WHO COUNTRY COOPERATION STRATEGY 2009–2014

UGANDA
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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>ACT</td>
<td>Artemisinin-Based Combination Therapy</td>
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<td>AfDB</td>
<td>African Development Bank</td>
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<td>AHFS</td>
<td>Adolescent Health Friendly Services</td>
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<td>AMS</td>
<td>Activity Management System</td>
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<td>AoW</td>
<td>Area of Work</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>CAP</td>
<td>Consolidated Appeal Process</td>
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<td>CBO</td>
<td>Community-Based Organization</td>
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<td>CCA</td>
<td>Common Country Assessment</td>
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<td>CCM</td>
<td>Country Coordination Mechanism (for the GFATM)</td>
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<td>CCO</td>
<td>Department of Cooperation and Country Focus</td>
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<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<td>CFI</td>
<td>Country Focus Initiative</td>
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<td>CMH</td>
<td>Commission for Macroeconomics and Health</td>
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<td>DAF</td>
<td>Director, Administration and Finance</td>
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<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<td>DfID</td>
<td>Department for International Development</td>
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<tr>
<td>DOTS</td>
<td>Directly-Observed Treatment Short-Course</td>
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<td>DPM</td>
<td>Director, Programme Management</td>
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<td>FY</td>
<td>Financial Year</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GHI</td>
<td>Global Health Initiatives</td>
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<td>GOU</td>
<td>Government of Uganda</td>
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<td>GTZ</td>
<td>German Development Cooperation</td>
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<td>HAC</td>
<td>Health Action in Crisis</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HDP</td>
<td>Health Development Partners</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HMN</td>
<td>Health Metrics Network</td>
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<td>HPAC</td>
<td>Health Policy Advisory Committee</td>
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<td>HSD</td>
<td>Health Subdistrict</td>
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<td>HQ</td>
<td>WHO Headquarters</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<td>ASC</td>
<td>Inter Agency Standing Committee</td>
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<td>ICC</td>
<td>Interagency Coordination Committee/Internally Displaced Population</td>
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<tr>
<td>DSR</td>
<td>Integrated Disease Surveillance and Response</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
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<tr>
<td>IRS</td>
<td>Indoor Residual Spraying</td>
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<tr>
<td>ITN</td>
<td>Insecticide-Treated Net</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<td>JRM</td>
<td>Joint Review Mission</td>
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<td>KIDDP</td>
<td>Karamoja Integrated Disarmament and Development Plan</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOES</td>
<td>Ministry of Education and Sports</td>
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<td>MOFPED</td>
<td>Ministry of Finance Planning and Economic Development</td>
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<td>MOLG</td>
<td>Ministry of Local Government</td>
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<td>MOPAN</td>
<td>Multilateral Organizations Performance Assessment Network</td>
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<td>MOSS</td>
<td>Minimum Operating Security Standard</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<td>NCD</td>
<td>Noncommunicable Disease</td>
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<td>NDA</td>
<td>National Drug Authority</td>
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<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>NHP</td>
<td>National Health Policy</td>
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<td>NPO</td>
<td>National Professional Officer</td>
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<tr>
<td>NTD</td>
<td>Neglected Tropical Disease</td>
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<td>OSER</td>
<td>Office Specific Expected Results</td>
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<tr>
<td>PEAP</td>
<td>Poverty Eradication Action Plan</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PMDS</td>
<td>Performance Management and Development System</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>PNFP</td>
<td>Private Not-For-Profit</td>
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<td>PPPH</td>
<td>Public Private Partnership for Health</td>
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<td>PRDP</td>
<td>Peace, Recovery and Development Plan</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<tr>
<td>RBM</td>
<td>Results-Based Management</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>RED</td>
<td>Reaching Every District</td>
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<td>SBWG</td>
<td>Sector Budget Working Group</td>
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<td>SHI</td>
<td>Social Health Insurance</td>
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<tr>
<td>SIDA</td>
<td>Swedish International Development Agency</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SSA</td>
<td>Special Services Agreement</td>
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<tr>
<td>STC</td>
<td>Short-Term Consultant</td>
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<td>SWAp</td>
<td>Sectorwide Approach</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UNCT</td>
<td>United Nations Country Team</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHRO</td>
<td>Uganda National Health Research Organisation</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNMHCP</td>
<td>Uganda National Minimum Health Care Package</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VHT</td>
<td>Village Health Team</td>
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<td>WCO</td>
<td>WHO Country Office</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WR</td>
<td>WHO Country Representative</td>
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EXECUTIVE SUMMARY

The WHO Country Cooperation Strategy 2009–2014, aims to improve the quality and effectiveness of the work of WHO in Uganda, supporting the government’s efforts to eradicate poverty through improved health outcomes. It sets out the strategic agenda for WHO in Uganda for the next six years, taking cognizance of the recent WHO Country Focus Policy. Through the second generation CCS, WHO aims to be more responsive and aligned to country needs and expectations guided by WHO’s comparative advantage, taking into account the activities of other development partners and actors. The CCS has been developed through a consultative process led by the WHO Representative.

Although the health indices in Uganda remain unacceptably high, some improvements have been registered in the recent past in maternal and child health as well as sanitation, access to water and education areas. Maternal and child mortality rates at 432 per 100 000 and 76 per 1000 live births, respectively, and HIV/AIDS sero-prevalence at 6.4%, still remain high in spite of the implementation of several proven interventions with varying levels of coverage. Although coverage of key interventions remains modest, inequalities still persist. Poverty remains as an underlying factor for the poor health indicators. There is a threat that the country may not meet some of the Millennium Development Goal (MDG) targets. The Health Sector Strategic Plan III 2009-2010 and 20013-2014 (HSSP III) is being formulated to guide the sector and a national strategic plan has been developed to guide multisectoral response to HIV, of which the health sector is the core. There are inequalities in access to services between rural and urban areas, different socioeconomic groups and various education levels.

The sector is underfunded to meet the increasing level of health services as demanded by the increasing population, cost of new technologies and number of districts. Expenditures on health as a percentage of total government expenditure ranged from 7% to 10%, below the Abuja target of 15% during the period of the first Country Cooperation Strategy (2000-2001 and 2005-2006). In 2006-2007, per capita expenditure on health amounted to US$ 15; government contribution amounted to US$ 5 per capita while donor projects and global initiatives contributed US$10 per capita. This level of funding is inadequate to meet the cost of the minimum package of services in HSSP II, estimated at US$ 38 per capita. Inadequate prioritization in the sector results in underfunding of critical aspects of health sector programmes.

Major achievements of the first CCS included support to health sector-wide approaches; analysis of pro-poor financing policies; guidance on operationality of the Health Sub-Districts; and support for development of appropriate policies, guidelines, tools and standards. Operational research and evaluations were carried out in the various programmes, and several publications were produced, the results of which have been used in policy reviews and updates. Inservice capacity-building in critical areas in addition to long-term training in public health were supported, and catalytic work was undertaken in a pilot initiative on making pregnancy safer, the mama kit initiative, model health subdistrict, and integrated delivery of community-based interventions through village health teams. Scaling up of key interventions was supported, including expansion of TB DOTS; increasing access to ARVs, HCT and PMTCT services; and nation-wide implementation of home-based management of fever. Support was provided for strengthening HMIS, scaling up implementation of Integrated Disease Surveillance and Response (IDSR), epidemic preparedness and response, and revitalization
of immunization. Polio eradication was achieved and Uganda has been certified polio free. Measles morbidity and mortality was reduced by over 90%, and a pentavalent vaccine was successfully introduced into routine immunization programmes. WHO responded to humanitarian crisis through the Health Action in Crisis (HAC) unit, and suboffices were established for facilitation in Gulu, Kitgum and Pader. WHO is a co-chair of the Health and Nutrition Working Group under the District Disaster Preparedness and Management Group; WHO is the lead organization for the Health, HIV/AIDS and Nutrition Cluster within humanitarian response.

Lessons learnt from the first CCS include: the need for comprehensive planning based on predictable funding for better results; ensuring availability of staff to implement planned activities; the importance of adequate consultation with government officials and all levels of WHO at the planning stage to avoid numerous additional activities; the importance of using indicators in the biennial plans that adequately measure the work of the WCO; and the need to make the strategic agenda more specific and to ensure that it is reflected in the biennial plans.

The second CCS will focus on the following broad areas:

- Promoting health and preventing disease,
- Providing programmes of national interest,
- Strengthening health systems,
- Strengthening partnerships.

To enable WHO to take action in these areas, the current capacity of the WCO will be strengthened to meet these challenges. The required technical and administrative support staff and logistics will be provided in collaboration with key development partners to enable WHO to bring together its technical capacity to ensure that the Ministry of Health and health development partners are better informed and equipped to play their crucial roles in health development. In fulfilling the strategic agenda, certain staff adjustments will be undertaken. There will be need for a modest increase of staff in some areas, particularly health systems and both maternal and child health. Reprofiling and redefining roles of different positions will also be done. There will also be a need for additional support through short-term contracts and agreements for performance of work.

Adequate funding will be critical for implementation of the strategic agenda within the country to improve health outcomes. A substantial increase in both the regular and extra budgetary funds will be required.

This CCS will undergo a mid term review after two and a half years of implementation and evaluation at the end of five years. These will assess adherence to strategic agenda as well as positive and negative programme results based on biennial workplans and office reports. Evaluation will be both internal and external; results will be disseminated to the MoH and partners, and they will also be used for more effective engagement where appropriate.
The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution’s coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO’s action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the “Harmonization for Health in Africa” (HHA) and “International Health Partnership Plus” (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO’s Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa
SECTION 1

INTRODUCTION

The second WHO Country Cooperation Strategy 2009–2014 aims to improve the quality and effectiveness of the work of WHO in Uganda, supporting government efforts to eradicate poverty through improved health outcomes. It sets out the strategic agenda for WHO in Uganda for the next six years, taking cognizance of the recent WHO Country Focus Policy. Through the CCS, WHO aims to be more responsive and aligned to country needs and expectations guided by WHO’s comparative advantage, and taking into account the activities of other development partners and actors.

In 2000, the first CCS was developed for Uganda for five years up to 2005. Since then there have been changes in the national and global development agenda affecting the collaboration between WHO, the Government of Uganda and the various health development partners.

These changes include:

(i) the Millennium Development Goals (MDGs);
(ii) the Eleventh General Programme of Work, (A global health agenda) 2006-2015;
(iii) the Medium Term Strategic Plan (MTSP) (2008-2013);
(iv) Strategic orientations for WHO Action in the African Region, 2005-2009;
(v) the Government of Uganda Poverty Eradication Plan 2004/5-2008/9 (PEAP);
(vi) the Health Sector Strategic Plan II (2006-2010) (HSSPII);
(vii) United Nations Development Assistance Framework (UNDAF 2006-2010);
(viii) UN reforms;
(ix) and Paris Declaration on harmonization and alignment as a means to make donor aid more effective.

New opportunities for funding have also been put in place such as the Global Health Initiatives and debt relief. It is in response to these changes that the second generation CCS was developed to align with the new National Health Policy and the HSSP III, as well as the MTSP framework. In addition, lessons learnt from the first CCS have been taken into consideration.

The second CCS was developed through a consultative process led by the WHO Representative (WR). Teams comprising of WHO and Ministry of Health (MoH) officials were formed and led through a series of briefing about the CCS; the objectives, process and outcomes. There after, a standardized format with variations for the engagement of the different stakeholders was developed. Partners from the following groups were consulted: NGOs; bilateral health development organizations; UN agencies; academia; district health teams; ministries of education, finance, planning and economic development; the African Development Bank (AfDB) and World Bank; police and prisons. Two group sessions were held, one for health development partners which started the discussion on donor mapping,
and another with the MoH. The MoH session was attended by the Minister of Health, Director-General of Health Services and other senior officials. Following this, the WHO Country Office (WCO) conducted an internal evaluation of the first CCS to highlight achievements and challenges. A stakeholders meeting was held to review the first draft and solicit comments before finalization of the document.

WHO’s efforts will be directed at maximizing synergies and achieving complementarity with all stakeholders guided by this document in a dynamic manner. Thus the second CCS will provide general guidelines for WHO’s operations in Uganda in the medium term and will influence the work of the Organization at all levels.
SECTION 2

DEVELOPMENT CHALLENGES

2.1 POLITICAL CONTEXT

Over the past 10 years through a reform process Uganda has been decentralized politically and administratively from 45 to 82 districts. This has posed serious financial and human resource challenges.

2.2 SOCIOECONOMIC CONTEXT

The population is estimated at 28.2 million, with an average population growth rate of 3.4%. Total fertility rate is estimated at about 6.7 children per woman in 2006.\(^1\) Around 78% of the population live in the rural areas.

Per capita income is still low at US$ 270. Average inflation rate has been below 5%. Continued high population growth is undermining the gains achieved in the current economic growth of 5.5%, posing a challenge to the government as it strives to reduce poverty. The proportion of the population living below the poverty line declined from 38% in 2004 to 31% in the 2006.\(^2\) The conflict-affected north remains the poorest region, with 61% of the population living below the poverty line in 2005-2006.

2.3 HEALTH STATUS AND HEALTH SECTOR CHALLENGES

Status of Health

Although indicators remain unacceptably high, some improvements have been registered in the recent past as shown in Table 2.1.

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\(^1\) Uganda Demographic and Health Survey 2006, Kampala, Uganda Bureau of Statistics.

Table 2.1: Trends for the health-related outcomes in the Poverty Eradication Action Plan, 1990-2000

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<tr>
<td>IMR(deaths/1000 live births)</td>
<td>122</td>
<td>81</td>
<td>88</td>
<td>76</td>
<td>68</td>
<td>Reduce IMR by 2/3, i.e. to 41 deaths per 1000 live births</td>
</tr>
<tr>
<td>Under 5 MR (deaths/1000 live births)</td>
<td>180</td>
<td>147</td>
<td>152</td>
<td>137</td>
<td>103</td>
<td>Reduce U5MR by 2/3, i.e. to 60 per 1000 live births</td>
</tr>
<tr>
<td>MMR(deaths/100 000 live births)</td>
<td>527</td>
<td>506</td>
<td>505</td>
<td>435</td>
<td>354</td>
<td>Reduce by ¾, i.e. to 131 per 100 000 live births</td>
</tr>
<tr>
<td>Stunting (chronic malnutrition)</td>
<td>38</td>
<td>38</td>
<td>38.5</td>
<td>32.2</td>
<td>28</td>
<td>Reduce people suffering from hunger by ½, i.e. to 19%</td>
</tr>
<tr>
<td>Net primary enrolment ratio (% of relevant age group)</td>
<td>58 boys 48 girls</td>
<td>84 boys *58 girls</td>
<td>90 boys 89 girls</td>
<td>Net enrolment 100*</td>
<td></td>
<td></td>
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<tr>
<td>Primary completion rate (% of boys and girls)</td>
<td></td>
<td></td>
<td>38**</td>
<td>69</td>
<td></td>
<td>Net enrolment 100*</td>
</tr>
<tr>
<td>Access to safe water (% of pop.) **</td>
<td>45</td>
<td></td>
<td></td>
<td>87 Urban 64 rural</td>
<td>100* urban 90* rural</td>
<td>(90) integrate into gov. policies, reverse loss of environ-mental resources, halve proportion of people without access to safe water and sanitation</td>
</tr>
<tr>
<td>Access to improved sanitation **</td>
<td></td>
<td></td>
<td></td>
<td>65 Urban 56 rural</td>
<td>100* urban 80* rural</td>
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</tr>
</tbody>
</table>

* PEAP targets more ambitious than MDGs. **Data for 2005

Sources: 2004 PEAP, Demographic and Health Surveys, National Household Survey 2005/2006

Coverage of essential interventions remains low. The country achieved DPT3 coverage of 80%, but 49% of districts have coverage below 80%. The proportion of under-five children and pregnant women sleeping under insecticide-treated bednets (ITNs) is currently 9.7% and 10.1%, respectively, while intermittent preventive treatment coverage is only 16.6%, far below the Abuja target of 60%. Antenatal coverage (four visits) is 62%; the contraceptive prevalence rate has remained low at 24% with a variation of 43% in urban areas and 21% in rural areas. Unmet need for family planning increased from 34% to 41%. Indicators for TB case detection rate and treatment success rate are 49.6% and 73.2%, respectively, well below the WHO tuberculosis control targets. This is complicated by an HIV/AIDS co-infection rate of 50% among TB patients.

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1 HMIS, MoH, 2006.
3 Uganda Demographic Health Survey 2006, Kampala, Uganda Bureau of Statistics.
HIV prevalence is estimated at 6.4%, and comprehensive knowledge about HIV still remains low at 28% and 36% among women and men, respectively. PMTCT coverage stands at 29%. Accredited antiretroviral treatment sites increased from 48 in 2003 to 303 as of December 2007, providing ARVs to 121,218 (39% of people who need ARVs), of which 8.6% are children. The National Strategic Plan was formulated to guide a multisectoral response for the next 5 years, with the health sector as the core.

There are inequalities in access between rural and urban, different socioeconomic level and education level. This situation points to the fact that although Uganda may meet some of the MDGs at national level, this may not hold for some of the regions and population groups in the country.

**Disease Burden**

The burden of disease remains predominantly communicable diseases although there is also a growing burden of noncommunicable diseases. The Health Management Information System (HMIS) 2006 demonstrates an increasing burden of NCDs, including mental disorders accounting for 1.38% of total outpatient contacts. Neglected tropical diseases (NTDs) remain a major problem in the country, endemic in many districts, and particularly affecting the rural poor communities.

### 2.4 DEVELOPMENT CHALLENGES

**Health Sector Strategic Plan**

Uganda is currently implementing the second Health Sector Strategic Plan (HSSP II 2005-2006 and 2009-2010), which states that “the primary purpose of the National Health System is to attain a good standard of health by all people in Uganda, in order to promote a healthy and productive life and reduce morbidity and mortality from the major causes of ill-health and premature death, and reduced disparities therein.” The Ugandan National Minimum Health Care Package (UNMHCP) is the vehicle for delivering this strategy.

In response to HSSP I, the second CCS contains five principal strategic areas: health sector policy analysis, institutional development and partnerships; health systems development; combating communicable and noncommunicable diseases; reproductive, child and adolescent health; and environment and healthy lifestyles. The majority of activities within the plan of action were in line with the first CCS, but this did not preclude additional activities outside the plan, originating from the Organization and at country level. However, the areas of work increased from 18 in 2002/03 to 24 in 2004/05. In its operationalization, several achievements were realized but a number of challenges are still relevant. These are listed below.

**Balancing the Levels of Work**

There was a need for a balance between the work of policy and strategic development as opposed to catalytic work which is demanded mostly for routine implementation. WCO capacity to provide support

The capacity of WCO to fully support the sector through the first CCS was constrained by human and financial resources. Available human resources were unequally distributed among the various areas of work; whereas for financial resources, budgetary realization was

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the main challenge. Promised funding for some areas of work was not received, leading to underfunding, reprogramming and cancelling of some activities.

Organization, Management and Delivery of Health Services

Further decentralization within the health sector led to the creation of the health subdistrict (HSD) as an integral part of the district health system. Roles and responsibilities of the different levels were defined. A critical challenge is the weak capacity in planning, management and human resource development at the decentralized levels. While the central MoH has made guidelines and service standards available to district officials, enforcement remains a challenge as district health workers are primarily accountable to district authorities. Health service delivery is based on a five-tier system including national, regional and general hospitals as well as various categories of health centres. The package of services to be delivered at each level of care and referral mechanisms are clearly defined. Effective integration of service delivery remains a challenge and will require configuration of planning guidelines and harmonization of availability of inputs. Village health teams (VHTs) were put in place to bring community-based interventions to the grassroots level. However, to date only 30% of these have been trained.

Health Financing

The health financing sector is underfunded to meet the increasing level of health services demanded by the increasing population, cost of new technologies and number of districts. Expenditures on health as a percentage of total government expenditure has remained below 10% for the last six financial years (FY), far below the Abuja target of 15%. In the FY 2006-2007 the Government of Uganda (including donor budget support) contributed 33% (US$ 5 per capita) while donor projects and Global Health Initiatives contributed 67% (US$ 10 per capita). This level of funding is inadequate to meet the cost of the minimum package of services estimated at US$ 38 per capita.

In as much as the health sector needs additional resources, there are a number of issues that need to be addressed. Firstly, there is need for putting in place measures for better efficiency in resource utilization. Secondly, there is need for obtaining from the Ministry of Finance, Planning and Economic Development (MoFPED), greater clarity about additionality and budget ceilings that may limit the capacity of the sector to absorb additional resources. Thirdly, while acknowledging that donor projects and Global Health Initiatives do make a significant contribution to health sector funding, alignment of these funds to sector priorities needs to be ensured. To raise additional funding for the sector, plans are well underway to establish a health insurance scheme. Concerns to be addressed include taking care of the poor and ensuring that additional resources from social health insurance do not translate into a decrease in GOU allocation to health.

Human Resources

The number of qualified health workers is still inadequate for effective service delivery. In addition, there is unequal distribution of health workers between and within districts as well as an inappropriate skills-mix. Health worker remuneration is generally poor, leading to poor retention and demotivation, while attracting and retaining qualified staff are challenges in remote districts with difficult living conditions.

All health training schools are under the Ministry of Education and Sports (MOES). Although this is desirable, there is need for clarification and better understanding of roles and responsibilities of both health and education sectors for better management of training
schools and programmes. The preservice training curricula are outdated in some aspects and require continuous and systematic updating.

Technical assistance, which at the moment is provided in an uncoordinated manner, needs to be pooled and harmonized to strengthen human resources development. Although substantial funding to the sector is realized from donor projects, only 5% is spent on human resources for health. A human resources policy and strategy are now in place and if well implemented will address some of these issues.

**Medicines and Health Technologies**

Essential medicine requirements to enable provision of the UNMHC have been estimated at US$ 3.8 per capita. When ARVs, pentavalent vaccine and ACT are included, cost per capita increases to US$ 8. Current level of funding is inadequate; for the FY 2006/07, government funding for essential medicines was estimated at US$ 1.7 per capita. Funding from Global Health Initiatives for large cost items (pentavalent vaccine, ACT and ARVs) contributed US$ 2.3 per capita. Current levels of drug stock out are at 35%. Additional challenges include uncoordinated procurement of medicines and supplies by different partners, inadequate capacity in the Ministry of Health to provide proper oversight, weak supply chain management and under resourced capacity of the National Medical Stores. Inadequate capacity at the National Drug Regulatory Authority (NDA) for quality control analysis of medicines has resulted in undue delays in the release of supplies.

Current provision of blood transfusion and diagnostic services is not in tandem with aspirations of HSSPII due to various health system constraints.

**Information for Health Planning and Management**

Indicators and data requirements have been agreed and tools for data collection developed. Although timeliness and completeness of HMIS has improved greatly in the past, the quality of the data needs to be improved. Data analysis and utilization remain very weak at all levels in the system and feedback mechanisms from higher to lower levels need to be strengthened. Reporting on certain disease conditions such as noncommunicable diseases (NCDs), neglected diseases, injuries and disabilities needs to be improved.

In the past five years, Uganda has been implementing the Integrated Disease Surveillance and Response system (IDSR). Capacity assessment during outbreaks reveals differences ranging from inadequate health worker management skills to lack of laboratory logistics and ill-equipped district rapid response teams. Funding for epidemics and other emergency response is not prioritized in the sector budget.

Knowledge management has become very important in the recent past. Although a lot of research has been undertaken, the current weak capacity for coordination has hampered proper identification of research priorities, dissemination of results and getting research into the policy agenda. Systems for documentation, dissemination and utilization of good practices need to be developed.

**Determinants of Health and Intersectoral Collaboration**

Inadequate structures and mechanisms to foster coordination and collaboration particularly at the central level in the areas of agriculture, education, gender, water and sanitation have limited the extent to which the health sector can engage other sectors, which may have a direct or indirect impact on health outcomes. Gender and right-to-health perspectives are yet to be fully mainstreamed into sector policies and programmes.
In spite of the increasing burden and concern about diseases of lifestyle, there is a dearth of information as to the magnitude of the risk factors such as physical inactivity, undue stress, smoking and diet that predispose to noncommunicable diseases. Health promotion programmes are yet to incorporate a lifestyle approach.

**Private Public Partnership for Health (PPPH)**

The private sector, including private not-for-profit providers (PNFPs), accounts for approximately 60% of services. A policy exists for collaboration with the PNFP facility-based subsector, and subventions have been provided to this subsector for the last 9 years. Implementation of the policy poses serious challenges both at the central and district levels. Difficulties still persist in the harmonization of incentives for health workers between GOU and PNFP facilities which has led to staff mobility from PNFPs to the public sector.

**Humanitarian Action in Crisis**

Conflict in northern Uganda over the past 19 years has led to a humanitarian crisis with about 1.6 million people living in internally displaced populations (IDP) camps in five districts. The insurgency has abated significantly as peace talks progress. While a large number of people still reside in the camps, some IDPs have moved to transitional or permanent settlements, and this has stretched current capacity for humanitarian response. As the disarmament process continues in Karamoja, there are possibilities that the degree of insecurity will escalate, requiring further humanitarian assistance.

**Conclusion**

The WHO Country Office will be reprofiled to fulfil the current CCS strategic agenda. Attempts will be made to ensure comprehensive and rational planning, greater maximization of Global Health Initiatives and resource mobilization at country level. Through these efforts, WCO through the CCS, will be better placed to support the sector to address these systemic challenges which are still relevant yet required for better health outcomes.
SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS: AID FLOW, INSTRUMENTS AND COORDINATION

3.1 OVERALL TRENDS IN DEVELOPMENT ASSISTANCE

Uganda’s development strategies are articulated in the Poverty Eradication Action Plan (PEAP) 2004/05-2008/09. The MDGs have been fully mainstreamed within the PEAP, making it the overall guiding framework for investment. Volume 3 of the PEAP (2003) “Building partnership to implement the PEAP,” spells out the partnership principles, and is designed to guide development partner behaviour and support. The principles outline the modalities for support with preference for budget support as the mechanism to increase the effectiveness of development assistance. Presently, the modalities for development assistance include central budget support and project support.

Uganda receives high levels of inflows of development assistance amounting to approximately 12% of the gross domestic product (GDP) and about 50% of the government budget. In addition to bilateral and multilateral development assistance, Uganda receives funds from Global Health Initiatives such as the GFATM and GAVI, funds for humanitarian assistance through the Consolidated Appeal Process and other mechanisms. The expansion of government expenditure has not matched domestic revenues, and the fiscal deficit stands at 7.2% of GDP in FY2005-2006. A central objective of the government’s macroeconomic strategy is to reduce the overall fiscal deficit to 6.5% by 2013-2014 by restraining growth in government expenditures while raising domestic revenues.

Uganda signed the Rome and Paris declarations to improve the effectiveness of development assistance and has provided baseline indicators to enable monitoring of progress. Several development partners, including the AfDB, Austria, DfID, Germany, Netherlands, Norway, Swedish International Development Agency and the World Bank, have committed to the Uganda Joint Assistance Strategy which was finalized in December 2005. The Strategy commits to aligning support to the PEAP as well as use of government systems and processes. It also presents a common assessment framework for determining levels of finance to improve predictability of aid.

3.2 SECTORWIDE APPROACH FOR HEALTH DEVELOPMENT

The MoH and its development partners in the sector agreed to the implementation of a common programme of work through a sectorwide approach (SWAp). Within a SWAp arrangement, individual attribution is not possible except for a few donor projects. The HSSPII 2005/06–2009/10 was launched in October 2005 and the MoU for its implementation, to

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*The PEAP is updated every three years; this is the third edition of the PEAP.*
which WHO is a signatory, was signed by 22 development agencies in May 2006. The key agencies supporting health are the AfDB, Austrian Agency for International Development, Belgian Cooperation, DANIDA, DfID, the EU, FAO, French Cooperation, GTZ, Ireland Aid, Italian Cooperation, JICA, Netherlands Cooperation, NORAD, SIDA, USAID, UNDP, UNICEF, UNFPA, UNHCR, World Bank and WHO.

In addition to defining the objectives of the SWAp, the MoU lays out shared obligations, modalities and structures for cooperation among the partners and procedures for amendment or termination of the MoU itself. The MoU dictates that all resources available for health be applied within the framework of the HSSP II and in accordance with the priorities set therein. The MoU is monitored to assess the level of compliance by the different partners.

Efforts have been made in the past to channel most of the funding through budget support. The majority of partners opted for budget support although some still run projects which thus makes it difficult to enumerate total funding by donors. The sector registered a reducing trend in project funding as a percentage of overall sector budget from approximately 50% to 42% between 1999 and 2003, although this has been disrupted by incoming global initiatives such as GAVI, PEPFAR and GFATM. MoFPED introduced output-oriented budgeting in order to improve accountability and performance for the different sectors, and the same concept has been adopted at the sector level.

3.3 MECHANISMS FOR COORDINATION

At the health sector level, there are several structures working on different issues. The Health Policy Advisory Committee, composed of GoU, development partners and civil society, advises on sector policy, programme planning and monitoring performance. The Sector Budget Working Group advises on resource allocation, budgeting, initiation and renewal of sector projects. The scope of work and membership of these structures are being expanded to handle governance issues of GHIs such as the GFATM through the already-articulated long-term institutional arrangement. Development partners working in the health sector formed the Health Development Partners group in order to provide a more formal forum for coordination, reduce transaction costs and strengthen partnership with the GoU. In addition, Inter-agency Coordination Committees comprising of GoU and the developing partners coordinate inputs and monitor performance of specific programmes.

Joint review missions are undertaken by all stakeholders twice a year. The April/May review is a technical review meeting which addresses performance of key programme areas while the October/November review receives the report on health sector performance for the completed FY and the annual sector plan; the review also considers budget priorities for the following FY. A national health assembly is held once a year to canvass the support of district leaders and policy-makers at the national and district levels towards improved delivery of health services and accountability. There are technical working groups tasked to work throughout the year, focusing on programme implementation, actions and undertakings agreed upon in the joint review mission.

3.4 COORDINATION OF HUMANITARIAN RESPONSE

Within the international humanitarian community, the Inter-Agency Standing Committee country team, which comprises the heads of key UN and non-UN humanitarian partners, is the primary mechanism for inter-agency coordination, policy development and decision-making on humanitarian assistance.
3.5 UNITED NATIONS COUNTRY TEAM

The United Nations, the Common Country Assessment and the UNDAF present a concerted effort to harmonize the UN’s programme of work and align to national programmes. The UN plays a key role in the monitoring of MDGs, and ensuring appropriate response to humanitarian emergencies.

3.6 CHALLENGES AND OPPORTUNITIES

Although the country is generally implementing policies and strategies that should foster good performance and economic growth, inefficiencies in the system have resulted to resource wastage. The absorption capacity remains low due to system-wide weaknesses, especially at decentralized levels. Lack of local markets to supply prequalified health commodities and medical equipment, parallel and bureaucratic procedures impact on the timely availability of these commodities. Accountability practices that emphasize financial accountability but exclude technical audit to ascertain achievement of objectives have resulted in funds not reaching intended beneficiaries. Inadequate mechanisms of ensuring sustainability of development partner funded projects may lead to the reversal of recorded achievements.

The government’s emphasis on maintaining macroeconomic stability as opposed to spending in social sectors has frustrated efforts to increase fiscal space within the Medium Term Expenditure Framework (MTEF) and subsequently has increased allocation to the health sector. Development partner conditionalities, earmarking, inadequate coordination of development assistance inflows and weak stewardship by the MoH undermine the effectiveness of development assistance. Inadequate prioritization in the sector results in underfunding of critical aspects of the health sector programme.

Consultation also revealed that there are a number of partners working in different areas within the health sector. Analysis reveals the following deficiencies of partner involvement in supporting the sector: incomprehensiveness, piecemeal approach, omissions where some areas were neglected, limited coverage based on pilots or geographic preferences, and short-term interventions. In facing these challenges, partners requested WHO to focus on the following: leadership role as a technical agency and in knowledge management, health systems strengthening, supporting priority programmes and strengthening partnerships, including donor coordination and fostering intersectoral collaboration.

Development partners’ commitment to making aid more effective as stipulated in the Paris Declaration and SWAp structures should be exploited. The WCO has the challenge of living up to partner and government expectations, which calls for realization of additional resources, and availability of competent staff to respond to requests in a timely manner.
WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been and is still undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and the achievement of the health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy.  

4.1 GOAL AND MISSION

The mission of WHO remains “the attainment by all peoples, of the highest possible level of health” (Article 1 of WHO Constitution). The corporate strategy, the Eleventh General Programme of Work 2006-2015\(^\text{10}\) and the document \textit{Strategic orientations for WHO action in the African Region 2005-2009}\(^\text{11}\) outline key features through which WHO intends to make the greatest possible contributions to health. The Organization aims at strengthening its technical and policy leadership in health matters as well as its management capacity to address the needs of Member States, including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage,\(^\text{12}\) these are:

(a) Providing leadership in matters critical to health and engaging in partnership where joint action is needed;
(b) Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
(c) Setting norms and standards, and promoting and monitoring their implementation; Articulating ethical and evidence-based policy options;
(d) Providing technical support, catalysing change, and building sustainable institutional capacity;
(e) Monitoring the health situation and assessing health trends.

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\(^9\) WHO EB105/3, A Corporate Strategy for the WHO Secretariat.
4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas; these include: Investing in health to reduce poverty; Building individual and global health security; Promoting universal coverage, gender equality and health-related human rights; Tackling the determinants of health; Strengthening health systems and equitable access; Harnessing knowledge, science and technology; Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda focusing on health development, health security, health systems, evidence for strategies, partnerships and improving the performance of WHO. In addition, the success of the Organization shall be measured in terms of results in women’s health and the health of African people.

4.4 GLOBAL PRIORITY AREAS

Global priority areas have been outlined in the Eleventh General Programme of Work. They include:

(a) Providing support to countries in moving to universal coverage with effective public health interventions;
(b) Strengthening global health security;
(c) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
(d) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
(e) Strengthening WHO leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities have taken into account the global documents and resolutions of WHO governing bodies, the health Millennium Development Goals and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational strategic objectives which are outlined in the Medium Term Strategic Plan (MTSP) 2008-2013. These regional priorities have been expressed in Strategic orientations for WHO action in the African Region 2005-2009. They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy-making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructure.

In addition to the priorities mentioned above, the Region is committed to supporting countries to attain the health MDGs, and assisting in tackling the human resource challenges. In collaboration with other agencies, assisting countries to source financing for their national

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goals will be done with the leadership of countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and the installation of Intercountry Support Teams to further support countries in their own decentralization process so that communities may benefit maximally from the technical support availed to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

(a) Strengthening the WHO Country Offices;
(b) Improving and expanding partnerships for health;
(c) Supporting the planning and management of district health systems;
(d) Promoting the scaling up of essential health interventions related to priority health problems;
(e) Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the WHO corporate strategy at country level will vary from country to country depending on country-specific contexts and health challenges. By building on the WHO mandate and its comparative advantage, the six core functions of the Organization, as outlined in Section 4.2, may be adjusted to suit individual country needs.
SECTION 5

CURRENT WHO COOPERATION

As the strategic agenda is developed, there are a number of principles and lessons learnt to provide guidance in the process. These reveal the changing landscape of WHO cooperation in Uganda.

Firstly, the first CCS was instructional about the need to focus on a number of key priorities and deliverables with predictable funding in order to make an impact and have a balance in engagement between upstream and downstream work. This was also clearly presented as an expectation by partners for WHO to enable the generation of evidence to back up policy guidance for action.

Secondly, harmonization and alignment to national systems is very crucial if national capacity and institutions of the health sector are to be strengthened and above all for improving aid effectiveness. In a sector with so many actors, with a growing threat of a return to projects, there is the potential risk of a fracture of the health system if coordination is weak. WHO will need to position itself within the health partnership to ensure adherence to the harmonization and alignment principles. WHO’s negotiating and brokering skills will be critical. In recent times, never has the health agenda received such high visibility with an unprecedented flow of resources. In this light, countries are now expected to provide universal coverage for key priority diseases such as malaria and to improve performance and efficiency. WHO’s role will be crucial in strengthening national capacity for data management and improved data quality.

Thirdly, the vicious cycle between poverty and health is well known and well documented in Uganda. Achieving universal coverage for most of the key interventions that can affect health outcomes will need innovative strategies for service delivery at the community level. WHO’s role to support the country to refocus on Primary Health Care principles will be important.

Fourthly, the release of the Uganda Demographic and Health Survey data is timely. Health status indicators though showing a slight improvement are still very poor. Evidence reveals that improvement of health outcomes depends on a range of interventions beyond the control of the Ministry of Health, hence, calling for greater intersectoral collaboration. WHO will need to play an increasingly influential role on other sectors such as education beyond the traditional health sector. Positioning itself to influence the Ministry of Finance, Planning and Economic Development to increase health sector resources will also be critical in light of macroeconomic policies which impact on budget ceilings.

It is expected that during the implementation of the second CCS, peace will return to the troubled north and affected districts. The Peace Recovery and Development Plan which covers 40 districts, and to which WHO has contributed, will require from WHO additional skills in health systems strengthening and capacity building. Because of the weak capacity of these districts, WCO field offices will be maintained in view of the need for WCO presence.
The main objective of the strategic agenda is to ensure that all energies, efforts and investments are pooled together to improve health outcomes. Focusing on health outcomes will help to better assess achievements against the expected targets of the HSSP II and MDGs for Uganda. In addressing these principles, WCO is well placed with its role as permanent secretariat for health development partners. Among the roles of WCO is briefing partners and ensuring that interventions are oriented towards HSSP II. Secondly, the WCO ensures that government lives up to its responsibilities and performs its stewardship and accountability roles.

The MTSP has provided thirteen (13) Strategic objectives (SOs) to guide WCO’s work at country level. Through the second CCS, the WCO will examine all SOs to select those that will impact most at country level. The WCO will take advantage of the keen interest in international health and development for scaling up and reaching universal access for key programmes such as HIV/AIDS, tuberculosis and malaria. In addition, global efforts to address system-wide challenges such as the Global Health Initiatives work and alliances which are in line with the SOs will be harnessed. Regional efforts which contribute and are in line with SOs will also be facilitated. The SOs also provide an excellent opportunity for integration of activities and clustering of programmes so as to maximize linkages and harmonization between programmes, thereby minimizing duplication. To ensure this, WCO will be organized into five (5) clusters (including administration and support services), each with a cluster coordinator and secretary.

In as much as WCO will be strengthened and reprofiled to meet the new direction of the current CCS, it will be impossible to put in place all the required capacity to support the country. There will be need to link closely with the Intercountry Support Team, the WHO Regional Office for Africa and WHO headquarters. Efforts will be made to ensure that the Organization works as one. The one WHO planning approach will be adopted in consultation with all levels of the Organization to ensure that the support required from the IST, Regional Office and headquarters over the biennium is reflected within the workplan.
In line with the Paris Declaration, the Accra Agenda of Action and WHO’s commitment to IHP+ principles, the Country Strategic Agenda is aligned with the health priorities of the Uganda National Development Plan 2009/2010–2013/2014. These strategic directions, which also fall within the three WHO organization-wide strategic domains, are shown in Table 6.1.


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<td>2. Promote inter-sectoral collaboration</td>
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6.1 Promote health and prevent disease

*Promote health and prevent disease*

WHO will support the MoH to:

(a) Develop comprehensive advocacy packages to increase community awareness, promote physical activities and encourage healthy diets towards prevention of diseases; strengthen institutional capacity to develop health promotion programmes and implementation of appropriate interventions;
(b) Provide technical support on application of methods such as behaviour change communication, health education, social mobilization, and advocacy in health programmes;
(c) Promote partnerships with the media, civil society, city councils, and the private sector in the implementation of health promotion activities;
(d) Support priority health programmes to empower individuals, families and communities to participate in disease prevention and demand quality health services.

**Tackle Social Determinants of Health**

WHO will:

(a) Document underlying socioeconomic determinants of health, raise awareness and stimulate appropriate intersectoral action;
(b) Coordinate actions aimed at addressing the broad determinants of health that influence health and well-being.

### 6.2 FOCUS ON PROGRAMMES OF NATIONAL INTEREST

**Scale up Priority Programmes for Improved Health Outcomes**

WHO will support the MoH and partners to develop a practical approach to scaling up a number of key and effective interventions to accelerate attainment of the MDGs with costed plans such as the Road Map for Maternal, Child and Newborn health and the Child Survival Strategy using the life course approach.

In this regard, WHO will support the following:

(a) Adoption of the relevant global and regional policies, strategies and guidelines for key priority programmes to local conditions;
(b) Subjecting of selected strategies and interventions to a rights-based approach and gender analysis so that they are responsive to the special needs of vulnerable groups and gender perspectives;
(c) Integration of delivery strategies for key interventions in both public and private institutions and at the community level based on the VHT model (PHC) approach;
(d) Development of a framework for scaling up key interventions, including required institutional capacity, inputs and cost implications;
(e) A monitoring and evaluation framework to provide analytical and disaggregated reports that demonstrate progress towards the MDGs and other internationally-agreed development goals by geographic location, socioeconomic groups, sex and age.

**Enhance Capacity for the Prevention and Control of Major Communicable and Noncommunicable Diseases**

The expansion of key interventions and support systems of the following programmes in both the public and private sectors will be essential for improved health outcomes.

**Malaria**

Integrated approach to malaria control focusing on case management, including home-based management of malaria and strengthening diagnostics; integrated vector control,
particularly IRS and ITNs; intermittent preventive treatment for malaria in pregnant women; and early epidemic detection and response.

**HIV/AIDS**

(a) Capacity building and institutional strengthening for the implementation of national strategies and actions for prevention, care and treatment services;

(b) HIV counselling and testing, prevention of mother-to-child HIV transmission, prevention of HIV transmission in healthcare settings, prevention and control of sexually transmitted infections and provision of medical male circumcision;

(c) Access to ART services for adults and children, with a particular focus on integration with TB, sexual and reproductive health, and child and adolescent health services;

(d) Monitoring the AIDS epidemic and drug resistance;

(e) Access to home-based care at community level.

**Tuberculosis**

(a) Strengthening laboratory capacity for quality microscopy, culture and drug sensitivity testing;

(b) Consolidation of community-based DOTS and engaging the private sector through expansion of public-private mix DOTS;

(c) Strengthening capacity for integrated TB in HIV care;

(d) Monitoring of drug resistance (multidrug-resistant and extensively drug-resistant) to TB drugs and ensuring access to second-line TB drugs;

Strengthening partnerships will be the key in attaining the above. WHO will therefore continue to support the Uganda Stop TB Partnership with advocacy, coordination and resource mobilization.

**Neglected Tropical Diseases**

The WHO will:

(a) Strengthen partnerships to increase access to integrated services that will enable attainment of NTD control, elimination, and eradication goals;

(b) Develop a comprehensive advocacy package to increase awareness and profiles of NTDs;

(c) Provide surveillance and monitor progress towards attainment of control, elimination and eradication goals.

**Noncommunicable Diseases**

The WHO will:

(a) Support MoH capacity to strengthen, harmonize and expand current integrated disease surveillance systems to include noncommunicable diseases;

(b) Work with MoH, the media, civil society, city councils, and the private sector in the implementation of a comprehensive health promotion package, policies and strategies for NCDs control, with a focus on control of tobacco and substance abuse, mental health and neurological disorders, cancers, diabetes and heart diseases;
(c) Promote physical activity and diet as a basis to address the key risk factors of noncommunicable diseases.

**Strengthen Reproductive Health and Child Survival**

*Sexual and reproductive health*

The WHO will work with the MoH to:

(a) Strengthen institutional capacity to deliver focused (GOAL) antenatal clinic and emergency obstetric care services;
(b) Support the implementation of the road map for reduction of maternal, newborn and child morbidity and mortality;
(c) Provide tools, norms and standards for scaling up family planning services.

**Child and Adolescent Health**

The WHO will:

(a) Support implementation of the Child Survival Strategy;
(b) Set service standards and strengthen systems for systematic monitoring and improvement in the quality of care for maternal and child health services at all levels;
(c) Operationalize school health policy for delivery of a defined package of health services to school-going children; Mainstream Adolescent Friendly Health Services into routine service delivery;
(d) Promote a comprehensive package that addresses tobacco, alcohol and substance abuse, risky sexual behaviour, injury prevention and safety among adolescents.

### 6.3 STRENGTHEN HEALTH SYSTEMS

**Strengthen Health Systems, Including Management of Medicines and Technologies**

Based on past experiences, WHO will focus on the following areas.

**Organization and Management of Health Services**

The WHO will work with the MoH and the Ministry of Local Government to:

(a) Support the strengthening of the health subdistricts, including capacity-building and institutional strengthening;
(b) Strengthen district capacity and influence the prioritization and allocation of resources controlled by the District authorities;
(c) Support strengthening of hospitals for better service delivery;
(d) Support mechanisms to organize integrated services;
(e) Strengthen the village health teams (VHT) programme.
Health Financing

The WHO will:

(a) Engage the MoFED for increased investment in health with clarity on additionality;
(b) Support the budgeting and planning process ensure equitable resource allocation and harmonization and alignment of donor projects and GHI into the planning and budgeting process within the MTEF in line with the Paris Declaration;
(c) Strengthen health financing performance assessment and utilization of information to guide policy and development of strategies;
(d) Build capacity of MoH to undertake routine efficiency monitoring and value for money studies;
(e) Support the development of a benefit package, accreditation system and a monitoring and evaluation system for the health insurance scheme.

Develop Human Resources for Health

The WHO will:

(a) Support the monitoring of trends of HR development, particularly in relation to the human resource needs for attainment of the MDGs;
(b) Support approaches to improve the performance and utilization of the workforce;
(c) Facilitate establishment of an inservice training management information system to track all inservice training and introduction of integrated in-service training modules;
(d) Support capacity-building in prioritized areas as identified in the human resource development plan;
(e) Work with the ministries of health and education as well as professional associations in updating curriculum and the management of health training institutions;
(f) Support innovative approaches for HR organization and placement for better service delivery by the private sector; with set norms and standards to complement the public sector.

Strengthen the Management of Medicines and Health Technologies

The WHO will:

(a) Support regular updates of national medicines policy, essential medicines lists and clinical guidelines to respond to changing environments;
(b) Support promotion of transparency of medicines pricing through provision of information;
(c) Support the implementation of the Roadmap for the procurement and supply chain management of medicines and other health supplies;
(d) Strengthen the capacity of national drug authorities to handle pharmacovigilance and vaccine regulation;
(e) Support the sector to develop policies and strategies for the safe and efficacious use of traditional medicines;
(f) Strengthen blood transfusion services;
(g) Support strengthening of laboratory and diagnostic services.
6.4 STRENGTHEN INFORMATION FOR HEALTH PLANNING AND MANAGEMENT FOR IMPROVED HEALTH OUTCOMES

Health Management Information Systems

The WHO will:

(a) Increase institutional and capacity building for improvement and management of the revised Health Management Information System;
(b) Within the Health Metrics Network framework, strengthen other health-related data sources;
(c) Support the strengthening of national, district and subdistrict health capacity for analysis and use of HMIS data for planning and management purposes;
(d) Support implementation of the sector statistical Strategic Plan.

Integrated Disease Surveillance and Response

The WHO will:

(a) Support capacity-building and operationalization of the International Health Regulations;
(b) Support MoH capacity to strengthen and harmonize current integrated disease surveillance systems;
(c) Strengthen preparedness and response capacity at national and district levels to epidemics, new and emerging disease outbreaks such as avian influenza, severe acute respiratory syndrome and ebola in a timely manner;
(d) Support the MoH to undertake capacity assessment at district and national levels to provide an indication of the gaps that should be addressed to enhance emergency preparedness;
(e) Support institutional strengthening and capacity-building (guidelines, tools and supervision system) for scaling up the community-based surveillance system;
(f) Support the revision of the 5-year IDSR plan to incorporate the new International Health Regulations (2005).

Knowledge Management and Research

The WHO will:

(a) Support documentation and advocate for inclusion into routine services best practices in health that have been subjected to technical and cost effective analysis;
(b) Support capacity-building and institutional-strengthening of the MoH to develop systems for knowledge management in its various forms;
(c) Engage all health partners, including NGOs, on a regular basis through policy dialogue and technical briefings on critical and emerging health issues;
(d) Strengthen the institutional framework of Uganda National Health Research Organization (UNHRO) and its capacity to coordinate research activities within its purview;
(e) Assist UNHRO to institute a network of researchers and research organizations and in particular linking it to WHO collaborating centers in the African Region;
(f) Support UNHRO to develop a mechanism that will bring together policy-makers, researchers and programme managers to develop a research agenda and disseminate results in order to get research results into the policy agenda;
(g) Support key operational research and WHO collaborating centres within Uganda.

Emergency Preparedness and Response
The WHO will:
(a) Strengthen preparedness and response capacity at national and district levels to emergencies, including epidemic outbreaks, natural and man-made disasters in a timely manner;
(b) Support the MoH to undertake capacity assessment at district and national levels to provide an indication of the gaps that should be addressed to enhance emergency preparedness;
(c) Support institutional strengthening and capacity-building for implementation of the health component of the Peace, Recovery and Development Plan and the Karamoja Integrated Disarmament and Development Plan.

6.5 PROMOTE PARTNERSHIPS

Partnerships for Better Coordination and Synergy for Improved Health Outcomes
Given the scope and potentials of partnerships for health, WHO will contribute to:
(a) Support the implementation of the IHP+ process for better alignment of partners to national priorities;
(b) Strengthen MoH capacity to better utilize technical assistance by facilitating TA mapping, needs assessments and evaluation;
(c) Ensure that UN contributions to health development, through the UNDAF, are in line with the sector strategic plan, and, where practical, engage in joint planning based on comparative advantage;
(d) Work with the MoH and Ministry of Local Government to strengthen public and private partnerships;
(e) Support implementation of the Peace Recovery and Development Plan through a health systems strengthening approach;
(f) Support and promote, where possible, PHC principles for implementation of community-based interventions that will lead to increased access and availability of services;
(g) Promote active participation of communities to ensure that the health system is responsive to national and various local priorities.
Intersectoral Collaboration for Improved Health Outcomes

The WHO will:

(a) Review and strengthen a mechanism for intersectoral collaboration with health-related sectors such as agriculture, education, gender, and water and sanitation;
(b) Work with the Ministry of Agriculture to support development and monitoring of food and nutrition policies, particularly in setting up norms and standards with a special focus on the *CODEX Alimentarius*;
(c) Work with environment, water and sanitation stakeholders to promote and model healthy settings initiatives;
(d) Ensure mainstreaming of gender and right-to-health perspectives in health sector policies and programmes.
The strategic agenda for second CCS will be implemented through the biennial workplans and will have financial and human implications at all levels of the Organization. Implementation of the strategic agenda will ensure participation of communities and all relevant stakeholders, nondiscrimination, accountability, transparency, equity in access especially for the vulnerable groups.

7.1 COUNTRY OFFICE

The new aid architecture has presented WHO with opportunities to manage the re-invigorated partnerships between countries and donors. It is in this light that health development partners have requested WHO to assume the position of permanent secretariat to the partnership.

To enable WHO to take these actions, the current capacity of the WCO will be strengthened to meet these challenges. The required technical and administrative support staff and logistics will be provided in collaboration with key development partners to enable WHO to bring together its technical capacity to ensure that health development partners are better informed and equipped to play their crucial role in health development.

7.2 HUMAN RESOURCE IMPLICATIONS

In fulfilling the strategic agenda, certain staff adjustments will be undertaken. Firstly, there will be the need for a modest increase of staff. In health systems, there is need for one additional staff to address issues of partnerships, resource mobilization and rights-based approaches to health. Also, at least one additional staff will be needed to strengthen the maternal and child health programme.

Secondly, functions of the disease prevention and control officer (DPC) will be redefined in line with Regional Office guidance to redeploy some of the functions to other programme officers and enable DPC to undertake proper oversight and coordination of specific programmes and Global Fund related issues. In the same vein, functions of other professional officers need to be redefined and reprofiled. The current staffing level for humanitarian action will be reviewed in light of the evolving changes in the north, the PRDP, Karamoja situation, KIDDP and within the existing surveillance, disease response and health systems strengthening mechanisms. At the minimum, there will be a core team that will be able to start up a relief response. To strengthen monitoring and evaluation, capacity of professional staff will be built and the functions of the data manager will be broadened to include programme monitoring and evaluation.

Thirdly, there will also be a need for additional support through short-term contracts and agreements to perform work. In addition, the complement of secretarial support staff will be reviewed in order to ensure that there is a good balance between technical staff and support staff.
7.3 FINANCIAL IMPLICATIONS

Adequate funding will be critical for implementation of the strategic agenda within the country to improve health outcomes. Implementing the strategic agenda will require a substantial increase in both the regular and extrabudgetary funds. Extrabudgetary funds will be sourced at global, regional and local levels. The WCO has experience in mobilizing resources locally and will build on this in the second CCS.

7.4 INSTITUTIONAL STRENGTHENING AND CAPACITY BUILDING

In preparation for the general management system, there will be the need to upgrade information technology equipment according to the required specifications. Relevant capacity will be built to manage and utilize the system.

The conference room is large enough to service sizeable meetings. In this regard the room will be equipped with a public announcement system and microphones. It will be important to ensure the maintenance of the global private network and video conferencing facilities. The library services will be strengthened with additional workstations, and electronic library facilities will be installed. In view of these expanded operations, there will be need to ensure continued functioning of the office, replacement of equipment and transport fleet.

Staff capacity-building will be undertaken for all categories of staff in areas of identified need. Provisions will be made for professional staff to undertake short courses and participate in international seminars and meetings relevant to their discipline.

7.5 RESPONSIBILITIES

Country Office

The Country Office will be responsible for implementing the second CCS through the biennial workplans. In so doing, the Country Office will respect the corporate culture of the Organization and link individual staff performance to the results of the Organization. Efforts will be made to balance upstream and downstream work to respond to MoH and partner expectation. Guidelines developed at the global level will be adapted to suit country contexts, and timely transfer of matters of public health will be undertaken. Partner coordination will be strengthened, and partner strengths will be harnessed in implementing HSSP III and response to emergencies. To support the implementation of the PRDP, the field offices will be maintained with a minimum core staff. Resource mobilization at country level will be continued.

Regional Office including Intercountry Support Team

Technical support will be sought from the Regional Office when required. During the planning process, the Regional Office and HQ will be consulted to ensure one WHO country workplan. In addition, country plans will be harmonized with Intercountry Support Team workplans to enable rapid and timely access to such technical support. It is expected that the Regional Office will support resource mobilization for countries and provide strategic information about possible opportunities to aid resource mobilization. Furthermore, the Regional Office will support networking with other regions for inter-regional exchange of best practices, ensure the timely transfer of information on matters of public health and organize technical assistance where this cannot be provided in the Region. The Regional Office will also monitor implementation of the regional agenda.
**Headquarters**

HQ will develop global guidelines and support networking, particularly with the Global Health Initiative. Where the Regional Office is not in a position to provide technical assistance, support will be sourced from HQ. HQ will support the country to mobilize resources to implement the second CCS and will also provide information and intelligence on strategic issues. In addition, HQ will monitor implementation of the global agenda. HQ will also be expected to provide guidance on global health policy issues, linkages to social determinants of health and ensure the maintenance of a coherent corporate culture.

The process of developing the second CCS has been highly consultative and has involved an in-depth analysis of several policy documents that contribute to WHO’s work at country level. It also builds on the lessons learnt from the first CCS. The process identified external and internal challenges to the sector. The following are the strategic directions for WHO over the lifespan of the current CCS in supporting the country to address identified challenges:

(a) Promote health and prevent disease;
(b) Focus on programmes of national interest;
(c) Strengthen health systems;
(d) Strengthening partnerships;

In determining the strategic agenda, consideration has been given to the contributions of other partners and the need for government ownership and leadership. Strengthening the WHO Country Office with the recommended measures such as human resources, financial requirements, institutional and capacity building, staff reprofiling and provision of coordinated and harmonized support from all levels of WHO will be crucial in enabling the WCO to achieve the desired results of the CCS.
SECTION 8

MONITORING AND EVALUATION OF THE SECOND COUNTRY COOPERATION STRATEGY

The CCS is a strategic document and not a plan; thus it will have no direct indicators or monitoring log frame. Emphasis will be put on aligning plans of action with the CCS strategic agenda and routine monitoring of achievements of indicators in the plan of action using existing tools such as the biannual monitoring as well as the annual and biennial evaluation frameworks.

The second CCS will undergo a mid-term review (formative evaluation) after two and a half years of implementation and a summative evaluation at the end of five years. The formative evaluation results will be used to redirect the CCS if necessary. Both the formative and summative evaluations will also assess adherence to the strategic agenda, positive and negative programme results based on biennial workplans and office reports. The summative evaluation will provide lessons learnt during implementation of CCS. The mid-term review of the second CCS will coincide with the end of HSSP II and will be informed by the evaluation of HSSP II. Evaluation will be both internal and external, and results will be disseminated to the MoH and partners, and it will also be used for more effective engagement where appropriate.
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