5.5 Constraints

Labor intensive negotiations for policy and plan to roll out a SWAp

Labor intensive negotiations for financing of health package and delivery reforms

Resistance to new collaboration with NGOs

4.2.5.6 Lesson

- Effective dialogue and negotiation of service delivery reforms require patience and repetitive consultations between stakeholders over a long time in concurrence with institutional capacity development for policy management.
- Changes or reforms require a long lead time to undertake the negotiation before rolling them out.

4.2.5.7 Recommendations

- HSSP I implemented many of the reform initiated with success and it would be prudent to take the opportunity of this review to consider how to further revitalize especially the quality assurance, technical oversight and support supervision practices for attaining better service delivery outputs and performance.
- Explicit measures need to be put in place to build institutional capacity for negotiation and implementation of reforms in NHP II and the HSSIP.

4.2.6 The implementation phase of service delivery policy interventions in NHP I (2001 – 2010):

4.2.6.1 Implementation success in HSSP-I

Implementation of services reforms in HSSP-I gained much success (*see results of HSSP-I in Table 1 on page 19 and Figures 4, 5, & 6 on page 19 above*). As implementation of NHP I reforms through HSSP I got underway in 2001 to 2005, additional support not originally envisaged became available for Scaling up selected interventions through support from bilateral donors (PEPFAR) and through Global Health Initiatives as well as for Health System Strengthening (HSS) for effective service delivery for attaining better health outcomes. Key interventions were significantly scaled up and the use of the network of health service outlets increased tremendously. As of 2004, an estimated 72 percent of health facilities were deemed to be 'functional' (Ministry of Health 2004). Technical innovations were successfully introduced and rolled out nation-wide for the management of HIV/AIDS, Malaria, Tb and for childhood immunization with new vaccines. Access to HIV testing and counseling including provision of condoms as well as male circumcision and Anti Retro Viral (ARV) treatment were extended nationwide. New regimen of anti-Tb treatment as well more effective multi drug therapeutic approaches became widely available. Altogether the service delivery reforms in NHP I gave effect to better access to effective health care and mitigated the financial barriers to access demonstrating the re-emergence of a trend towards better health outcomes even for the usually refractory reproductive health indicators.

4.2.6.2 Declining service delivery performance in HSSP-II implementation

The momentum of this success shows a slow down during implementation of HSSP II. Oversight and supervision of especially front-line health workers for primary care has declined rendering unworkable the management of innovative cadres developed through task shifting mechanisms. A significant drop occurred in the financing envelop available for delivering the UNMHP during implementation of NHP II. Similarly External funding that accounted for almost 80 percent of the total health budget in 1997/98 (Mukooyo & Wabwire 2003) dropped to approximately 50% percent in 2005/ 06 (USAID, 2006). Funding from a number of Global Health Initiatives have been put on hold and are declining owing to weak financial management institutional arrangements for ensuring accountability. The falling resource envelope and weak management institutional capacity for HSSP II combined to cause a reversal of some of the gains attained in implementing HSSP I. Another constraining factor is the lack of an enabling regulatory/legal framework for service delivery provision that spells out the scope of their mandate, oversight arrangements as well as entitlements and expectations of served populations in their catchment areas. The lack of progress to develop and enact a health services act as provided for in HSSP II, is a major and an almost insurmountable obstacle for improving services delivery. The movement toward organizing health services around people's needs and expectations so as to attain people-centred care requires further evolution, supported by an appropriate legal frame, to interpret for action, the PHC approach recently adopted through ratification of the 2009

WHO resolution for Renewal of Primary Health Care whose operational policy reform elements are set out above following the definition of health service delivery.

4.2.6.2. Achievement he implementation phase of service delivery policy interventions in NHP I (2001 – 2010):

- Nation-wide Implementation of UNMHP
- Strengthening of UNMHP with ARVs as well as nd new anti malarial and anti Tb control measures.
- Institutional capacity strengthening of district teams for service delivery initiated
- Roll out of PPP collaboration for service delivery
- Nationwide rollout of health sub-district outlet units

4.2.6.3. Constraints

- *Weak Institutional capacity for implementation*
- *Falling resource envelope*

4.2.6.4. Lesson

A falling financing envelop has a substantial negative effect upon utilization and access to services delivery.

4.2.6.5. Recommendation

- As noted and advised by the MTR (2009/2010) the declining level of oversight of the front-line primary care cadres lowers their morale and effectiveness to deliver services, therefore it would be prudent for the health system leadership to review and appraise oversight arrangements, field level arrangements for support supervision such as the Yellow Star Program (YSP), and QA instruments for re-application in implementing HSSIP.
- Work to develop the legal framework to support and enhance over-sight for health services delivery, should urgently be reconsidered for re-activation and fast tracking in HSSIP as it was not accomplished in HSSP I & II.
- Measure should urgently be articulated to mobilize adequate financing of the UNMHP

4.3 Health workforce reforms;

4.3.1 Introduction

The world is experiencing a global health workforce crisis characterized by widespread shortages, mal-distribution and poor working conditions. In order to address this crisis, the international community has undertaken several studies and convened global consultations which have led to the promulgation of good practice guidelines in health workforce education and training, retention and management. A global movement has also emerged that has clearly linked the HWF crisis to the achievement of the MDGs and country health outcomes. Whereas Uganda has developed a National HRH Policy and Strategy and the HSSIP includes a good situation analysis, there is no reference to the new global directions that the global community is taking in this important field This discussion links the Uganda HWF plans with the new global directions as the country is one of those identified as having a critical HWF shortage (WHR 2006).

Definitions:

The Health Workforce embraces all persons with or without formal training who contribute to the protection, maintenance and improvement of health. (WHO)

The definition of health workforce **implies three interlinked aspects of availability, competence and management at operational level.**

Availability of health workforce includes the absolute numbers, their distribution and their skill mix. Availability is influenced by policy, organization, by attraction retention and absorptive capacity of the health system, by attrition and brain drain and by changes in epidemiology and medical technology.

Competence includes technical skills, interpersonal skills, patient centered attitude and professionalism. To develop these skills and characteristics, good education, training and socialization are essential. The quality of medical education in low income countries is suffering and continued professional development and in-service training are under developed. If competent HRH are available in the health service then their motivation and behavior will still be dependent on working conditions organizational context and management.

The management of health workforce deals with administrative tasks and with human relations. It aims to optimizing health workforce contribution to organizational performance by motivation, commitment and staff development.

In many low income countries, especially sub-Saharan Africa HRH problems are chronic and have to do with all the above factors. In some the problems are worsening, with increasing imbalances in all dimensions and inadequate regulation of training institutions leading to problems in quality. The health workforce is the driving force of health care delivery systems and is the main determinant of quality of health care.

A well performing workforce is one that acts in ways that are responsive, fair and efficient to achieve the best health outcomes given available resources and circumstances. There should be adequate numbers of skilled and motivated workforce, evenly distributed with the required tools to perform in order to contribute positively to the success of the health system.

The world health report of 2006 identified 57 countries that currently have critical shortages of health workforce. The proportional shortfall is greatest in sub-Saharan Africa with 36 and Asia with 12 countries. These countries are considered as priority countries.

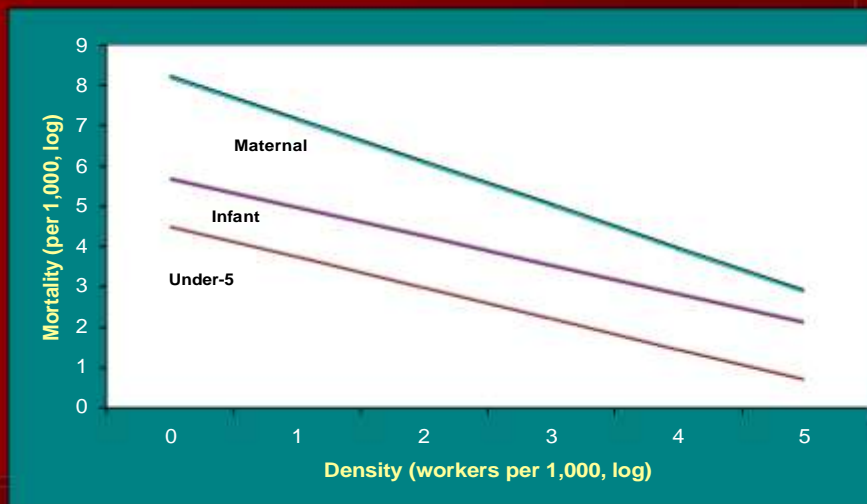
4.3.2 Situation analysis of the Health Work Force (HWF)

4.3.2.1 HWF and Health Status

There is evidence to show that health indices have a direct correlation with health workforce numbers and distribution as illustrated in figure 7.

Figure 7: HRH availability and impact on MDG targets

HRH availability and impact on MDG targets



Source: Anand & Barnighausen 2004

Further, countries that were found to have critical HWF shortages are also the same countries that are lagging behind in the achievement of MDG 4 and 5 (see figure 8 and 9)

Figure 8: Countries with critical HWF shortages (Source: WHR 2006³²)

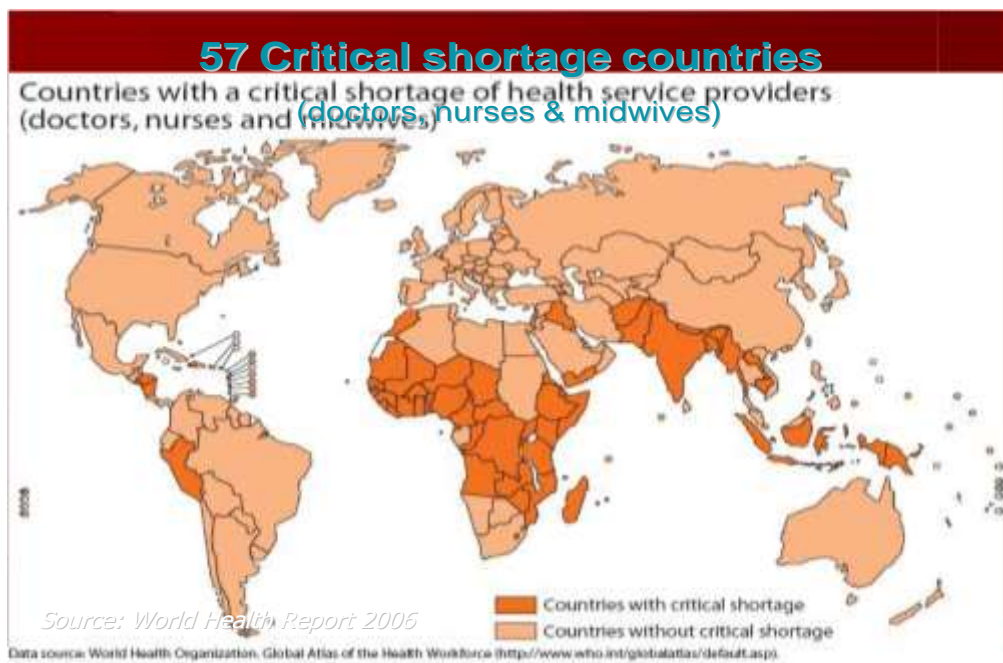


Figure 9: Countries Lagging Behind in the Achievement of MDGs 4 and 5 (Source: Count down 2015³²)

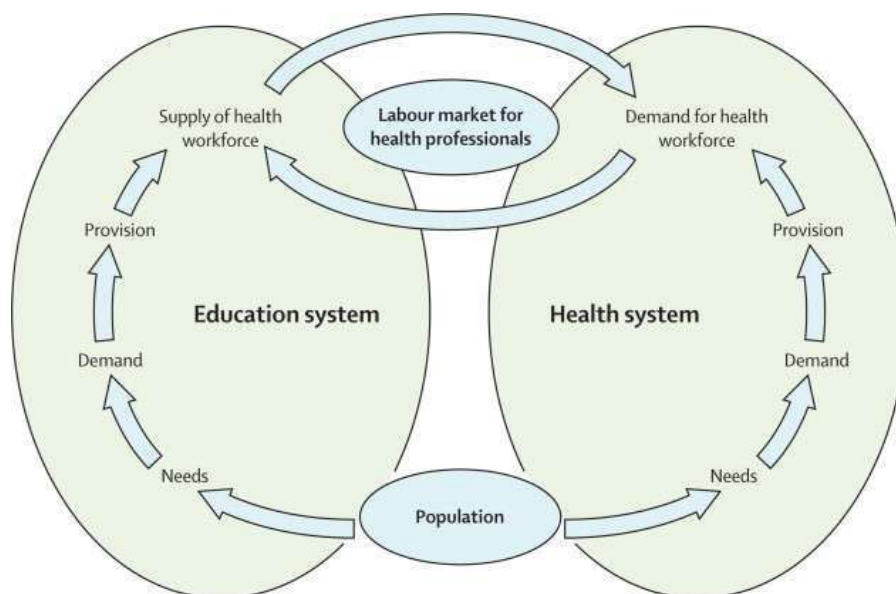


4.3.2.2 Transforming Education to strengthen health systems

There is evidence linking professional education, and health outcomes. A recent WHO report states “Insufficient collaboration between the health and education sectors as well weak links between educational institutions and health systems can create a poor match between medical education and the realities of health service delivery. These systemic constraints perpetuate skill flow away from underserved communities that bear the burden of poor health and force institution to choose between global excellence and local responsiveness in skills and competence of medical trainees” (WHO Scaling up Medical and Nursing & Midwifery Education 2011)

The framework shown below illustrates the complex interactions between the education and health systems.

Figure 10: The complex interactions between Education and the Health Systems. (Source: Health Professionals for a New Century: Lancet 2010)



Source: Health Professionals for a New Century: Lancet 2010

Two other global study reports highlight the critical need for close collaboration between the education systems and the health systems namely; the study on Social Accountability of Medical Education³³ (Charles Boelen 2010) promote the inculcation of attitudes and skills to enable graduates to work in their own communities as professionals and, the Sub-Saharan African Medical Schools Study - SAMSS (George Washington University School of Public Health and Health Services 2010),³⁴ points out the emerging role played by the private sector in HWF education and the need for closer supervision by both sectors working in tandem. In Uganda this is an opportune moment to embrace these new directions in HWF education and training.

4.3.2.3 Country Coordination and Facilitation (CCF)

In response to the global health workforce crisis, the Kampala Declaration and Agenda for Global Action, endorsed at the first-ever Global Forum on Human Resources for Health held in 2008 in Kampala, Uganda, sets out areas for action over the next decade by all partners. However, translating these strategies into action at the country level has in many cases been challenging, particularly given the complex and ever-changing nature of the human resources for health arena and the wide variety of stakeholders involved.

To address the need for country coordination, GHWA has developed a tool that facilitates the participation of all stake holders in every country in the training, retention and management of the HWF known as the CCF. In September 2009, GHWA held a conference in Ghana where a delegation from the Uganda MOH, MOES, MOPS, MOFEP and the PNFP sectors were represented to disseminate this tool. The country is in a good position to implement the tool which is not mentioned in the HSSIP . An example of this good practice in Zambia is shown in the box.

BOX 2 - Country Coordination Mechanisms for HRH in ZAMBIA

An example of effective HRH coordination within the health sector programme is the HRH Technical Working Group in Zambia and the development partners' policy committee of the health SWAp coordination mechanism. In 2005, Zambia developed its first National HRH Strategic Plan, following a directive from the President of the Republic. The planning process was collaborative, involving stakeholders that included the MoH Human Resources Department, Cabinet Office, bilateral and multilateral cooperating partners, the Churches Health Association of Zambia, NGOs, the Zambia National AIDS Network, regulatory institutions and professional associations such as the Zambia Medical Association and Zambia Union of Nurses Organization. The HRH strategic plan is comprehensive, harmonized, evidencebased and budgeted for five years and is monitored and evaluated against annual targets. The plan is also the framework within which the HRH Technical Working Group operates as it seeks to increase the number of trained and equitably distributed health staff across the country through the implementation of local, regional and international policies. The HRH Technical Working Group meets monthly and seven task groups report to the group on recruitment, retention, performance management, HRH information systems, national training and operational plans, the community health worker strategy, and financial tracking. Achievements include harmonization of the implementation of the HRH programme, creation of a dedicated HRH funding basket, and scale-up of interventions. In the past five years, the HRH Technical Working Group has also helped contribute to:

- an increase in medical officers from 84 to 161;
- growth in the number of health care workers increased to reach 882;
- 26 training institutions received additional funding and two training institutions were re-opened that were previously closed;
- a direct entry training programme was launched for midwives parallel to the traditional midwifery training programme and now accounts for 40% of all midwives nationally; and
- Growth in the production and absorption of healthcare workers

4.3.2.4 ANALYSIS OF COMMUNITY HEALTH WORKERS (CHW) - (Achievements, Lessons, Constraints and recommendations for improvement)

The role of CHW in the provision of health services and health promotion has been widely accepted. At the 2nd Global Forum of the HWF, all countries both developed and developing endorsed the practice of training and deploying CHW at the front line of the health system. In Uganda there is a pool of these cadres including Village Health Teams, vaccinators, expert clients and Nursing Assistants. Nursing Assistants were intended to accelerate the scale up of access to the UNMHC at the rural health units. 3,400 of these were trained during the first year of HSSIP I and more were trained in later years. Unfortunately, while they were expected to work under supervision, they were left to work on their own and blamed for rising to the occasion with limitations and the cadre abolished in 2007/08. There is a body of opinion that is of the view that this was a mistake as this cadre of health workers has potential to deliver results when well managed and recommend that the matter should be revisited. Several studies have been carried out in Uganda on CHW and a review of these is recommended to guide further discussion on this important topic (Sekimpi, Pariyo).

4.3.2.4.1. Achievements

Uganda has used the various categories of these CHW to increase coverage and equity of access to care in underserved communities.

4.3.2.4.2. Constraints

The scope of practice for the auxiliaries was defined but they can take on complicated tasks beyond their skills if there is no oversight and the outcomes become less positive and they are unfairly blamed.

4.3.2.4.3. Lessons

Provision of support and supervision is crucial to maximizing productivity of CHWs.

4.3.2.4.4. Recommendations

- Several studies have been carried out in Uganda on CHW and a further review of these studies is recommended to guide future discussion on this important topic (Sekimpi, Pariyo)³⁵.
- The sector still faces health workforce shortage and as it strives to produce qualified health workers a formal review of the nursing assistants program should be done by the Ministry of Health to gain evidence for further action on the nursing assistant.
- Explore possibility of training clinical officers to perform essential emergency surgical procedures

4.3.2.5 Pre-service training and Skill Mix

In the period 1978-1986 There was no explicit Human Resources for Health policy and plan to guide the production and management of human resources for health. The reality was that despite the already existing establishment norms the staffing ratios varied enormously among hospitals and district Medical Offices. There was little correlation between the number of staff in place and the establishment norms, or hospital bed numbers or even patient workloads. (Owor 1987, HRH survey 1991 Oscar Gish 1993)

Basic training in Uganda was under the Ministry of health undertaken by Government and non-government institutions. During the upheavals of the seventies and early eighties training institutions were looted and damaged. The training curricula were curative based but with the declaration of Alma-Ata which recommended the adoption of Primary Health Care and utilization of suitably trained health teams of health workers that should include doctors, nurses, midwives, auxiliaries and community health workers the various curricula required orientation to Primary Health Care. (Alma-Ata 1978)

The entrants to health training institutions were primed by career guidance including visits and talks by health professionals and besides having the basic academic requirements had to undergo a physical interview in which the understanding of the candidate of what he/she was going in for and attitudes could be judged.

Public sector reforms recommended transfer of training institutions to Ministry of Education and Sports for better integration within the national educational policies, strategies and plans and retention of the in-service training institution. While the restructuring report states that the Ministry of Health is expected to work closely with Ministry of Education and Sports to ensure that the interests and concerns of Ministry of Health are accommodated in the operations of the institutions, the specific roles and responsibilities appear to be an impediment. (Turyamuhika report 1998)³⁶

Decisions concerning human resource development in the education sector should be effectively guided by requirement for health policies and plans. Training of health workers shows mismatch between the burden of disease and health service requirements on the one hand and training outputs on the other hand.

Employers are especially concerned about the poor quality or lack of practical training of recently qualified candidates. The root cause of the training problems appears to be the un-resolved key issues relating to the transfer of the health training schools to the education sector. (HRH Strategic Plan 2007)

Liberalization of education sector led to mushrooming of private health training institutions with deterioration in the quality of training. Whereas the shifting of the basic health training institutions to Ministry of Education where this core function lies, the operational arrangements to take care of the interests of many other stakeholders have not worked as expected.

The Registered Comprehensive Nurse (RCN) and Enrolled Comprehensive Nurse (ECN) training programs started in Uganda in 1994 and 2003 respectively. Prior to that Enrolled Nursing, Enrolled Midwifery, Registered Midwifery, Registered Nursing were conducted as independent courses. RCN and ECN programs aimed at producing skilled health professionals with competencies in general nursing, midwifery public health, psychiatry, paediatrics and management. It was envisaged that the multipurpose nurse would be deployed to primary health care posts and be able to meet the majority of health needs in the rural communities. However there has been growing concern over the quality of training and competencies of RCN and ECNs. Many of the RCN and ECN graduates have not been absorbed in Government health facilities due to lack of clarity over their status in relation to the establishment structures. The report of the evaluation of RCN and ECN training program June 2011 finds that the programs are still relevant but found deficiencies in the curricula design, implementation and capacity of training institutions. Some of the recommendations include re-training of the graduates in midwifery and mental health, review of curricula content and implementation arrangements.

Uganda is still faced with critical health workforce problems related to absolute numbers, skills mix, recruitment and retention, remuneration, motivation and management which require to be addressed by all stakeholders.

There is a critical and urgent need for effective coordination of all stakeholders. Coordination mechanisms in some countries have produced good results for the health workforce.

4.3.2.6 Post graduate Training:

In order to ensure the availability of an appropriate pool of key skills needed by the population, the planning for post graduate training should be prioritized. At the present time there are many graduates who get scholarships from donors to undertake PHD and Master level courses in non-touch subjects to the detriment of clinical skills such as surgical specialties including anesthesia, pathology and infectious diseases, mental health etc.

As pointed out in the section ‘transforming education to strengthen health systems’ the interdependence of the health and education sectors is paramount. Balance between the two systems is crucial for efficiency, effectiveness, and equity. The two Ministries should work as close partners for the development of appropriate health workforce.

4.3.2.6.1. Achievements

- HWF Basic health training institutions have increased in number and the private sector is involved.
- Increased awareness of the linkages between Education and Health systems in HWF production.

4.3.2.6.2. Constraints

- Professional Associations as well as employers are concerned about the poor quality of recently qualified graduates of some cadres
- The anticipated working arrangement between Ministry of Health and that of Education and Sports is not functioning satisfactorily.

4.3.2.6.3. Lessons

- There are many stake holders involved in education and training, recruitment, retention and management of health workforce.
- There are many good practices globally and within the continent on health workforce multi-stakeholder country coordination

4.3.2.6.4. Recommendation

There is a global movement of HWF Education and Training, retention and Management whose recommendations are relevant to Uganda.

- It is recommended that Uganda adopt global good practices guidelines on country coordination and establish a health workforce multi-stakeholder consultation and management forum (CCF/GHWA)
- It is recommended that planning for postgraduate training should be prioritized and resources made available to train teams of practitioners in all key clinical and public health specialties.

4.3.2.7 In-service training/ Continuous professional development (IST/CPD)

The declaration of Alma-Ata recommended the adoption of Primary Health Care and utilization of suitably trained health teams of health workers that should include doctors, nurses, midwives, auxiliaries and community health workers. (Alma-Ata 1978)

There was need for orientation of training to Primary Health Care. This was the start of vertical refresher courses for health workers that were carried out by the vertical programs. Most health workers at this time spent most of their time moving from one workshop to another with little time to implement what has been learned.

The Ministry of Health/AMREF through the Uganda Health Training and Planning Project funded by CIDA Canada, established the Health manpower Development Center in 1982 as center for continuing education of health workers. This center was gazetted as such in 1987. Through this center it was possible to integrate the different training curricula into Integrated Operational level courses (OPL) in 1988/89 and subsequently the integrated Mid-Level Management courses (MLM). The curricula for basic training were reviewed to take care of PHC and its components.

HMDC had developed and consolidated areas of expertise.

- A distance learning program (DLP) for health workers with a network of DLP centers in districts. This was a vibrant program with a range of courses which benefited health workers at their places of work.
- HMDC had negotiated with Uganda Broadcasting Corporation free airspace airing radio program for health workers recorded in its own studio in Mbale. These facilities are available at the center.
- HMDC developed a short course for health instructors to enable them improve their teaching skills.
- Developing in-service training capacities in districts (TNA, Skills Eva)
- District health services management

The activities of this center were largely donor dependent and when the various projects wound up the activities stalled.

The Restructuring Report of Ministry of Health provided that the In-service training Institution should be retained by the Ministry of Health. Accordingly HMDC was neither placed under MOE&S nor under the MOH. In practice, HMDC has no legal mandate and should not be entitled to government funding. In fact when MOE&S found out this anomaly, it ceased making monthly releases through the CAO Mbale. But owing to historical attachment, the MOH took over support to HMDC.

The in-service training strategy of Ministry of Health (2001) was reviewed in 2007 but there remains poor uptake of the strategy mainly because of lack of funding.

Draft report of the Technical Support Mission on the Institutional Capacity Building in Planning Leadership and Management Project to the Ministry of Health and Belgian Technical Cooperation (April 2011) recommended HMDC and its regional branches could be developed and utilized as the health sector training and capacity development resource.

HMDC legal status and mandate is unclear and activities are stalled as a result of lack of funding.

The world in which all professionals practice is changing. Clients are becoming more knowledgeable and more demanding. Technology continues to affect all aspects of our lives. The knowledge-base of the professions, and of the sectors in which they operate, has also increased. With such developments come new opportunities: new clients, new areas of practice and new methods of working. These changes demand ever-evolving knowledge, skills and understanding.

The attainment of a professional qualification is not an end in itself - it is merely the beginning. Updating skills and knowledge on a continuing basis is essential to career progression, and is a requirement by professional regulatory bodies for certification for practice. The health sector needs to adopt a planned and structured approach to post-qualification learning for its workforce.

There is a move by the regulatory councils and associations, in the East African Community, to harmonize continuing professional development and regulatory mechanisms. Uganda needs to revitalize its structures in readiness for this harmonization. The health sector in Uganda has established IST/CPD structures but they have not been very active. These structures are:

- (i) National Steering Committee for IST/CPD
- (ii) HMDC
- (iii) Regional Focal centers for IST/CPD
- (iv) Districts Focal persons for IST/CPD
- (v) Professional associations
- (vi) Professional Councils

4.3.2.7.1. Achievements

In-service training strategy

Orientation of Health Workforce to PHC

Orientation of pre-service curricula to PHC

Established Health Manpower Development Center (HMDC) for continuing education of health work force
The health sector has IST/CPD structures in place which worked well in the past.

Evidence of having achieved hours of continuing education is a requirement by the Professional regulatory bodies for re-certification for practice.

A number of institutions have being accredited as CPD centers.

4.3.2.7.2. Constraints

The revised in-service training strategy has remained largely unimplemented for lack of funds
HMDC legal status and mandate is unclear and activities have stalled as a result of lack of funding.
Integration of training in crosscutting knowledge and skill areas is possible but requires involvement of all players.

4.3.2.7.3. Lessons

Sustainability of in-service training requires budgetary provision

4.3.2.7.4. Recommendation

- While HSSIP makes reference to CPD training sites, it does not emphasize the development and support of the HMDC as the center for spearheading In service training and CPD. There is need to build on successes of HMDC model to strengthen in-service training and skills development in specific areas.
- The MOH needs to define the mandate, position and staffing of the center as a pre-requisite to its transformation.
- Ministry of Health needs to create a budget item and avail funding for in-service training.
- There is need to review the operational mechanisms of these structures to enable them function smoothly

4.3.2.8 Recruitment and Retention

Arising from the inadequacies on recruitment and management of health workers found by the Health Policy Review Commission the establishment of the Health Service Commission was enshrined in the Constitution chapter 10 articles 169 and 170. One of its mandates was to review the terms and conditions of service, standing orders, training and qualifications of the members of the health service and matters connected with management and welfare and make recommendations to government. Evidence from key informant interviews pointed out that the HSC has concentrated mostly on recruitment and not the other core functions of addressing conditions of service and health workforce development in general.

Recruitment, deployment and management of district health workers were decentralized to the districts and though districts were trained to manage district health services, the area of health workforce management remains weak. (HRH Strategic Plan, 2007)³⁷. Instances of corruption, political interference and other vices such as sectarianism have led to appointment of unqualified persons in stead of trained health workers. Examples of wrongfully employed persons include drivers and cleaners occupying posts for qualified health workers were quoted. (Key informant interview: ACHEST Study to track newly qualified doctors in Uganda)
Decentralization of health services and creation of Health Sub-districts necessitated the re- defining of services to be offered and staffing norms for the different levels of care.

The minimum Health Care Package stipulated the basic range of services that is expected to be provided at various levels of the health care system.

HSSP I established minimum staffing norms for the various levels of the health system based on the package to be provided at that level.

Inadequate staffing to coordinate various activities, especially midwives, doctors, anesthetists and laboratory technicians at health center IV was noted. Human Resources for Health reforms implemented under HSSP 1 resulted in marked improvement with an increase in proportion of approved posts filled by qualified health workers from 33% in 1999/2000 to 69% in 2004/2005. However, a reduction of proportion of posts filled by trained health workers from 75% in 2005/2006 to 38.4% in 2006/2007 was noted in

subsequent reviews. There after an improvement was again noted to 79% in 2007/2008. (AHSPR 2004/2005; 2006/2007; 2007/2008; 2008/2009; 2009/2010)

HRH biannual report Oct 2010-March 2011 shows that at the end of June 2010, only 25 districts out of the old 80 districts had a health worker staffing status above the HSSP 11 target of 65%. 26 districts had a staffing status ranging from 50 – 64%. Another 26 districts were in the range of 31 – 49% while 3 districts were 30% and below. There were marked staffing status variations ranging from 123% in Kampala to 20% in Maracha-Terego district. The districts have further been sub-divided into 111(112) districts currently and therefore stretching the already existing health workforce further.

The salaries of health workers in the country are still low compared to those in the countries in the region. A newly qualified doctor in Uganda has earns 788,988 as compared to his counterpart in Kenya with an equivalent of 2,088,000. A senior doctor at consultant level in Uganda earns 2,358,323 as compared to his counterpart in Kenya with an equivalent of 6,142,200. (HSC). This scenario is a recipe for disaster.

Health workers continue to trickle out to greener pastures in the region and beyond. Some health workers have abandoned the health sector and turned their attention to other gainful activities.

4.3.2.8.1. Achievements

Health Services Commission was established

National Health Plan 1 HSSP 1 and Uganda minimum health care package by level were developed

Minimum staffing norms by level to deliver the minimum health care package by level agreed

The districts were trained to manage decentralized health services

4.3.2.8.2. Constraints

Districts with peculiar disadvantages have difficulties in attracting, recruiting and retaining qualified staff.

4.3.2.8.3. Lessons

The various documents give varying percentages for filled posts giving the impression that the establishment baselines used are not the same.

4.3.2.8.4. Recommendation

- Given the persistent staff inequities across districts, difficulties of attraction, slow recruitment and poor retention by disadvantaged districts, a comprehensive review of all issues related to the health workforce should be undertaken..
- Review and reconcile HRH establishment levels to respond to the implementation needs of HSSIP.

4.4 Health Information reforms;

4.4.1 Background and Definitions for Health Information Systems

Definition of HIS

*“A well-functioning **health information** system is one that ensures the **production, analysis, dissemination and use of reliable and timely** information on health determinants, health system performance and health status” (WHO 2007).³¹* This definition sets out the three key expectations from operation of a health information system as being to enable the building of our knowledge on:

- health determinants in the population served by a health system,
- health system performance and,
- Health status of the population served.

Yet, despite the system being the best in this sub-region Africa and delivering the best health indices in the sub-region at that time after independence in the years 1962-1971, Uganda was implementing an inherited Health Information System (HIS) from the colonial Government, that was much in its infancy, and was only sufficient to inform health system leaders on just a few aspects of health system performance and on some aspects of progress with the health status but with little or no information on health determinants in the population. The vital registration system (of births and deaths) was almost completely destroyed. Population counts in Uganda started about 110 years ago with the 1911 Population Census. Scientific population and housing censuses have since been conducted at intervals of about ten years since 1948 with the next one expected next year in 2012. The introduction of selective PHC in the period after its declaration at Alma Ata from 1978 to 1985 saw to a fragmented effort to revive the HIS with vertical intervention based approaches running in parallel with the remnants of the health facility based information collection of over 240 indicators provided from in the colonial public health Act and its regulations which have not been repealed to date although most are out of use. This situation was further distorted by emergence of project implementation units (PIU) during the post conflict/post war period of 1986 to 1995. The key reforms of the HIS were further distorted into a re-design effort towards an HMIS to meet the requirements of the vertical intervention based health projects. These short comings have continued as a challenge to the HIS in Uganda. Introduction of the comprehensive planning approaches and SWAp in the period 1996 to 2000 made little impact on the HMIS domination of the HIS reform effort in Uganda despite progress and innovations in the area of HIS with the emergence of HMN and IHP+ frameworks³⁸ for tracking HSS as a monitoring and evaluation framework for health progress and system performance.

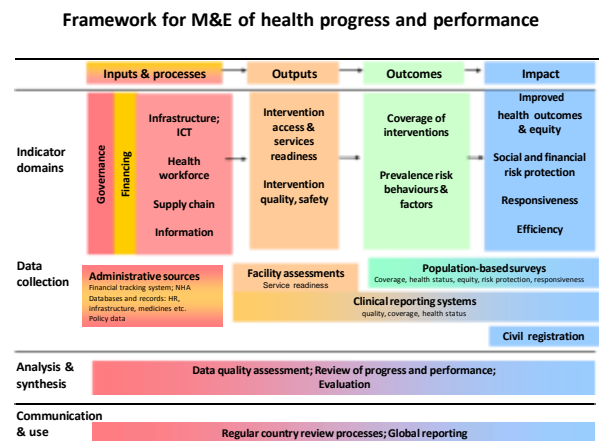


Figure 11: Framework to track Health System Strengthening (HSS)

4.4.2 Development of the HMIS for projects

Key developments included the undertaking of trials of a new HMIS; the building of evidence base for the Burden of Disease (BoD) and cost effectiveness studies to support elaboration of minimum health care packages; the initiation of country-wide computerization of the HMIS especially in the period 2001 to 2010 when GHI supported the scale up interventions such as ARV access; the initiation of more systematic articulation of data-base inventories of system components notably the National Health Accounts (NHA) for system financing; the health workforce inventories; infrastructure and equipment inventories; a supply chain management framework especially for stock control of family planning and other priority intervention supplies including vaccines and essential drugs etc., and in addition an effort was initiated to gain better insight into the prevalence and incidence of diseases through an Intergrated Disease Surveillance system in parallel with occasional household, community and population demographic surveys in-between national population censuses. No effective progress was made towards revival of vital registrations. This is further constrained by Weak capacity for health surveys, analysis as well as use of population census data, Weak capacity for economic & statistical analysis of population as well as of health care through put data; weak or no capacity to build capacity for absorbing on-going innovations in the evolution of HIS frameworks Worst of all, is the gross underfunding of all efforts to develop a compressive HIS throughout the entire review period of the last 32 years.

It is against this background that the HMN and the MoH working in collaboration with the WHO conducted a “SWOT” study^{39; 40} of the HIS in Uganda in 2007 to guide the development of measures for strengthening it in the subsequent planning period of 2010/2011 and beyond. The figure below summarizes the findings of this assessment and the report sets out key recommendations. While most elements analyzed were present, they were found to be functionally inadequate. Despite many strengths and opportunities for improving the “HIS” identified, the

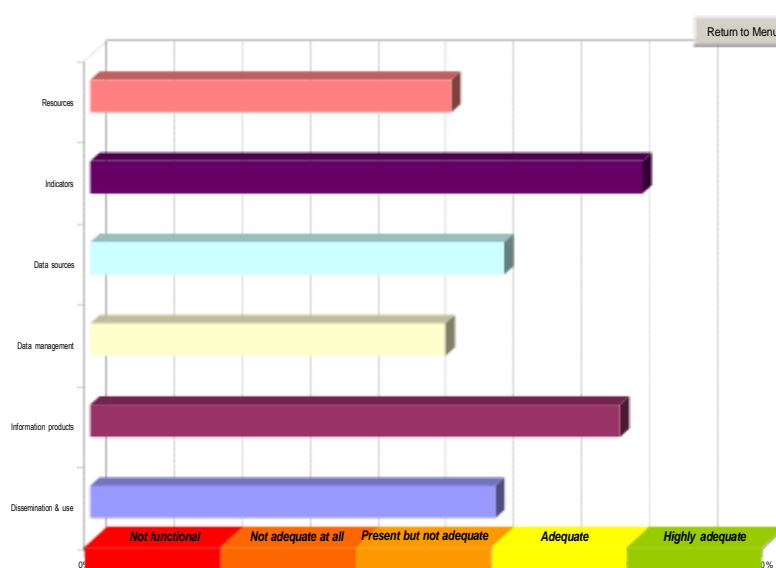


Figure 12: The Status of Health Information System in Uganda

overall assessment found that health information products were not being used adequately to advocate for policy change; including the need for strengthening HIS in order to build confidence and reduce mushrooming of donor-driven parallel information systems. Explicit action is not specifically set out in the NHP I and HSSIP to implement the large number of useful recommendations from this assessment. ***The HMIS dominance still persists and still largely serves the intervention based vertical perceptions of delivering the minimum package of services. As a result much attention is paid to monitoring arrangements with little or no attention paid to evaluation, no formal independent evaluation of either NHP-I/HSSP-I or of HSSP-II are reported.*** An improved inter-sectoral approach needs to be adopted for HIS development and operation using the new IHP+ and HMN/ framework for tracking actions for HSS toward the MDGs as well as better and equitable health outcomes.

Achievements

- Project Information sub-systems introduced
- HMIS established
- UDHS and household surveys established
- Integrated Disease Surveillance programs strengthened for health system performance assessment and BoD appraisal
- Data bases of system components established (NHA / Infrastructure / HRH)
- Evidence for Minimum packages built
- National and District BoD profiles developed.

Constraints

- Overall policy on HIS is not effective
- Weak capacity for system performance assessment and Evaluation
- Weak vital registration system (births and deaths)
- Weak and incomplete disease surveillance
- Weak capacity for health surveys, and analysis as well as use of population census data
- Weak capacity for economic & statistical analysis of population health data

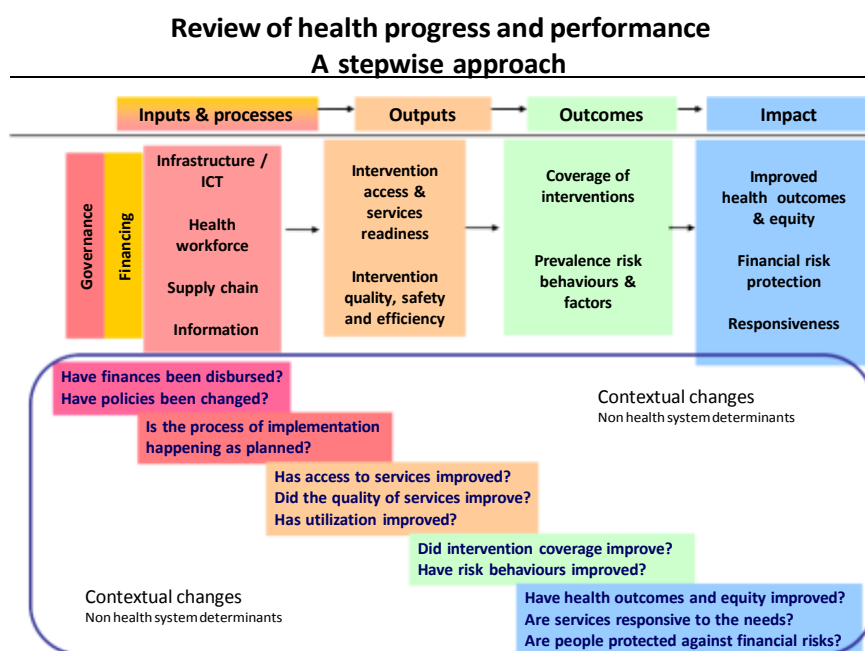
Lessons

Weak national policy on HIS leads to multiple uncoordinated efforts that weaken rather than strengthen capacity to provide information for decision making on health development

4.4.3 Recommendations for Health Information systems

In light of this situation, it would be most prudent for the MoH and partners to consider the following:

- An independent evaluation of NHP-I implementation through HSSP – I and II needs to be conducted to learn from the undertaking of the reform implemented;
- Explicitly incorporate a separate focused section on measures for HIS development in the NHP II and HSSIP including a review of its governance, legal and regulatory arrangements.
- Develop a strategy to articulate an adequately financed approach for building a comprehensive HIS that identifies health determinants while tracking health progress and system performance that feed into an explicit knowledge management platform to support generation of health intelligence for policy and decision making.
- Articulate the strategy above in a technically sound step-wise fashion to build upon existing HMIS so as to transform it into a comprehensive HIS using the other elements of the HIS that have evolved lately such as IDRS, system component databases such as NHAs; and on-going surveys etc. and including the building of capacity for assessment of inequalities in health outcomes, progress with mitigating actions on social determinants of health as well as capacity for statistical economics analysis.



- Specifically develop capacity to assess the availability and readiness to deliver health care services on regular basis.
- Articulate an inter-sectoral strategy to coordinate and facilitate a national effort to build capacity for a vital registration system in Uganda to accurately register births and deaths.
- Articulate a collaboration mechanism for inter-sectoral collaboration on collection and analysis of survey data and population /community census data including capacity for effective participation and contribution to household surveys and population census as key stakeholders to regularly review of progress towards MDGs .

4.5 Reform of Health Infrastructure Equipment, Medical Products, Vaccines and Supplies

4.5.1 DEFINITIONS:

1.1 A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficiency and cost effectiveness, and their scientifically sound and cost-effective use.

1.2 The Uganda Government aspires to provide adequate quantities of affordable, good quality essential medicines and health supplies that are accessible to all who need them.

1.3 The Uganda National drug policy was therefore formulated through the Uganda Pharmaceutical Sector Strategic Plan, with the sole purpose of ensuring the availability and accessibility at all times of adequate quantities of affordable, efficacious, and good quality essential medicines.

1.4 In the Ugandan context, like other sub-Saharan African countries, there is a public perception that the availability of drugs in health facilities is equated to the effectiveness of the health system.

4.5.2 SITUATION ANALYSIS:

2.1 The supply of medicines and essential supplies has been a basic requirement for the delivery of essential services to the populace based on PHC principles (1978-1985). Following its adoption, the Global debate on selective PHC implementation including the essential drug programs (EDPs) ranged on.

The Owor's review commission of 1986-1989 gave detailed analysis of the health system status of that time and formulated several recommendations which included addressing the issues of medical drugs and equipment. These were implemented in 1993 when a health policy white paper and three year rolling plan framework was put in place. Also at this time, the National Advisory Committee on Medical equipment (NACME) was appointed and inaugurated in 1989 to address the concerns of the government for the sorry and dilapidated state of medical equipment in the country. This led to the formulation of a National Policy on equipment in the health services based on clear guidelines on standardization, technology suitability, cost effectiveness, maintenance and other considerations. The first National Medical Equipment Policy was launched in 1991 and it became a guiding tool for government on a number of highly technical negotiations with friendly governments and potential donor agencies. The formulated policy covered all the areas of its terms of reference, including aspects on procurement standardization, specification, maintenance and rehabilitation of health equipment.

The establishment of the engineering Department that later evolved into the Health Infrastructure Division has been one of the first implemented recommendations of the committee.

Another very important mile stone was the inauguration and launching of the National Drug Policy and the National drug Authority Act of 1993 (NMS and NDA). The public enterprise reform and Divestiture (PERD) was also passed in 1993. This act liberalized and privatized the drug supply system. Consequently, memorandum of understanding (MoU) was signed between the Ministry of Health and the National Medical Stores to act as the distribution arm of drugs and equipment for ministry of health. Between 1996 and 2000 the major event was the ushering in of the structural adjustment programs (SAPs). This period witnessed the formulation of the local government act of 1997 which led to the decentralization of the medical supplies. As mentioned in other sections of this report, several reforms with ranging implications were initiated at this time.

The last ten years (2001-2010) witnessed the coming into force of the public procurement and disposal of Public Assets Authority. (PPDA Act, 2002/3) of NDA, which had gone ahead to form its own Committee on

Medical Equipments and Devices (COMED), unfortunately, the terms of reference for this committee had not been fully agreed upon. Firstly NDA was not in a position to amalgamate the whole of NACME members into its umbrella. This would be too huge and expensive for the already poorly funded NDA. Secondly many of the members of NACME derive their legitimacy directly from the MOH, which was wary of funding such a Committee.

4.5.3 NMS -National Medical stores

National Medical Store (NMS) is an autonomous government Corporation established by the National Medical Stores Statute no. 12 of 1993, which came into effect on 3rd December, 1993.

The Ministry of Health is responsible for the National Health policies in the country, the National Drug Policy (NDP) inclusive. The major components of the NDP are:

- Regulatory control of Pharmaceuticals, which involve control/regulation of import, export, local manufacturing, marketing practices, distribution, use and registration of Pharmaceuticals.
- Promotion of local production, this includes investment incentives, transfer of technology, and associated taxes.
- Supply of Drugs, which involves identification of therapeutic needs, selection of drugs, quantification of requirements, procurement of drugs, distribution and use.
- Ministry of Health through the 1993 NMS statute delegated the drug supply function to National Medical Stores. Hence the formation of - an autonomous institution NMS to replace the former Central Medical Stores (CMS) which was a department of the Ministry.
- National Medical Stores is responsible ensuring continuous distribution of Pharmaceutical products in a financially viable and sustainable manner to public health facilities. These currently include; Uganda Essential Drug Kits, STI drugs, Family Planning Products and Ministry of Health direct distributions to the Districts.
- The overall MOH picture of HRH at NMS is mixed. In November 2008 only 51% of the approved positions at national level were filled. The situation is worse in conflict and post conflict as well as in rural and hard to reach areas. The reasons for this are many and are covered in the section on Health Workforce.

Achievements:

- Although the workforce was initially low at NMS, it has greatly improved with expansion of the workforce.
- NMS benefited from government decision to inject the much needed funds. In fact the entire essential medicines fund was from then being channeled directly into the NMS budget. Over the last two years NMS has witnessed the increase of its budget which currently stands at 201 billion from the 30 billion before 2008. In addition it now gets its funding direct from the MOF and it has been mandated to procure all the spectrum of essential medicines, with the shift of the 70% of the budget previously allocated to Local Government. With its current responsibility to deliver to the last mile,(push system) marked improvement in availability of drugs to the periphery is now being realized. However, the emerging evidence on the ground from grass root interviews indicates that the deliveries are done two monthly, unfortunately these tend to run out within the first month.
- Efficient and economic procurement of medicines and certain other medical supplies of good quality primarily to the public health services.
- Secure safe and efficient storage, administration, distribution and supply of goods in question in accordance to the National Drug Policy and Authority.
- Establishment and maintenance of systems to ensure the quality of goods supplied.

- Estimation of current and future needs as a basis for procurement, planning and budgeting by the corporation itself and the Ministries concerned.
- No user fee is paid in the lower level health units and general wings of publicly owned hospitals whereas the private sector charges user fees.
- Harmonized procurement of third party drugs
- Expansion and modernization of NMS own storage capacity, with enhance cessation of hiring private storage space, thereby reducing on costs for this item.
- NMS offers the widest range of essential and vital drugs in one shopping centre. Current steps to review the PPDA laws with a view to relaxation in favour of NMS.
- Representation of NMS Board at top management of the MOH
- The creation of the Presidential Medicines and Health Unit which has greatly helped in the oversight role of MOH in general and of NMS in particular. Last mile delivery of medicines and health supplies by NMS which has ensured efficiency, accountability and transparency

Constraints:

The performance of NMS during the period 2006-2011: This was characterized by its resolve in the area of medicines and health supplies, to continue supplying adequate quantities of affordable, good quality essential medicines and health supplies that should be accessible to all who need them.

- Currently, only 30% of the essential medicines and health supplies (EMHS) required for the basic package are provided for in the budget. In 2006/7 the contribution from the global initiatives was US\$ 2.39 per capita out of the US\$ 4.00 per capita spent. Yet the Bamako recommendation is US\$ 9 per capita and WHO recommendation and Abuja declaration target is 15% of the national budget.
- The inadequate budget to meet the remaining 70% of the drug needs.
- The high population growth rate which will continue to put pressure on the national budget.
- The uninformed and misinformed civil society unaware of the right to health and resigned to unavailability of medicines and other health supplies.
- The public tolerance to corruption and poor service delivery.
- Resistance to positive change by DHOs and Local Government managers previously benefitting from decentralized procurement of medicines and health items.
- The procurement and disposal legislation which has created a disabling environment for the speedy operation of NMS.

Lessons:

The MOH in the Health Policy 1999-2009 and in the HSSP 2000/1-2004/5:

- Establishment of the Uganda National Minimum Healthcare Package (UNMHCP) to which Uganda citizens are entitled. (This put particular emphasis on management of communicable diseases, especially HIV/AIDS, malaria and tuberculosis. The focus on these three diseases is in line with the broader country strategy outlined in the Poverty Eradication Action Plan (PEAP) and with efforts to meet targets set in the MDGS)(NHP I & NHP II)
- The MOH is also responsible for the Essential Drug List for Uganda (EDLU) to meet the requirements of the UNMHCP.
- This role is enshrined in section 8 of the same Act *"There shall be a national list of essential drugs which shall be revised from time to time"*
- Essential Drugs list for Uganda (EDLU) 2001 and the delivery of Essential medicines is one of the key facets of the National Health Policy (NHP) and is dependent on a broad network of interdependent institutional entities such as the Ministry of Finance, Planning and Economic Development (MoFPED), Local government, Private sector suppliers, donor organizations, Third Party Programmes and NGOs.
- The need to create more awareness and hence empowerment of the masses about the right to attainment of the highest standards of health.

- There is need for continuous dialogue with all stakeholders and partners in order to iron out operational obstacles.
- The policy should be geared towards giving opportunities to local production of medicines and other health care items so as to shorten the lead times and reduce the importations costs.
- There is also a need to encourage regional cooperation so as to maximize on bulk procurements.

Recommendations:

It is recommended that essential drugs which are defined as those that satisfy the needs of the majority of the population should always be available in adequate amounts and appropriate dose forms.

- Central procurement of essential drugs is recommended because it is the most cost-effective method for the public sector because the discounts attained through bulk procurement are translated into affordable prices to the end user.

4.5.4 NATIONAL DRUG AUTHORITY (NDA) 1993 – 2011

The National Drug Authority (NDA) was established by an Act of Parliament in 1994, currently the National Drug Policy and Authority (NDP/A) Act Cap, 206 of the laws of Uganda (2000 edition). The mandate of NDA is to promote use of safe efficacious and good quality medicines and also to protect the population of Uganda against the use and effects of poor quality, counterfeit and expired medicines. This is in line with National Drug Policy, 2002, which among others seeks to improve the efficiency and effectiveness of the NDA in ensuring the required control of human, veterinary and commercial traditional medicines. The role of NDA is also embedded in the National Veterinary Drug Policy, 2002, whose vision is to have quality veterinary drugs accessed by all stakeholders for sustainable animal health and production.

Achievements:

- **Assessment** of medicines for quality and efficiency.
- Registration of medicines before use in the Uganda market.
- Inspecting and licensing of all pharmaceutical outlets in Uganda.
- Inspecting foreign pharmaceutical manufacturing facilities that export their medicines to Uganda.
- Licensing medicines importers.
- Testing of drug samples for compliance to standards.
- Sensitizing health workers, district officials, local councils and members of the public on all matters relating to rational medicines use, pharmaco-vigilance and effective drug regulation etc.
- NDA is implementing the MoH policy of making injections safe by phasing out importation and use of standard disposable syringes in favour of syringes with re-use prevention features.
- NDA is implementing the MoH new malaria treatment policy by phasing out the importation of discarded/abandoned anti-malarial drugs from the Ugandan market. The categories of products that were phased out include Amodiaquine, Artemisinin-based preparations presented as monotherapy, Chloroquine injection and tablets and Sulphadoxine or Sulphamethoxypyrazine and Pyrimethamine combinations.
- Following a request from the Ministry of Health, NDA approved the de-classification of ACTs from Prescription-Only-Medicines to Over-the-Counter drugs so that they are available at community level in line with the MoH policy on first line treatment for uncomplicated malaria.
- NDA worked with MoH to regulate the spraying of Dichlorodiphenyltrichloroethane (DDT) and the main task of NDA was to ensure that DDT met the quality requirements. In line with this mandate, NDA undertook to test the quality of DDT.

- NDA implemented the policy shift from mandatory testing (i.e. batch-by-batch sampling at the ports of entry and testing in the laboratory before release) of anti-malarials, anti-TBs and ARVs to routine testing
- NDA implemented the policy shift from mandatory testing (i.e. batch-by-batch sampling at the ports of entry and testing in the laboratory before release) of anti-malarials, anti-TBs and ARVs to routine testing
- NDA has strengthened the quality assurance system which involves several stages namely; manufacturing process, registration of medicines, imports (verification of proforma invoices) and testing of consignments that arrive in the country in order to reduce on the failure rate of drugs and other health care products.
- The counterfeits are as a result of smuggled products through unmanned border points. NDA is collaborating with other law enforcement agencies such as URA (Customs), Police etc in handling cross border movement of drugs and the fight against smuggled, counterfeit and substandard drugs.
- Since 2004, NDA has been carrying out mandatory post-shipment testing of male latex condoms before entry into Uganda.

Constraints:

- Lack of funding by government. It is run on funds primarily raised from the registration of drugs. This lack of funding from the mother MOH. This has greatly affected the speed of evolution of NDA, which is now forced to levy fees on drug importer for its survival. This has a negative effect in that it raises the overall cost of drugs to the ultimate consumers at grassroots level.
-
- Weak Boards and Management, and lack of transparency often hampered its activities; Lack of capacity to test the actual active pharmaceutical ingredients (API) The expansion of its qualified workforce with the recruitment of more pharmacists to fill the technical jobs, particularly of drug inspection and pharmaco vigilance.
- Lack of capacity to fill all the required posts. Training of pharmacists is expensive and takes long. It will therefore be sometime before NDA can meet its desired workforce.
- Recurrent conflict with the pharmaceutical society of Uganda which keeps on blocking actions of NDA, often with legal threats, because of employing unqualified personnel to do professional jobs e.g. drug inspection

Lessons

- The creation of the committee on equipment and medical devices has improved the performance.
- The current laboratory has very limited capacity to test sundry items like gauze and syringes. It can only reasonably test condoms and gloves.
- The current expansion of the structural capacity of the quality laboratory near Mulago hospital. This has widened the scope of testing of drugs, sundry and devices, which had been very limited.

Recommendations:-

- Continued dialogue is called for with the MOH and partners to obtain more funding and expertise.
- Public awareness should be promoted on self-prescriptions, drug reactions, complications and failures.
- Build and expand capacity for NDA to effectively address quality issues of medicines, health care products and equipment.
- Create a budget line direct from MOF to facilitate NDA expand its capacity to effectively carry out its regulatory roles.

Transformation of NDA into NFDA

- NDA has requested the Hon. Minister, MoH to follow – up with Cabinet on the decision and way forward

4.5.5 NATIONAL ADVISORY COMMITTEE ON MEDICAL EQUIPMENTS (NACME)

Inauguration

The National Advisory Committee on Medical equipment (NACME) was appointed and inaugurated in 1989 by the Minister of Health. At that time there was concern of the Government for the sorry and dilapidated state of medical equipment in the country. There was also a need to formulate a National Policy on equipment in the health services based on set clear guidelines on standardization, technology suitability, cost effectiveness maintenance and other considerations.

The Committee produced the first National Medical Equipment Policy in 1991 and guided government on a number of highly technical negotiations with friendly governments and agencies. The formulated policy covered all the areas on its terms of reference and included aspects on procurement standardization, maintenance and rehabilitation of health equipment.

The establishment of the engineering Directorate that later evolved into the Health Infrastructure Division has been one of the first implemented recommendations of the committee.

During the last five years the status of NACME in the MOH has come under scrutiny. There have been attempts to shift its operations into the ambit of NDA, which has gone ahead to form its own Committee on Medical Equipments and Devices (COMED). Unfortunately, the terms of reference for this committee have not been fully agreed upon. Firstly NDA was not in a position to amalgamate the whole of NACME members into its umbrella. It would be too huge and expensive for the already poorly funded NDA. Secondly many of the members of NACME derive their legitimacy directly from the MOH, which unfortunately was wary of funding such a Committee.

Fortunately the terms of reference of NACME were revised as per the National Medical Equipment Policy of 2009 which resulted in the following:

Achievements:

- Revision of the policy on Medical Equipment, update of the standard list and preparation of the specifications therein,
- Formulation of the policy on medical sundries, standard lists, and preparation of the specifications,
- Carrying out quality assurance on medical equipment through review of specifications prior to procurement, participating in tender evaluations, and inspection of equipment on delivery and equipment performance audits in health facilities.
- Research on medical equipments.
- Many institutions have already benefited from NACME, including Mulago Hospital, CHOGM project in Entebbe Hospital and the Equipment Credit line of the Global Fund.

Equipment in relation to the Health Strategic Plans

“Unfortunately, apart from mentioning equipment in the leading number 4.6 of HSSP I, of 2000-2005, no comment is made at all on this subject. There is no mention whatsoever of Medical Equipment in HSSIP, and

yet this is an important area of health delivery at all levels, particularly curative". The facts on the ground unravel the following:

Constraints:

- Inadequate supply of up-to-date equipment, coupled with lack of human resource to use, maintain and repair.
- High attrition rate of the available equipment due to donation of outdated or reconditioned equipments.
- Multiple sources of equipments from different world manufacturers and donor agencies.
- Lack of capacity standardization, apart from copying what is provided by WHO and first world countries, whose standards are higher than those of exporting sources to the third world countries like Uganda.
- Rapidly advancing technology, coupled with higher pricing of modern equipment.
- High attrition rate of the available equipment due to donation of outdated or reconditioned equipment.
- Lack of standardized sourcing.
- Lack of capacity for standardization in a changing environment;
- Rapidly advancing technology, coupled with higher pricing of modern equipment

All these facts put a lot of operational and financial strains on third world countries and are detrimental to the safety to life. *(This area needs to be clearly spelled out in our policy framework and addressed in practice in order to protect the lives of our people).*

The Lessons:

- The need to keep updating the standard list of equipment.
- The formulation of policy on medical sundries.
- The carrying out periodically the quality assurance on medical equipment.
- The need to increase capacity to detect fake or outdated equipment imported into the country.
- NACME operational model was a success.

Recommendation:

- There is need to resist temptations by some organizations/ NGOs to liberalize village class C pharmacies to dispense antibiotics and other classified drugs.
- *HSSIP should include on planned activities those to address medicines and pharmaceutical industry in Uganda.*
- Inadequate supply of up-to-date equipment, coupled with lack of human resource to use, maintain and repair should be addressed.

4.5.6 NDA and NMS

Constrains:

- Legal framework has overlaps and constraining provisions that limit optimal productive operations
- Budget allocation imbalances distort push / pull system for drugs to districts
- Pharmaceutical desk set up for national policy guidance in MoH

- Intervention of Presidential Monitoring Unit has helped to mitigate underfunding by almost 10 fold funding increase and increased availability of essential drugs nation-wide
- Legal frame for NDA/NMS/PPDPA & PERD is not harmonized
- NDA not in a position to amalgamate NACME
- NACME of MOH and Commission on Medical equipment and devices (COMED) of NDA parallel competing entities,

4.5.7 Overall Lessons and Recommendations for NHP II and HSSIP.

Essential Drug List EDL (U) and UNMHP

- Promote regional and international cooperation to address present deficiencies including quality issues and tackle emerging issues.
- Rationalize process and regularly quantify drug needs and sundries by the MOH and relevant organs and partners.
- Support and facilitate NMS to achieve harmonized procurement and distribution of drugs and supplies.
- Evaluate home based treatment packages

National Medical Stores

- Facilitate NMS to fully participate in regular quantification of medicines and health care product needs.
- Ensure adequate funding for NMS and encourage/facilitate bulk procurement;
- Expand quality assurance for healthcare products and medicines, and equipment.
- Harmonize legal frame to facilitate preferential and harmonized procurement system for medicines and other health products.
- Establish a standing Committee of stakeholders to advise on human and animal drugs and food industry.
- Provide oversight and support on local production, procurement and disposal of medicines and sundries.
- Establish an emergency fund for procurement of some essential medicines vaccines by districts and MOH

NACME

Review scope of NACME to explicitly:

- Provide a separate/independent legal framework
- Provide in its mandate the role for specification and oversight of Health Infrastructure apart from equipment so as to be consistent with NHP II.
- Clearly articulate policy, strategy and investment framework for medical equipment

4.6 Health financing reforms;

4.6.1 Background and Definitions of health financing

*“A **good health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated*

with having to pay for them. It provides incentives for providers and users to be efficient,” (WHO 2007)³¹. One of the leading challenges facing the health system in Uganda is inadequate funding and the absence of a nationally agreed framework for raising, pooling and paying for health care. The public health system depends on taxes and donor money and allocates approximately \$10 per capita for health which is far less than the \$35 per capita recommended by the WHO Commission on Macroeconomics and Health excluding ARVs and ACTs. Further, the National Health Accounts show that out of pocket expenditure by the population accounts for 60% of health expenditure. The international community is currently engaged in active discussions on health financing. The WHA2011 passed a resolution on Universal Health Coverage as did the ECSA Health Community at the Ministerial conference in October 2010 in Harare.

Uganda in an effort to raise adequate funds for health in a fair and socially supportive manner that protects against financial catastrophe of its population, has been actively discussing modalities for addressing the significant financing gap. However, the discussion has not been broad and deep enough to include all key stake holders. In the light of global interest in this matter, this is a good time for Uganda to engage the population and stakeholders.

4.6.2 Situation Analysis of Health Financing

4.6.2.1 Health financing during the social upheaval period of 1978 - 1985

Heavy investment in health and education just prior to and after independence resulted not only in rapid improvements of health outcomes in Uganda but was in addition related to rapid economic development (Dunlop et al., 1973)⁴. The dropping level of health investments in the 1970 era of political upheaval reversed this trend. In the early attempt to implement PHC, donors came to assist with a project financing approach based on selected interventions during the 1980s global financial crisis. These efforts did not yield positive results despite good intentions. Donor financing of vertical projects was the key health financing reform introduced at the time when the domestic financing effort was at its lowest.

Achievement

The country benefited from adoption of this selective PHC approach that attracted some donors.

Constraints

- *Lack of concurrence on financing arrangements for comprehensive PHC implementation*
- *Low health financing envelope*
- *Shortage of essential medical commodities and supplies*
- *Informal payment mechanisms for services enhanced*
- *Weak, non- explicit health policy*
- *Unsustainable vertical projects*

Lesson:

The relationship between health and development has long been known in Uganda.

The distortionary effect of vertical health programs was noticed quite early in Uganda's history.

Recommendation:

Intervention based financing requires rigorous impact assessment of its effects on overall health financing and health system output.

4.6.2.2 Health financing during the post conflict period of 1986 - 1995

The subsequent period of health financing reforms were conducted during a period of economic Structural Adjustment programs (SAP). There was great pressure and influence to introduce the widespread application of “user fees” for access to basic services (*Financing health services in developing countries: an agenda for reform, Volume 34 - John S. AKIN, Nancy BIRDSALL, & David M. De FERRANTI - 1989*)⁴¹. The policy did not work well and was retrogressive.

Achievements:

- Cost-sharing through a User Fee Policy introduced in the health system
- A minimal improvement was achieved in the quality of some clinical services for those that could afford;
-

Constraints

- The key constraint of user fees was the creation of a real barrier to access to services especially for the poor.
- *There was low capacity to implement the reforms with a failure to structure user charges to promote their efficient use and a lack of effective exemption structures to protect the poor.*
- *There was little consensus on cost sharing as a reform with CSOs raising-up against it.*
- *The utilization rates of formal health system were shown by the UDHS 2000 to have fallen sharply in the 1990s as well as the health outcomes and did not recover until abolition of user fees for basic health services was re-established.*

Lesson:

The negative impact of user fee policies upon utilization of services that resulted in falling access to services and loss of health outcome gains was overshadowed by the prospects of revenue collection gains and as such not predicted in advance.

Recommendation

Negotiation of health financing reform requires a structured national dialogue to explicitly define income groups to be targeted and creation of the institutional capacity for collection, pooling and paying for services.

4.6.2.3 Health financing during the planning for Poverty Eradication Period of 1996 - 2000

The fight to eradicate poverty was the country’s response to SAP. Key financing reforms introduced the pooling of funds for health to execute a common investment program for health development called SWAp and in addition resulted in the abolition of user fees. Another important reform was the introduction of direct transfers to districts for PHC implementation and the establishment of of Poverty Action Fund (PAF) at the center with special budget support funding from the HPIC initiative of the World Bank.

Achievement:

- Health Financing Strategy development initiated - A health financing strategy was tabled and discussed to guide the Swaps effort – While a broad consensus failed to emerge, it proved useful in going forward.

- Budget reforms were initiated; *AG office Strengthened; budget and financial management procedures Strengthened*;
- Matching of donor disbursements to domestic commitments piloted through projects
- Fiscal decentralization through PHC grants to district was established
- Increased allocation to health through Poverty Action Fund
- Capacity was built for policy dialogue to support resource mobilization to the sector
- Studies to review alternative financing and introduction of Health Insurance were conducted (Harvard University Group and University of Hannover Group)

Constraints

Key constraints included the slow progress towards consensus on policies during a period of falling utilization rates of health services and a low capacity to implement reforms. The structuring of exemption mechanism for the poor also failed to work in practice.

Lessons:

- Reform negotiation requires a long time of building trust
- Reform negotiation capacity is built interactively in practice over a long time of engagement with stakeholders
- Reform consensus requires more than technical soundness of interventions.
- A health financing strategy is a useful framework to guide financing reform negotiation and implementation.

Recommendations:

- Urgently review previous health financing strategies for reforms to enhance system revenues to support health service delivery.
- Comprehensively re-appraise implications of available studies on Health Insurance

4.6.2.4 Health financing during the implementation period of the NHP-I: 2001 - 2010

Studies that explored the impact on health service utilization and catastrophic health expenditures using data from National Household Surveys undertaken in 1997, 2000 and 2003 showed that utilization among the poor increased much more rapidly after the abolition of fees than beforehand. Unexpectedly, the incidence of catastrophic health expenditure among the poor did not fall, a finding attributed to the continuing underfunding especially of drugs and commodities.^{42; 43; 44} The reforms established “pools” for health financing through implementation of a Swaps in the health sector. This greatly improved domestic support to the health sector and the financing envelop grew significantly in the first part of this period of 2001 to 2005. The parallel implementation of vertical programs for priority intervention by global financing mechanisms had a negative effect on the initially positive outcomes of the Swaps financing reforms. Subsequently, the institutional capacity for financial management, oversight and accountability were overwhelmed resulting allegations of corruption. These negative effects have been accompanied with a falling resource envelope and reversals of health outcome growth trends as occurred during SAP reforms in

the health sector. An extensive review of the health financing situation was conducted in 2009 and the findings have in part been used in the HSSIP, but there are aspects of previous studies of alternative health financing options in Uganda that may further need to be taken into account. A key short-coming of the analysis however, is the traditional approach adopted for that analysis and review. Reference could be made to the approach introduced by Joe Kutzin (Kutzin J., 2001),⁴⁵ that is possibly more robust to guide thinking and planning for health financing reforms at country level⁴⁶. Kutzin's framework focuses on the functions of a health care financing system, namely:

- *The revenue collection function,(the sources)*
- *The function of pooling of funds and,*
- *The function of purchasing of services.*

This framework is useful in assisting to guide detailed discussions about how to design each aspect or function of the financing system to achieve specific objectives, taking account of the country-specific context. It leads to a more comprehensive consideration of the full range of system elements and interactions between the different health care financing functions and in this way provides an important basis for more effective design and implementation of health care financing policy reforms. The framework of the health financing review of the previous national financing strategy in NHP I, focused upon maximizing returns on the pooling function of health financing through the Swaps. This was because the infrastructure and institutions for alternative pooling mechanisms (such as social health insurance) were weak and needed to be built as a pre-requisite.) The organization of the purchasing function and institutions for revenue collection also needed much work before roll out of reforms. Given the limitation of the approach for the Uganda health financing review of 2009, a comprehensive discussion of the functions is not presented in both the review report and the NHP-II/HSSIP. For example the three financing scenarios discussed in the HSSP broadly state that the mechanisms for financing the services set out in the HSSIP to implement the NHP-II shall not raise adequate funds for health services under any of these settings but the scenarios are based upon contentious input assumptions and with little discussion of expected productivity. In particular limitations to the current pooling (SWAp) arrangements need to be considered along with alternative pooling mechanisms as well as alternative collection and purchasing options before narrowing down to a particular choice. Further still, no explicitly practical social marketing approach is articulated to gain concurrence on the proposed reforms. These short comings are in part also noted by the AHSR report of 2000/2010 and the JANS report on the HSSIP conducted by partners in 2010.

Achievements

A Health Financing Strategy was partially implemented and SWAp successfully established.
Health resource envelope positively grew with the resource pooling reforms under the SWAp.
Budget reforms were implemented

Constraints:

- Weak oversight and financial management capacity
- An over stretched under-performing institutional capacity led to possible corruption, loss of trust, and a declining resource envelope
- Health system output and outcome growth trends begun to show a downward reversal

Lesson:

Re-introduction of heavily funded vertical intervention based programs have had consistent negative effects on health system performance core indicators and health outcomes.

Recommendations for health financing:

- Urgently expedite work to develop a health financing strategy as part of the HSSIP.
- Conduct a more realistic financing range of scenarios based upon a more complete discussion of the varying options of basic financing functions
- Initiate a dialogue process for a social strategy to agree financing reforms with stakeholder across the country.
- Explore options for building further the institutional capacity for the core health financing functions.
- Explicitly articulate a migration plan to mitigate impact of existing and future vertical financing program operations whenever required.
- Explicitly articulate measures to mitigate low capacity for financial management, oversight and accountability.

5 Key Recommendations

Introduction:

The following five recommendations are synthesized from the situation analysis that followed extensive literature review, key informant interviews, grass roots district surveys and the guidance from the Steering Committee and two Stakeholder consultations that were held as part of the study. The recommendations address particular aspects of both NHPII and HSSIP and are targeted at improving these documents.

5.1. The health of individuals and communities is a prime concern of all societies. There is abundant evidence to show that countries that have achieved the best health indices at low cost are the ones that have undertaken collective multi-sector and multi-stakeholder national dialogue on population health. Such dialogue is led at the highest political level and results in a social and political compact between the government and the population. In Uganda, while the HSSIP acknowledges the need for a national compact and multi sector action, practical steps for its achievement are not articulated. There is a need for a broad inter-sectoral national dialogue on health and well-being of the people of Uganda. Health is currently viewed as treating and preventing diseases by the Ministry of Health and not as a way of life that is at the centre of the governance of society

It is therefore recommended that a structure under the leadership of the Rt Honorable Prime Minister be created to coordinate national dialogue and actions on the health and well-being of the people of Uganda. Establishment of another structure is recommended at technical level under the leadership of the Head of the Civil Service with the participation of the private sector and civil society. Similar structures should also be considered at district and sub county level.

5.2 The midterm review reports for HSSP-I and HSSP-II as well as information from Key Informant interviews have pointed out the difficulties that have arisen from the current structure of the offices and governance structures at the MOH headquarters. The difficulties experienced include conflicts between officers and departments, overlap of roles and delays in decision making. These have contributed to significant shortcomings in performance over the years. Further, there is evidence to show that the recommendations and decisions taken during the Restructuring exercise of 1998/99 were not fully implemented with respect to leadership roles in this highly technical ministry. There is a need to stream-line the decision making processes and redefining roles of various offices and organs in the MOH: Offices of PS / DG; Planning / QA; Resource Centre / Disease surveillance; HR development and Personnel; TMC, SMC, HPAC, NHA/JRM for more effective stewardship and governance of the health sector

While both NHP-II and HSSIP have discussed governance of the sector, they are silent regarding the well-known issues of sector governance structures. It is therefore recommended that a review is undertaken to streamline roles of the key offices and governance organs at the MoH headquarters.

5.3. There is evidence to show that technical oversight and supervision of services delivery has declined at all levels but more so of the front line health workers. Further, the Annual Health Sector Performance Report of 2009/2010 recommended the revival of consultant outreach program of supervision, and the reactivation of various supervision and QA practices however, these are not explicitly articulated in the HSSIP. There is need for review and institutionalization of a Systems approach for Supervision and oversight of services delivery including the use of continuous performance improvement approaches such as . Quality Assurance tools, leadership and management capacity development, negotiation and communication skills, routine self-assessment etc.

It is therefore recommended that in addition to other measures to strengthen health sector governance, a review is conducted of quality assurance procedures, tools and, supervision manuals already developed by the Ministry, so as to update and institutionalize them for immediate use, as tools for improvement of health services delivery.

5.4. Human Resources for Health are a critical input in all efforts to improve the performance of health systems in all countries. There is unanimity in the reviews of HSSP I and II and Annual Health Sector Performance Reports that the both the health and education systems are facing serious challenges in training and education, recruitment and retention and in incentives provided to the health workforce. At the global level, much attention has been applied to developing global good practice guidelines in health professionals training and management. These span the areas of skill mix planning, education and training that links the education and health systems, rural retention and incentive packages.

It is recommended that Uganda should take full advantage of these global guidelines as they are being used successfully by a number of African countries by undertaking a comprehensive review of health work force issues including education and training; recruitment and retention; HRH information systems and incentives in order to align them with global good practice guidelines.

Whereas the constitution and HSC Act provide a key role for the HSC to manage all aspects of the health work force and in light of persisting health workforce issues noted above, it is recommended that the scope of work of the HSC be evaluated and measures put in place to facilitate HSC to fulfill the broader mandate.

5.5 The midterm reviews and the Joint Assessment of HSSIP have noted that Uganda has, established service standard for delivery of the minimum health care package of services including implementation arrangements. Recommendations were made for development of measures (regulatory/legal framework) for assuring compliance by service providers. While this work was not accomplished as set out under HSSP II, the new HSSIP does not explicitly provide for its' being carried to completion to ensure guidance for oversight of the delivery of services in line with technical standards and public expectations. For example, health centers I, II, III and IV have clearly

defined roles yet most have not received the required minimum inputs to enable them to perform in accordance with their defined roles and to meet public expectations. There is need to review and agree service standards by level, mobilize necessary resources for inputs needed for compliance with the standards and establish mechanisms for ensuring that the required capacity is developed for sustainable performance according to the agreed service standard.

It is therefore recommended that a review of health care service standards be conducted with a view to:

- **agree and update existing service standards by level,**
- **develop a health financing strategy to facilitate mobilization of the necessary resources to support delivery of the agreed service packages and in compliance agreed service standards;**
- **establish regulatory or legal mechanisms to facilitate oversight in ensuring compliance and,**
- **Build capacity at all levels for oversight of implementation of the services package and eliminate corruption.**

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