THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

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

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

FEBRUARY 2020

WITH SUPPORT FROM

To INSERT LOGOS FOR WORLD BANK AND USAID

Table of Contents

Tables

Figures

Abbreviations

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

Foreword

Dr. Jane Ruth Aceng
MINISTER OF HEALTH

Acknowledgement

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

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

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

Thank You all

Dr. Henry G. Mwebesa
DIRECTOR GENERAL HEALTH SERVICES

Executive Summary

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

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

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

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

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

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

1. Expand community-level health promotion and prevention programs with an eye towards ensuring equity, inclusion and responsiveness to the needs of all citizens, including excluded or disadvantaged groups working with communities, civil society, private sector and Local Governments (LGs) to design, operationalize.

2. Develop and operationalize workable integrated multi-sectoral government-wide programs to address health determinants at community and Government level. Governance and coordinated strategic actions in other sectors to address health determinants such as

sanitation, food security, education, safe transport and housing can improve coherence of health programs across both public and private sectors.

3. Improve the quality, availability and breadth of essential, and increasingly specialized health care services by taking both demand and supply side views. On the supply side, improving technologies and health inputs, while on the demand side, meaningfully including the perspectives of patients and their communities to support accountability, performance management, and other feedback mechanisms including workforce production and performance management systems that incorporate the perspectives of patients.

4. Support systems improvement in governance, infrastructure, medicines, health supplies and vaccines, health workforce expansion and health information, research and innovation.

5. Determine the right mix of financing sources around which to structure a universal coverage scheme that focuses on both increased allocation of public resources to health and social protection programs and expanding financial risk protection for the population.

6. Strengthening the decentralized delivery of health services needs higher priority in resourcing and capacity development.

1 Introduction

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

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

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

1.1 The Health Services Dimension for UHC

Uganda's health system faces several challenges that limit the country from addressing rapidly expanding health needs. These range from poor quality of health services, to inadequate health workers, medicines and infrastructure in rural areas. Despite these challenges, Uganda's health system has made major progress over the last few decades, leading to the reduction in the Maternal Mortality Ratio (MMR), which currently stand at 336 per 100,000 live births[2], with 87% vaccination completion rates; the reduction in HIV prevalence which stands at 6.2% (4.7% and 7.6% among male and female respectively)[3], with 86% Anti-retroviral Therapy (ART) coverage; and a reduction in the burden of malaria which stands at 17%[4] in children under five years tested by rapid diagnostic test.

[1] Global Burden of Disease Report 2017

[2] Uganda Demographic Health Survey 2016

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

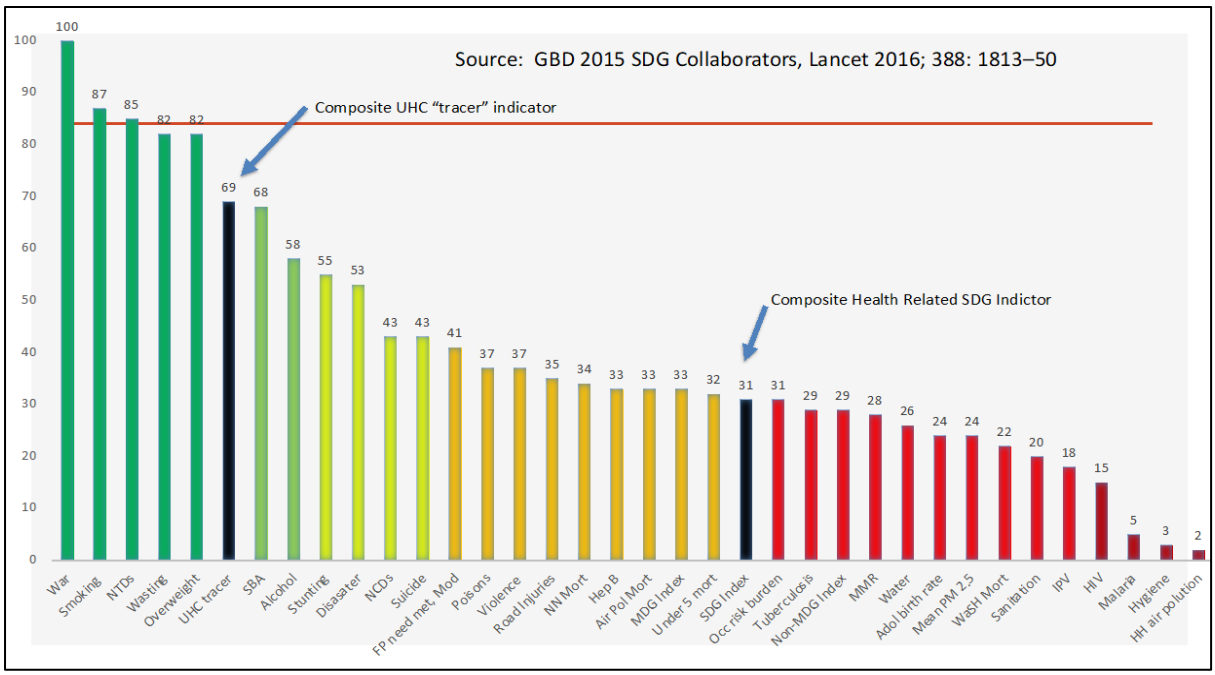
[4] Malaria Indicator Survey 2019

Currently, all the districts in Uganda have a hospital or a level IV primary care facility, with up to 86% of the population living within a 5km access to a health facility providing basic health services. Government's efforts to provide health services are also being supplemented by the private sector, which delivers about 50% of hospital health services and 35% of services at the primary care level. While a majority of the private for profit health facilities are located in urban areas[5], private not for profit (PNFP) providers do serve rural populations throughout Uganda[6].

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

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

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



For a limited set of indicators restricted to the UHC, Uganda's performance was estimated at 69% as per figure 1 above. The limited set of indicators is closely matched to the priority interventions in the essential health care package. These include: 1) met need with modern contraception; 2) antenatal care (one or more visits and four or more visits); 3) skilled birth attendance coverage; 4) in-facility delivery rates; 5) vaccination coverage (three doses of diphtheria–pertussis–tetanus, measles vaccine, and three doses of oral polio vaccine or inactivated polio vaccine); 6) TB case

[5] NPA (2018)

[6] Uganda Private Sector Assessment In Health, November 2017

[7] GBD 2015 SDG Collaborators 2016; 388: 1813–50

detection rate; 7) coverage of ART for populations living with HIV, and 8) coverage of Long Lasting Insecticides Nets (LLINs) for malaria endemic countries. This fairly high coverage for these indicators is proof that Uganda has made progress on the core elements in the essential health care package.

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

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

Tracer Indicators	UHC Index Score	Ideal score
SDG-UHC indicator 3.8.1: Service coverage index, 2015	**44**	**>90**
Family planning demand satisfied with modern methods (%)	**46**	**>90**
Antenatal care, 4+ visits (%)	**48**	**>90**
Child immunization (DTP3) (%)	**78**	**>90**
Care- seeking behaviour for child pneumonia (%)	**79**	**>90**
Tuberculosis effective treatment (%)	**40**	**>90**
HIV treatment (%)	**60**	**>90**
Insecticide - treated nets for malaria prevention (%)	**66**	**>90**
Surgeons per 100 000 population	**0.6**	1
At least basic sanitation (%)	**19**	**>90**
Normal blood pressure (%)	73	>90
Mean fasting plasma glucose (mmol/L)	**5.22**	**<5.6**
Tobacco non-smoking (%)	**90**	**>90**
Hospital beds per 10,000 population	**5**	**30**
Physicians per 1,000 population	**0.1**	**2.3**
Psychiatrists per 100,000 population	**<0.05**	**0.1**
International Health Regulations core capacity index (%) Country	**73**	**>90**

Source: WHO & WB, 2017

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

Additional Country Tracer Indicators	UHC Index Score	Ideal score
Births attended by skilled a health provider (%)	74	**>90**
Deliveries in health facilities (%)	73	**>90**
Ratio of maternal deaths in health facilities /100,000	148	**<41**
Proportion of health facilities without drug stock outs for 41 tracer medicines	85	**100**
Under five facility based deaths /1,000	18	<6
Malaria incidence cases	12,224,100	650,000
Diabetic rate (%)	3.4	0.4
Hypertension rate (%)	25	19
Cardiovascular proportional mortality rate (%)	9	<5
Annual cancer incident cases	80,000	<50,000

Cancer proportional mortality rate (%)	5	<3
Approved posts in public facilities filled with qualified personnel (doctors, nurses and midwives) (%)	75	100
Alcohol use (%)	5.8	1.3
Population accessing health insurance (%)	1	46

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

1.2 The Non-Health Sector Dimension for UHC

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

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

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

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

Source: WHO & WB, 2017

1.3 The Health Financing Dimension for UHC

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

Table 4: Health budget as proportion of total Government budget

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

Source: MoH AHSPR, 2018/19

While Uganda has wide and expansive essential package of health services, government financing is lagging. The essential health care package is still funded mostly by donors (42%) and out-of-pocket (OOP) payments (41%) creating issues for both sustainability and equity. World Health Organization (WHO) also provides a government spending benchmark for low income countries like Uganda of estimated $34 per capita as the minimum for a generic essential package, although GoU spends approximately $11 - 15 per capita, implying a major gap in domestic financing of health programs. Major large-scale priorities like childhood vaccination, HIV/AIDS, malaria and TB have also been supported for the most part by international donors, which is not sustainable, especially with the dwindling of donor aid to several recipient countries. Indeed, per capita net development assistance to Uganda sharply decreased from $54 to $42 USD between 2008 and 2015, before slightly picking up to reach $49 USD in 2017[8].

Table 5 indicates Uganda's aggregate performance on the UHC financial protection target, as measured by WHO and the WB (2017). The proportion of the population with large household expenditure on health as a share of total household expenditure or income remains high. At 10% of household total consumption or income, the incidence of catastrophic expenditure is at 12%

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

and 2.57% at 25% of household total consumption or income. Consequently, the incidence of impoverishment due to OOP health spending at a poverty line of US$1.90-a-day in 2011 was 2.68%.

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

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

Source: WHO &WB, 2017.

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

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

The high OOP expenditure for Uganda is also explained by the rapid growth of the private health providers. To date, about 50% of health services are delivered by the private sector. While the sector plays an important role in supplementing Government efforts in health service provision, the costs of services are highly constraining access by those who cannot afford. While Government provides subsidies to PNFP health service providers to reduce costs of care to the served population, it's insufficient to cause a significant impact. Likewise, private insurance companies have been established to serve but a few corporate sector employees.

1.4 Policy foundations for UHC in Uganda

A number of reforms have been instituted across sectors to help advance Uganda towards UHC. Past health financing reforms included introducing free services in public hospitals in 2001 and providing a Primary Health Care (PHC) grant to PNFP health providers in 1997 in order to lower the fees paid by their clients. The government plans to introduce a National Health Insurance Scheme (NHIS) as a mechanism for financing health care in Uganda, to facilitate the provision of

efficient, equitable, accessible, affordable, and quality health care to all residents[9]. Additionally, a set of other formative policies and strategies can support a foundation for coordinated and multisectoral movement towards UHC. These include the National Vision 2040; the second National Development Plan (NDP II) and the upcoming NDP III, which is under development, the HSDP, and the Presidential Economic Policy Paper (PEC) on UHC.

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

The NDP II focuses on empowering communities to take charge of their health, increased public private partnerships in health service delivery, and multisectoral collaboration across Ministries Departments and Agencies (MDAs) towards a common vision of a healthy Uganda, while the third draft NDP emphasizes the importance of social safety nets such as National Health Insurance, harnessing the demographic dividend, and improving quality and governance in the health and other sectors, amongst other priorities. The NDP II also envisions a structural change to improve the quality of services provided to the population and paradigm shifts from 1) facility-based to community-based delivery systems that empowers communities to take control of their health especially through health promotion and prevention actions, 2) dominantly public provision to public-private cooperation in service delivery; and 3) from siloed sector plans to more collaboration among relevant MDAs for collective action goals[10].

The HSDP 2015 – 2020 discusses investment in health governance and partnerships, making the essential package flexible to adapt to the changing health contexts and needs, having dedicated budgets for disease conditions with the highest increase in burden, sustained political commitment to UHC, and investments in health infrastructure as a set of essential actions. Additionally, the HSDP emphasizes the mobilization of multi-sectoral support for health involving

[9] National Health Insurance Bill May 2019
[10] NPA, Vision 2040 (2010)

all different stakeholders, with focus on areas like food security, nutrition, safe water, sanitation and health literacy. The government acknowledges the vital role that the private sector plays in the health system, which goes beyond direct health service provision to include supply of medicines and medical equipment, manufacturing, information systems, as well as training of the workforce. The vision for the health sector is to contribute to a healthy and productive population, economic growth and national development. The sector goal is directly related to UHC-accelerating movement toward UHC with essential health and related services needed for promotion of a healthy and productive life[11].

Finally, the PEC paper on UHC defines UHC as a process through which households are empowered to equitably create health and access a full range of quality health services (Health promotion, prevention, treatment, rehabilitative and palliative care) without financial hardships. UHC is also portrayed as a system built on a multi-sectoral approach with crosscutting sub-programmes along the identified determinants of health[12]. The MoH has adopted UHC definition that extends beyond the provision of medical services – to include the contribution of other interventions that address the determinants of health and wellbeing. The Ugandan definition is ***"all persons in Uganda have equitable access to comprehensive quality health and related services without financial constraints – all delivered through a multi-sectoral approach".*** This definition is strong in realising the competences, asserts and mandates that need to bear on the UHC agenda but outside of the realm of the health sector governance and mandates.

1.5 Process of developing the UHC Roadmap

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

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

The roadmap development process was steered by a Core Committee with membership from MoH, USAID, WHO and the World Bank, and a Multi-sectoral Committee. The Core Committee was charged with oversight of the roadmap development process, while input from the Multi-sectoral Committee ensured that multisectoral actions and perspectives were included in the

[11] MoH, Health Sector Development Plan 2015 - 20

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

roadmap. The Multi-sectoral Committee membership constituted local, regional and global experts, including those from the civil society, private sector and the academia. This process was participatory, consultative and collaborative, and was informed by the context analysis for UHC developments in Uganda and globally.[13] The 2 Consultants conducted a situational analysis, reviewed relevant global and national literature including information from existing health surveys, the HSDP 2015 – 2020 mid-term evaluation report, and other sector policy documents across the MDAs in Uganda, to understand their roles and readiness to contribute to achieving UHC and gather insights on best practices from regional and global levels.

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

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

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

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

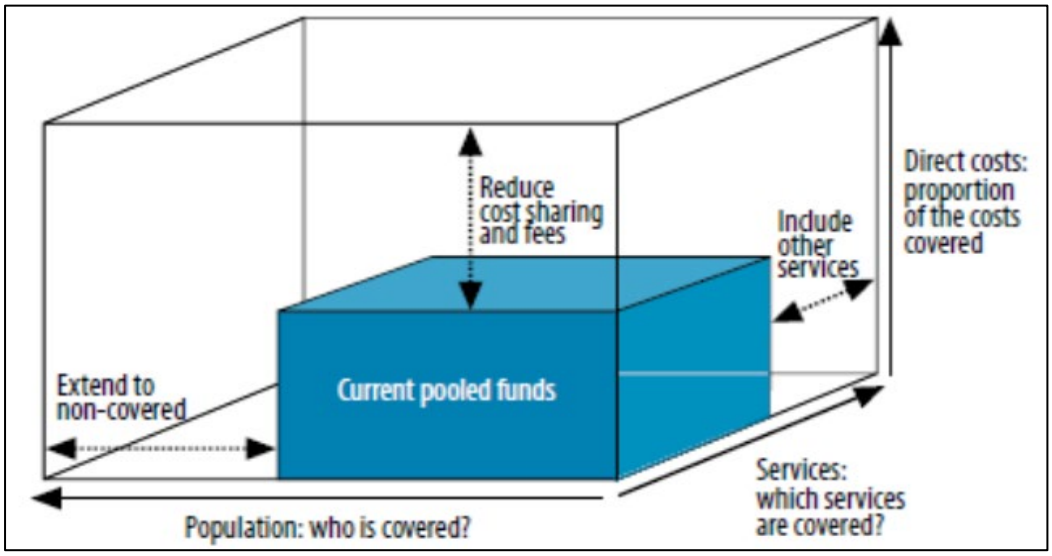
1.6 Theoretical underpinnings to the UHC roadmap

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

1. WHO UHC Dimensions and Health Systems Strengthening

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

Figure 2. UHC Cube



2. Determinants of Health

The determinants of health framework were used to broaden the scope for synergic actions across sectors to improve health and wellbeing. As illustrated below (see figure 3),[15] the

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

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

framework has the population and various biological factors at its centre, which are then moderated by personal choices, lifestyle, social and community interactions/networks. Other factors include food production, nutrition, education and working conditions, living conditions, economic engagements, water, sanitation and housing. Current and future capabilities and investments in these areas will also form addition set of key actions in UHC roadmap.

Figure 3: Framework for health determinants

3. Political economy

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

1.7 Objectives of the UHC roadmap

1.7.1 Main Objective

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

1.7.2 Specific Objectives

The specific objectives are;

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

2 Strategic Actions for UHC advancement

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

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

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

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

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

2.1.1 Considerations for Successful Expansion of the cHHP Program

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

2.1.2 Opportunities for Expanding the cHHP Program

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

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

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

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

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

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

Table 6: Outline of ideal contribution of different sectors to the UHC roadmap

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

	enforcement, standards for food and medicines products and regulatory vigilance for health risks.		preparation and Health Vocation planning
Finance, Planning and Economic Development	Expansion of the tax base and revenue collections; Allocation of finances to vital determinants of health; Better management of external aid for social programs; Expansion of employment opportunities and markets.	**Local Government**	Design and coordinate service delivery, orchestrating partnership and accountability for HPP and community development programmes.

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

1. **Stewardship** – Multi-sectoral action requires a clear driving entity in a specific sector. For UHC, the stewardship role lies with the health sector. The Multi-sectoral Committee that has guided the development of this UHC roadmap offers a unique platform to support the coordination of multi-sectoral UHC initiatives. This will ensure that different MDAs and sectors work towards a common UHC goal while minimizing the competition for resources.

2. **Capacity** – While multi-sectoral programming offers an immense opportunity, given that this is a relatively new way of working, the sector needs to account for the capacities needed to successfully engage with other sectors and MDAs in a meaningful way. This includes the capacity to participate in integrated planning and generate the required evidence to advocate with other sectors for new resources. In addition, there is a need to increase the capacity of LGs to implement the close-to-community actions that complements the health service provision.

3. **Clarity of mandate** – Once the entry points for multi-sectoral UHC action have been determined, the health sector will need to negotiate with other sectors and outline clear roles and responsibilities for the selected programming. This clarity will be achieved by empowering subnational governments through decentralization to plan and integrate programs in a manner that address the priority UHC goals for the communities while mirroring the central government concerns for UHC and other SDGs. This will allow for planning and delivery of more synergistic actions is more feasible at the sub-national levels.

4. **Multisectoral coordination** – Effective health promotion will require input and actions across sectors to address the underlying causes of poor health and mitigate injuries.

Coordination with sectors such as Agriculture (food and nutrition security), Water and Environment (Hygiene and Sanitation), and Transport (road safety) will be essential.

5. **Monitoring progress** – Indicators specific to multi-sectoral programming will be incorporated into the UHC monitoring plan.

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

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

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

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

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

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

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

Firstly, this roadmap promotes the interventions that represent good value including a mix of services that address high burden to the health system – for which the goal is immediate reduction of the disease burden. The second category represents service packages that already enjoy high coverage but with high population cohorts to be covered annually, e.g. Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) service package, which would require sustained coverage. The third category are services that require gradual improvement in coverage. Among these are skilled birth attendance and related emergency neonatal and obstetric care (EmNOC). The fourth category represents services that need to be initiated – especially given the impact they have on the population health if not unaddressed in the medium to long term, e.g. NCDs and most specialized care services such as renal and cardiovascular diseases. Regarding the quality of health services, the roadmap recognizes interventions both on the supply side (technologies, health inputs, accreditation system led by an integrated authority in charge of quality assurance and regulatory control systems across public and private providers) and the demand side (meaningfully including the perspectives of patients and their communities).

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

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

2.3.1 Considerations for increasing essential and specialized health care services

1. **Benefit package** – Improving the availability and the quality of health services is threatened by the fact that the health system is under-financed and relies on unstable and short-term financing such charitable donations as donor aid. Government needs to clarify what is in and out of the big "essential health care package" as currently defined. Using positive or negative lists is vital to communicate entitlements. Given the limited expansion in the fiscal space for domestic health budgets, the decisions on quality need to be grounded in the financial and nonfinancial resources available both domestic and external assistance program. Also, there will be a need to clarify the package of services that are covered by NHI- as outlined in the NHIS Bill - and how the uncovered are to be supported for UHC goals (e.g. tax funding). A strategic decision could be to insure for specialized services that attract high catastrophic costs for NHI instead of covering the same services that are provided free of charge through public financing.

2. **Health needs expansion** – The high population growth will entail a rapid expansion of health care needs. Also, chronic care and specialized services will require considerable funding. To mitigate this, effective community health promotion, effective multisectoral programs targeting health determinants and meeting the family planning needs are vital. Moreover, recent experiences show that the growth in the health care needs are less guided by a robust system of priority setting or evaluation of the costs and returns in health status improvements. New services also come with additional protocols for medical care - technologies, medicines and workforce training to ensure the capacity to provide quality services. Institutional structures to oversee the decisions to expand the package and to assess the implications on the system capacity, fiscal space and benefits to the affected groups will be necessary.

3. **Epidemiologic profile** – Diseases that make the biggest impact in lost health and productive days remain highly prevalent. Tackling these diseases needs priority in short-term. High-end specialized care such renal dialysis, cancer and organ transplant are expensive relative to benefits. Wider market for specialized service can draw patients from outside of Uganda.

2.3.2 Opportunities for increasing essential and specialized health care services

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

1. Health promotion is increasingly recognized as vital to the success of UHC.
2. Wide coverage of public health interventions e.g. EPI, malaria, HIV/AIDS and TB control, etc. generate savings in personal care by reducing incidence of ill-health.

3. Public tax revenue can be targeted to public health interventions like vector control, urban sanitation etc.
4. NHI is on the policy agenda. Aid programs and grants are helping the start-up costs.
5. Research opportunities to access grants, equipment and experts.

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

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

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

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

It's envisioned that decisions made within governance structures be informed by data extracted from the health information system and global evidence. This roadmap supports the expansion and implementation of UHC research agenda that the MoH has developed through SPEED project in 2016. Its findings will provide the health system decisionmakers with continuous up-to-date

knowledge on technical and non-technical solutions that could be adopted or contextualized for the realization of UHC ambition.

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

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

2.4.1 Considerations to support systems improvement

1. **Coordination of Partners -** Effort to better coordinate donor aid especially should be given priority through fragmentation reduction by creating joined-up aid pool (like UHC fund). This will help to lessen the burden of transaction-costs on the part of central and LGs. In the short-term, external aid programs should be directly towards community-level health promotion and PHC programs that represent good value in expanding coverage of essential services at this level and reducing preventable ill-health and related service costs. Moving forward, the development aid should be coordinated to increase the pool of funds to assist expand the service options and investments to aid the institutionalization of social health insurance and to enhance quality improvements.

2. **Coordination of providers** – The coordination across public, private and civic sectors is a prerequisite for success. Without clear role distribution, mutual exchange among providers, alignment in strategies implementation among the providers' network, it won't be possible to run the delivery system effectively. Regulatory systems by enforcing health behaviours and practices will underpin all these coordination efforts.

3. **Specialized service infrastructure revamp** – Uganda's health system needs a push to make specialized service infrastructure/buildings functional. But recurrent/operations costs control should remain a permanent concern. Furthermore, accreditation expansion to specialized services should be considered as a uphold to improve quality standards.

4. **Leveraging multisectoral human resources** – There is need to pool community level workforce for integrated support to community development e.g. Extension workers from agriculture, community development, religious groups and LG. All these resources are great additional hands that can and should be mobilized for the benefit of human resources for health.

2.4.2 Opportunities to support systems improvement

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

1. The new NDP III (2020/21 – 2024/25) emphasizes on the need to "*improve access and quality of social services including the delivery of Specialized Medical Care investment in health*" as one of strategies to achieve its strategic objective 3 that is increasing productivity, Inclusiveness and wellbeing of population. The political commitment put on the NDP at the highest level of the State of Uganda is going to attract all attention that will guide development actions soon.

2. Ongoing infrastructure that are being built like Uganda Cancer Centre of Excellence, Mulago Specialized Hospital, Mulago Specialised Women and Neonatal Hospital, will reinforce the health system capacity to provide high class specialised health services. Undoubtedly, these facilities reinforcement program is a cornerstone intervention and represents a strong signal that indicates the direction through which Uganda is expecting investments in the health delivery system.

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

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

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

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

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

2.5.1 Considerations for expanding of financial risk protection for the population

1. Private sector provision may grow faster as the NHIS provides opportunity for a stable provider payment system. Legislative agenda to make public sector providers effective in NHI will need prioritizing. Prior existence of free services is a major complicating factor for NHI in Uganda.

2. In the short-term Government financing need to markedly increase to address the quality and coverage gaps in the essential package and the majority (80% informal sector) unlikely to get into NHI in the short-term. Pressure on public funds to cover the uninsured may generate political risks for government.

3. Investments and reforms required to establish NHI may diverts attention of health reformers, sector leadership and policy elites in society for a long time.

4. OOP remains high for the majority of uninsured persons, raising equity concerns and increasing political pressure to use tax funds to provide insurance for non-insured.

5. Mobilization and social advocacy to push public expenditures towards specialized services packages is a likely outcome. This may negatively affect priorities accorded to public health interventions that are required to prevent illness and promote well-being – thus delaying the progress towards UHC goals.

6. Put in place mechanisms for controlling costs and mitigating collusion and potential for corruption in negotiating NHI contracts and billing systems and provider payments.

7. Strengthen regulatory systems to curb fraud, control costs, optimize quality in public and private sector.

8. Design institutional arrangement for health financing with the aim to build on established institutional arranges such as decentralization, PNFP bureaus and organized networks in the communities.

2.5.2 Opportunities for expanding of financial risk protection for the population

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

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

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

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

widespread and responsible for uncertainty in the implementation of planned activities and untimely accountability of funds.

Recent studies show limited room by LGs to negotiate local priorities with donor agencies. The concept of decentralization and its ideals in responding to local needs is getting eclipsed by vertical (top-down) programming and funding streams. Most Development Partners tend to select a sample of "project districts" and implement different health programs (or program elements) with variable geographic coverage in selected districts. This results in a "patch-work" of national coverage for programs and their outcomes. Short-term support for most of the off-budget support is another challenge that does not aid continuity and or sustainability.

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

2.6.1 Considerations to strengthen the decentralized delivery of health services

1) **Empowerment:** The UHC agenda, requires that decentralization of service delivery is well empowered to create the aggregate coverage goals for SDGs. This requires that capacity building and resourcing of LGs are aligned with the service delivery obligations.

2) **Integration:** More operational integration across government and non-government sectors needs to be deliberately designed to use the resources that flow to the LGs level. This can be through adoption of the program-based budgeting.

3) **Multi-sectoral collaboration:** There is potential workforce (salaried positions) in several departments of LGs that can form a pool of extension workers to deliver on health and related programs. These teams can work with religious and cultural leaders, associations, institutions, CBOs to support and coordinate community programs.

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

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

- Decentralization empowers LGs to plan and implement context specific interventions.
- The parish level provides the nucleus for bottom up planning and can be used to promote HIAPs.

- The community extension workforce at LGs can be pooled to address a comprehensive set of programs (both health and non-health) and leverage operational funds at the community rather than working in siloed manner.

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

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

3 Priority Interventions for the Uganda UHC Roadmap 2020 – 2030

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

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
1. Expand community-level health promotion and prevention (cHPP), and social protection programs	Operationalize the community health programming to scale up coverage – actions such as mapping community health structures, identifying gaps and developing an implementation / expansion plan.	X			MoH		Community-level health promotion and prevention plan developed
	Strengthen Health education and promotion to improve health literacy and facilitate informed decisions about health care, behaviours and more effective engagement with health providers	X	X	X	MoH	LGs, Partners	Increased health literacy
	Strengthen Integrated Disease Surveillance & Response System	X	X		MoH	LGs	% of weekly reporting from public health facilities
	Formalization of volunteer workforce (community health workers) for health promotion and disease prevention.	X			MoH		% of LGs with formalized Community Health Workforce
	Implement regular health promotion campaigns that mobilise self-help and community assert to improve the health projection and enhance health promotion.		X		LGs		% of LGs implementing health promotion

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
							campaigns e.g. sanitation days
	Expand and intensify low-cost community led actions to promote appropriate health, nutrition and hygiene practices at the household level, while creating awareness and demand for basic health services i.e. Family Planning, Malaria prevention, Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) services and micronutrient supplementation	X	X		LGs	MoH, CSOs, Partners	Package of low-cost community led actions developed and implemented
	Engage the private sector in provision of health promotion and health education to community members.	X	X	X	MoH		Private sector engaged in provision of health promotion and health education
	Promote meaningful client/citizen participation in planning, performance monitoring, and accountability	X	X	X	LGs		No. of LGs using bottom up planning, monitoring and holding accountability fora
	Expansion of frontline workforce for health promotion and disease prevention		X		MoH		% of positions filled
	Integrate refugee health services more effectively into affected communities.		X		MoH		Refugee health services integrated in the district health services
	Strengthen collaboration with private sector providers, pharmaceutical and medical device manufacturers to introduce low cost screening programs that support secondary prevention.		X		MoH		Low cost screening programs introduced

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Design financing modalities that allow for communities to access both public and private sector services as available.		X		MoH		% of population with prepayment mechanisms for health
2. Develop and operationalize integrated multi-sectoral government-wide programs to mitigate health determinants	Establish institutional arrangements and modalities towards multi-sectoral engagement for UHC at national level.	X			OPM		Institutional modality for multi-sectoral action established. No. of sectors implementing UHC interventions.
	Enforce multisectoral collaboration and synergies throughout planning and implementation.		X		OPM		Integrated multi-sectoral government wide programs developed
	Expand access to clean water and sanitation at community level coupled with sanitation campaigns (bulungi bwansi) undertaken by Local Councils and other community leadership.		X		MoW&E	MoH MoLG Political Leaders	No. of policies from key sectors that integrate UHC-related indicators.
	Conduct integrated community education and behaviour change campaigns with other sectors focussed on health education and health promotion around key topics such as nutrition, healthy lifestyles.		X		LGs		No. of integrated community education and SBCC campaigns held.

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Revitalise public health inspection and collaboration with other MDA at all levels to accelerate WASH (rural and urban) improvement.	X	X		MoH	LGs	Universal WASH coverage
	Expand the number of partnerships developed with actors from other sectors from groups such as civil society, development partners and private sector.		X		MoH		No. of partnerships developed with non-state actors from other sectors.
	Strengthen advocacy with MoFPED to allocate more resources for UHC.		X		MoH	Parliament CSO HDPs	Increased resource allocation for UHC-related interventions at national and LG level.
	Collaborate with MoFPED and other sectors to integrate UHC strategic actions into Uganda's taxation policies.			X	MoH		No. of taxation policies introduced for increased domestic funding for health
	Enforcement of the Public Health Act (regulatory measures and standards, for example on housing and domestic sanitation, road safety, food safety, environmental sanitation, pollution, alcohol & substance abuse).		X	X	LGs		No. of LGs enforcing the Public Health Act
3. Improve the quality, availability	Conduct a Burden of Disease study for Uganda	X			MoH		BOD study conducted

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

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Expand functionality of service provision especially for vital services such as CEmNOC.	X	X	X	MoH		% of HC IVs providing CEmNOC
	Establish an integrate authority to improve quality assurance and regulatory control systems across public and private providers.		X		MoH		Health Professional Authority established
	Establish a credible structure to guide on the priority setting and feasibility analyses for new innovations, technologies and protocols (*Potential to align to Health Technology Assessment (HTA) actions)*		X		MoICT		Structure established to guide on the priority setting and feasibility analyses for new innovations, technologies and protocols
	Establish partnerships with centres of excellence abroad to support the skills and technology transfer to Uganda.		X		MoH		No. of partnerships established
	Increase health facilities network, including through partnerships with the private sector, to ensure effective referral and timely access to services and treatment.	X	X	X	MoH		Health facility coverage by level
	Expand provision for specialized and referral service packages	X	X	X	MoH		Specialized and referral services packages expanded
	Strengthen the National referral networks for specialized care services		X	X	MoH		Referral network for specialized care functional

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Develop a plan for investments in the medical centres of excellence including public private partnerships.		X				Investment Plan for medical centres of excellence developed
	Establish a regular accreditation system for providers of essential health care services and specialized services with appropriate incentives and sanctions.			X	MoH		Accreditation system developed
	Link accreditation and quality improvement programs to health financing through mechanisms such as performance-based incentives.		X	X	MoH	MoFPED	Health financing linked to performance
4. Support systems improvement in governance, infrastructure, medicines, supplies and vaccines, health workforce expansion, health information, research and technology	Provide leadership structure for coordination of UHC-related programs across sectors.	X			OPM	MoLG	Coordination structure for UHC related programs in place
	Develop a multi-sectoral framework for UHC with clear roles for the key actors at all levels to include governance and coordination of actors and actions to improve health from all vital agencies.	X			MoH	LGs, Private Sector	Multi-sectoral framework developed
	Develop networked e-platform for mapping, reporting and coordination of all non-state health actors.	X	X		MoH	LGs, Partners	All non-state health actors mapped and resources tracked at all levels
	Building health leadership/managerial efficiency and effectiveness at district and hospital/health facility level	X	X		MoH	LGs, Private Sector	No. of health managers trained in leadership and management skills
	Set standards of practice and guidelines for different settings (Communities- in training institutions, schools work-places, homes,	X	X	X	MoH	LGs, Private Sector	Standards of practice and guidelines for

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	prisons, security institutions, etc.) for health and nutrition programmes.						health and nutrition programs for different settings
	Develop integrated Operational-level (OPL) and Mid-level Manager's (MLM) manuals for delivery of the UNMHCP		X		MoH	LGs	Integrated OPL and MLM manuals
	Revitalise Catchment Area Mapping, Planning and Action (CAPA) planning at all health facilities	X	X		LGs	MoH, CSOs	Facilities implementing CAPA or similar approaches
	Strengthen the Emergency Operation Centre (EOC) to ensure linkage and use of information generated from other sectors e.g. disaster management, disease outbreaks, pandemics and emerging global health threats for timely response.		X	X	MoH		All disasters responded to within 48 hours
	Develop and implement a National Action Plan (NAP) for Health Security	X	X	X	MoH		NAP for Health Security developed and implemented
	Establish Port Health Services for enhanced surveillance	X	X		MoH		% of designated PoE with permanent Port Health Services
	Evaluate and revise the public private partnerships strategy or plan to determine baseline provisions.	X			MoH		PPP strategy evaluated and revised
	Develop a National Master Plan for establishment, expansion and maintenance of public health infrastructure in the country linked to overall urban, roads and transport, electricity and water development plans.	X			MoH	LGs, MoSTI, MoWT,	National Master Plan developed

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
						MoEM, MOWE	
	Increase access to essential health care services by construction, rehabilitation and equipping of general hospitals and HCs.	X	X	X	MoH	LGs, Private Sector	% of targeted health infrastructure constructed/ rehabilitated & equipped
	Increase access to specialized health care services by construction and rehabilitation of referral hospitals and Super Specialized hospitals /Centres of Excellence.	X	X	X	MoH	LGs, Private Sector	% of targeted health infrastructure constructed/ rehabilitated & equipped
	Establishment of National and Regional Call Centres for Emergency Medical Services.	X	X		MoH		EMS functional
	Establish regional blood banks and blood storage facilities at all HC IVs.	X	X		MoH	LGs, Private Sector	Regional Blood Bank coverage % of HC IVs with blood transfusion services
	Improvement in coverage of staff housing.	X	X	X	MoH	LGs, Private Sector	% public sector health staff housed
	Improve capacity in equipment use and maintenance including retooling of the Regional Maintenance Equipment Workshops.	X	X		MoH		% of fully function REWs
	Establish an efficient, safe and environmentally sustainable Healthcare Waste Management System.		X	X	MoH	LGs, Private Sector	HCWM system established

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Capacity building in ICD coding for health providers at all levels to improve disease and death reporting and notification.	X			MoH	NIRA	ICD coding integrated in HMIS
	Establish and scale up a national Electronic Medical Records System in all public and private hospitals, HC IVs and high-volume HC IIIs with access to internet.	X	X	X	MoH	MoSTI, LGs	100% hospitals, HC IVs and, high volume HC III
	Establish a comprehensive health information system by integrating the electronic information systems within the health sector (HMIS, HRIS, CHIS, EMRS, WAOS, ERP, RX Solution, NDAMIS, HPRIS, e-Recruitment, CRVS, etc).	X	X		MoH	MoSTI, LGs	Comprehensive Electronic Medical Record, EHR and PHR established.
	Operationalization and scale up of the Community Health Information System.	X	X		MoH	LGs, Partners	Community health data linked to HMIS
	Strengthen the use of big data integrating HIS and other sectoral information systems for strategic information on UHC.		X		MoH		Decisions making based on evidence from multi sectoral data
	Strengthen coordination with private sector umbrella organizations in order to increase reporting from private sector providers.	X	X		MoH	LGs, Private Providers	% of private health facilities reporting through the DHIS2
	Conduct routine Data Quality Assessments for all health facilities.	X	X	X	MoH	LGs	Annual DQAs conducted
	Develop health research and development (R&D) strategy and national research priority agenda.	X	X	X	UNHRO	Academia	Health research strategy and agenda

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Strengthen health sector research institutions to undertake health impact assessments, research and analyses, jointly with non-health sector programmes.	X	X	X	UNHRO	MoSTI, UVRI, UNCRI, JCRC, Universities, LGs, Partners	No. of completed research works and publications
	Develop PPP investment plans for strengthening research for scientific evidence on the safety, efficacy, quality and availability of traditional medicine products.		X		UNCRI	Private Sector	Investment plan
	Conduct and publish research for scientific evidence on the safety, efficacy, quality and availability of traditional medicine products.	X	X	X	UNCRI	MoSTI, Universities, Partners	Research products and publications
	Develop a comprehensive 10-year HRH policy and strategic plan aligned to UHC.		X		MoH	MoPS, LGs	HRH Policy and Strategic Plans developed
	Recruitment of the health workers		X		MoH	MoPS, LGs, Private Sector	Staffing level
	Provide competitive wages/salaries for health care workers to improve job commitment and meaningful vocation.			X	MoFPED	Private Sector	Enhanced salaries
	Review/develop up-to-date schemes of service and standards of practice and job descriptions for all cadres.	X			MoH	MoPS, HPCs, LGs	Up-to-date schemes of service and standards of practice and JDs

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Design incentive schemes to improve staffing in areas of low coverage and high morbidity.		X		MoPS	L LGs, Private Sector	Harmonized incentive schemes for health workers
	Functionalize the existing HRIS and National Health Work Force Accounts to capture information on the entire health workforce in the Country and link it to the DHIS2 platform.	X	X	X	MoH	LGs	iHRIS functional in all LGs and health institutions
	Develop an e-personnel performance management, monitoring and reporting system.		X		MoH	LGs, Private Sector	Annual personnel performance analysis done
	Develop the Human Resource Development Strategy and annual HR Development Plans	X	X	X	MoH	LGs, Private Sector	HR Strategy and Annual HRD Plans
	Create special scholarship fund for priority skills and cadres in the health system such as Public Health Nurses, anaesthetics, diagnostic and health promotion and specialist workforce.			X	MoES		
	Train expert workforce for specialized services.		X	X	MoES		
	Develop a multi-sectoral plan for training of health workforce in appropriate skills and numbers.		X		MoES	MoH, HPCs	Training plan
	Increase the financial allocation for medicines and health supplies to a reasonable level at least $14 per capita by 2025.		X	X	MoFPED	MoH, NMS	Per capita budget allocation for medicines and health supplies
	Strengthen the National Pharmacovigilance system at all levels using information technology.	X	X	X	NDA	MoH, Private Sector	Functioning national e-Pharmacovigilance system
	Strengthening the post marketing surveillance of commodities on the market for both public and private sector.	X	X	X	NDA	MoH, Private Sector	Post marketing surveillance done

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
							for all commodities
	Review and harmonise standards for medical laboratory technologies including point of care tests (POCT), home health IT diagnostic devices and, diagnostic and imaging technologies.		X		MoH	NDA	Harmonised Standards for diagnostic technologies
	Promote production and appropriate use of indigenous and complimentary medical products and practices.	X	X	X	MoH	NDA, Private Sector, UNBS	ICMPs integrated into the national health system
	Develop a meaningful public private partnership framework for complementary investments in health infrastructure, medicine and health technologies and devices.		X		MoH	MoTI, Private Sector	
5. Develop the right mix of financing sources to increase public expenditures on health and social protection programs to expand financial risk protection for the population	Establish the NHIS.		X		MoH	Parliament, MoFPED	NHIS established
	Develop a NHIS Institutional Capacity Development Framework and implementation roadmap.	X			MoH		NHIS Framework and Implementation roadmap
	Align aid agendas to the national UHC priorities while strengthening country systems.	X	X	X	MoH	MoFPED, DPs	Joint annual plans and budgets
	Re-establish pooling of external aid for coordinated financing of UHC programs.		X		MoFPED		Pooled funding mechanism re-established
	Map and track resources from Health Partners.	X	X	X	MoH	MoFPED, DPs	% of HDP resources mapped and tracked

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Expand prepayment mechanisms for health care and scale-up pro-poor interventions such as demand-side incentives, including vouchers and conditional cash-transfers.		X		MoH		Coverage of prepayment mechanisms
	Harnessing the private sector through provision of a Medical Credit Fund or subsidies to fill critical gaps in care provision.	X	X	X	MoH	MoFPED, Private Sector, DPs	Level of financial support to the private sector
	Improve equity and efficiency in resource utilization through RBF scale up beyond RMNCAH.	X	X	X	MoH		Coverage of RBF mechanisms across key sector outputs
	Aim to allocate $60 per capita to improve coverage of major Health Prevention and Promotion and the Environmental Health Programs.			X	MoFPED		Increased per capita allocation for health
6. Strengthen the decentralized delivery of health and social protection services	Re-orient LGs about the roles and mandates to advance UHC goals alongside other programs vital for SDGs.	X			MoH		% of LGs re-oriented
	Strengthen multi-sectoral coordination at LGs level to better embed health priorities at decentralized level		X		MoLG		No. of Multi-sectoral programs implemented
	Provide guidelines and capacity building for more integrated planning, budgeting and implementation arrangements that enable greater synergy and value for money for health and non-health development programs.	X			MoLG		UHC Technical support program to LGs developed
	Consolidate the workforce for community levels programs across all departments of LGs to pool resources and experts to guide community development programs including cHPP.	X			MoLG		No. of community development programs including cHPP established
	Mobilise close-to-community and non-governmental actors to contribute to UHC programs alongside other development programs.	X	X		LGs	MoGLSD	

Strategic Action	Interventions	Short-Term (1-2 yrs)	Medium-Term (3- 5 yrs)	Long-Term (5 – 10 Yrs)	Lead in Gov't	Partners	Output Indicators
	Develop guidelines for improving alignment and sustainable coverage of health protection programs supported by off-budget funding streams.	X			MoFPED		
	Undertake coverage surveys to assess the service delivery gaps within the LGs and use local evidence to address inequalities and appropriate solutions to their correction.		X		UBOS	LGs, MoH	

4 Monitoring and Evaluation of the UHC Roadmap

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

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

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

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

Table 7: The UHC Roadmap M&E Framework

No.	Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	2030	Source of data
1.	Malnutrition rates (stunting)								
2.	Malnutrition rates (wasting)								
3.	Malnutrition rates (obesity)								
4.	Exclusive breastfeeding rate								
5.	Population with access to safe water (%)								
6.	Households with access to at least basic sanitation (%)								
7.	Women of childbearing age receiving modern FP (%) (mCPR)								
8.	Demand satisfied with modern methods in women aged 15 – 49 years who are married or in a union (%)								
9.	Fertility Rate (All) (%)								
10.	Fertility Rate (adolescents) (%)								
11.	Women who attended four or more antenatal care visits with skilled health professional during their most recent pregnancy (%)								
12.	Proportion of births attended by skilled attendants (%)								
13.	Postpartum care coverage (%)								
14.	Existence of a national screening program for selected NCDs (diabetes, hypertension, sickle cell								

No.	Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	2030	Source of data
	disease) and cancer (cervical cancer, prostate, breast)								
15.	Insecticide treated bed nets use (%)								
	a) All								
	b) Pregnant women								
	c) Children under 5 years								
16.	Coverage of preventive chemotherapy for applicable NTDs (%)								
17.	Incidence rate for key risk factors								
	a) Tobacco use								
	b) IPV								
	c) Alcohol abuse								
18.	Mortality rates attributed to key determinants								
	a) Pollution								
	b) Unsafe water sanitation, hygiene								
	c) Injuries								
19.	Immunization coverage rate, by vaccine (%)								
	a) BCG								
	b) DPTHibHeb3								
	c) HPV2								
	d) IPV								
	e) Rotavirus 2								
	f) Measles-Rubella								

No.	Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	2030	Source of data
	g) PCV 3								
	h) Polio 3								
	i) TT2+ Pregnant Women								
20.	Coverage of children receiving integrated child services (%)								
21.	Care-seeking behaviour for children with suspected pneumonia (%)								
22.	TB Case Detection Rate (%)								
23.	TB effective treatment coverage (%)								
24.	HIV Prevalence Rate (%)								
25.	People with HIV receiving antiretroviral therapy (%)								
26.	ART Retention rate (%)								
27.	Malaria prevalence rate (%)								
28.	Prevalence of non-raised blood pressure regardless of treatment status s (%)								
29.	Mean fasting plasma glucose (mmol/L)								
30.	Adults aged at least 15 years who had not smoked tobacco in the previous 30 days (%)								
31.	Alcohol per capita consumption								
32.	Facilities providing full complement of essential health services (by level, ownership, type) (%)								
	Health Centre IVs providing CEmMNOC (%)								

No.	Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	2030	Source of data
	Health Centre IIIs providing BEmNOC (%)								
33.	International Health Regulations core capacity index and health emergency preparedness.								
34.	Health security threats detected on time (%)								
35.	Coverage of the screening programs								
	a) Cervix								
	b) Breast								
	c) Prostate								
36.	Service availability and readiness index								
37.	Service units fully accredited for services (%)								
	a) Laboratories								
	b) Health facilities								
38.	Functional supportive supervision and mentoring system								
39.	Clients satisfied with services (%)								
40.	Service units with functional governance structures i.e. HUMCs and Hospital Management Boards (%)								
41.	Health facility density and distribution								
	a) National Referral Hospitals								
	b) Regional Referral Hospitals								

No.	Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	2030	Source of data
	c) General Hospitals								
	d) HC IVs								
	e) HC IIIs								
42.	Hospital bed density and distribution								
	a) Inpatient								
	b) Maternity								
	c) TB isolation								
	c) ICU								
43.	Health facilities reporting no stock out of the 41 tracer medicines/supplies (%)								
44.	Approved posts filled by skilled personnel (%)								
45.	Health worker density and distribution (doctors, nurses and midwives)								
46.	Coverage of birth and death registration								
47.	Integrated data repository								
48.	Presence of comprehensive country health database for past 5 years								
49.	Hospitals using correct International Classification of Diseases (ICD) coding (%)								
50.	Coverage of IDSR surveillance systems								

No.	Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	2030	Source of data
51.	Functional National Health Observatory								
52.	National budget allocated for health research (%)								
53.	% of population covered by health insurance								
54.	OOP Health expenditure as % of current expenditure on health								
55.	OOP expenditure per capita								
56.	Total current expenditure on health (% of gross domestic product)								
57.	Government expenditure of health as % of total current expenditure								

5 Implementation Arrangements

5.1 Governance Framework

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

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

5.1.1 National Level Governance

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

5.1.2 District/Urban Authority Level Governance

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

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

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

The HUMCs or HMBs in the public and private health facilities will continue to ensure quality health service delivery. With the refocus towards health promotion and disease prevention, the

HUMCs and HMBs will further commit to looking beyond the walls of their health facilities and address the root causes of poor health that are situated in the community and have a strong focus on improving the places where people live and work and where children learn and play.

5.2 Performance Management

5.2.1 UHC Roadmap Performance Management Framework

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

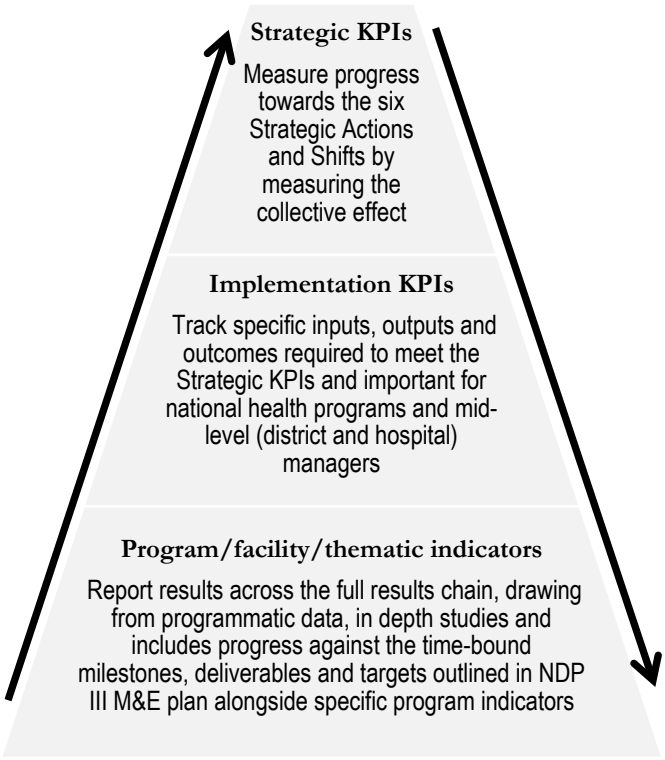


Figure 4: UHC Roadmap Performance Framework

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

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

measures, standardizing data requirements for different systems, and improving analysis and presentation for different users.

5.2.2 The Performance Review Management

The MoH and LGs have a responsibility to ensure that the delivery of healthcare services in Uganda is consistent with these strategic directions and priorities of this roadmap. To continually develop a health system that works effectively across levels, programs and departments and is well positioned to create a sustainable health system, the sector will seek to identify measures of performance that support delivery of the strategic directions, priority outcomes and derive the best value from the health budget. The KPIs will be presented as a dashboard to help communicate progress made on reducing disease burden, UHC, and system performance. The core elements of the performance review process are:

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