Ministry of Health

National Health Policy

Ministry of Health
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Kampala

September 1999

1. SITUATION ANALYSIS

1.1 Uganda, with a projected population of 20.4 million (Statistical Abstract 1997), that is 50.9% females and 49.1% males, experiences an annual population growth rate of 2.5% (1991 Census). Poverty among the population remains high with an annual GNP per capita of US$300 and approximately 46% of the people living in absolute poverty (1995/96 Monitoring Survey, Ministry of Finance, Planning and Economic Development). Poverty is recognised to be the main underlying cause of the poor health situation in the country. Associated factors are the low level of literacy, high prevalence of communicable diseases, emergence of diseases of lifestyles, inadequate provision and inequitable distribution of social services and amenities, and the general level of underdevelopment of service infrastructure. In response to this difficult situation, the Government of Uganda embarked on a major Poverty Eradication Programme with emphasis on the modernisation of agriculture, improvement of rural infrastructure, development of marketing opportunities, Universal Primary Education (UPE), Primary Health Care (PHC) and Water and Sanitation.

1.2 According to the Burden of Disease Study in Uganda (Ministry of Health, 1995), over 75% of the life years lost due to premature death were due to ten preventable diseases. Perinatal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total national death burden. Others at the top of the list include tuberculosis, malnutrition (with 38% of under-5s stunted, 25% underweight for age and 5% wasted), trauma/accidents and measles.

1.3 Apart from the heavy burden of infectious disease, Uganda is also simultaneously experiencing a marked upsurge in the occurrence of non-communicable diseases such as hypertension, cancer, diabetes, mental illness and chronic heart disease. Uganda has therefore, already entered the early phase of the epidemiological transition. While infectious diseases must be given priority, selective attention will be given to all the key determinants of ill health in Uganda, including unhealthy lifestyles and the rising toll of accidents.

1.4 Recent information indicates that mental health disorders confer a heavy non-fatal disease burden on the nation. However, mental health disorders do not appear in the Burden of Disease Study because this study relied on mortality data rather than morbidity data.

1.5 Geographical access to health care has been limited to about 49% of the population, i.e. population living within five kilometres of a health service

unit (Health Facilities Inventory 1992). Rural communities are particularly affected, mainly because health facilities are mostly located in towns along main roads. It has also been recognised that, there are marked variations in access to health care both within and between districts, ranging form 8.9% to 99.3%. Even among these health facilities, many do not provide the full range of essential primary health care services. More than 60% of mothers are not attended by trained health personnel during childbirth; access to safe water is only 48% (UDHS 1995), coverage with sanitary excreta disposal is limited to 47.6% (Concept Paper on Sanitation, MoH 1997) for the country as a whole. The collapse of the National Nutrition Surveillance System, as well as the nutrition rehabilitation services, has reduced effective prevention and management of acute malnutrition in Uganda. In addition, even the well-supported Expanded Programme on Immunisation records only 47% coverage of children as fully immunised before their first birthday (UDHS 1995). Furthermore, the health sector lacks an effective surveillance system and is without an up-to-date health database, both being essential pre-requisites for evidence-based decision making and management.

1.6 Hitherto, the different health needs and priorities of women and men have not been identified and addressed by the health system. Thus, development of health sector policies and programmes have not responded to gender concerns, showing little appreciation of the way in which inequality impact**s** on the health of the population. However, health problems related to gender-based violence and female genital mutilation are increasingly notable. Gender relations, sexuality and sexually related behaviour must be taken into consideration in policy, planning, and service delivery for better health.

1.7 Other major problems in the health sector are related to health care organisation, management and financing. In the past, the Uganda health sector was characterised by highly centralised management and authority. This problem is now being addressed by devolving powers to local governments. In addition, there is inadequate funding of the sector with total per capita health expenditure in the range of US$ 7 to US$12, with only US$ 3.95 attributed to government and donor spending, the balance coming from individual out of pocket payments (*Background to the Budget 1998/99*). This is further aggravated by inefficient allocation of available resources within the sector, with more than 63% of recurrent budget and 54% of trained staff concentrated in hospitals (*Health Manpower Requirements and Training Priorities in Uganda Study, 1993*). Mal-distribution of human resources, low staff morale arising out of poor remuneration and an over-dependence on untrained personnel in the primary health care facilities, pose major structural problems to effective implementation of health programmes. Furthermore, a weak management and support/supervision system, insufficient collaboration between the public and private sectors, together with inadequate co-ordination of development partners, have

resulted in less health outcome than would be expected from available resources. It should be noted that the private sector (i.e. NGOs, private practitioners and traditional medicine practitioners) which already plays a very significant role in health care in the country and presents a great opportunity for accelerating health care coverage, has yet to be fully harnessed

Although health status remains poor, there has been significant improvement. Between 1991 and 1995, the Infant Mortality Rate has decreased from 122 to 97, the Under 5 Mortality Rate from 203 to 147, the Total Fertility Rate from 7.3 to 6.9 while the Contraceptive Prevalence Rate has improved from 5 to 15%. Maternal Mortality is now estimated at 506 per 100,000 live births in 1995 (Source: Uganda Demographic and Health Survey 1995; Population Bulletin 1997; Population and Housing Survey 1991).

Some of the factors that have contributed to the improvement in health status include:

i) Increased Government allocation to the health sector. Government expenditure on health, though still low, has increased over the last ten years from 2.5% in 1987/88 to 9.0% in 1997/98 of the national budget *(MoH 1998 Costing the Minimum Health Care Package in Uganda)*. There has been a significant growth in the Primary Health Care Conditional Grant from UShs1.7bn in 1997/98 to UShs 6.4bn for 1998/99. Over the same period, grants to NGO hospitals have increased from UShs1.0bn for 24 hospitals in 1997/98 to UShs1.9bn in the 1998/1999 financial year for 42 NGO hospitals, with an additional UShs1.0bn for lower level NGO health units.
ii) Concerted effort in key program areas that are intended to address childhood killer diseases through immunisation and integrated management of childhood illness.
iii) Introduction of the Safe Motherhood Initiative to address the causes of high maternal mortality and morbidity.
iv) Quality Assurance measures introduced into the health care system.
v) Effective national programmes to control and prevent Sexually Transmitted Diseases, HIV/AIDS and Tuberculosis.
vi) Efforts to reactivate vector control in order to combat vector-borne communicable diseases.
vii) People's involvement in the management of health services through Health Committees and Health Unit Management Committees.
viii) The 3-year District Rolling Plan process.
ix) Intensified technical support to each of the 45 districts in the formulation of annual health work plans and budgets within the framework of their three-year Health Plans.

x) Updating of health legislation.
xi) Intensified public information and education for health and community mobilisation.

2.0 THE DEVELOPMENT CONTEXT

The National Health Policy and Strategic Plan Frame have been formulated within the context of the provisions of the Constitution of the Republic of Uganda 1995 and the Local Governments Act, 1997 which decentralised governance and service delivery. In addition the new Health Policy derives guidance directly from the National Health Sector Reform Programme and the National Poverty Eradication Programme, which was the cornerstone of President Museveni's last Election Manifesto. Furthermore, the Alma Ata Declaration of Health for All (HFA) strategy, provides significant input and guidance into the current policy.

2.1 Health and Poverty Eradication

For development to be sustainable, health and economic growth must be mutually reinforcing. Health is an essential prerequisite as well as an outcome of sound development policies. Without good health, individuals, families, communities and nations cannot hope to achieve their social and economic goals. It is therefore clear that the health sector will play a key role in poverty eradication and development in Uganda.

2.2 Mission Statement

The overall goal of the health sector is the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life.

2.3 The Guiding Principles

The following constitute the guiding principles for the National Health Policy:

a) Primary Health Care (PHC) shall remain the basic philosophy and strategy for national health development. To this end, a Minimum Health Care Package will form the primary focus of the health care delivery system;
b) Equitable distribution of health services shall be assured throughout the country, and priority shall be given to further decentralisation of the health care delivery system to ensure effective access by all sections of the population to the National Minimum Health Care Package;

c) Good quality health care shall be assured through cost-effective interventions, targeted at the most important health problems of the population, with an optimal mix of appropriate health technology and trained human resources, which are affordable and sustainable;

d) A high level of efficiency and accountability shall be maintained in the development and management of the national health system.

e) Greater attention and support shall be given to health promotion, disease prevention and empowerment of individuals and communities for a more active role in health development.

f) Emerging health problems, including health care for the elderly, shall be given appropriate attention at all levels.

g) The existing collaboration and partnership shall be further strengthened between the public and private sectors in health, including NGOs, private and traditional practitioners, while safeguarding the identity of each.

h) Health being an integral component of overall development, inter-sectoral co-operation and co-ordination between the different health-related Ministries, development agencies, and other relevant institutions, shall be strengthened for stronger solidarity in health development.

i) A gender sensitive and responsive national health system shall be achieved through mainstreaming gender considerations in planning and implementation of all health programmes. Gender sensitivity will require that gender related barriers to health care be removed. Equal weight shall be given to knowledge, values and experience of women and men, and that they participate equally in research, policy and decision making. Sexuality and sexually related behaviour and gender relations including child sexual abuse, violence against women, genital mutilation and other harmful practices shall be routinely taken into consideration and addressed in collaboration with the relevant stakeholders.

j) Efforts will be intensified to promote sustainable additional health financing mechanisms.

2.4 The Policy Objective

The overall objective of health sector policy is to reduce mortality, morbidity and fertility, and the disparities therein. Ensuring access to the Minimum Health Care Package, detailed in Chapter 4 below, is the central strategy to this end. Other strategies creating the enabling conditions for delivery of the Minimum Health Care Package are itemised immediately below.

2.5 Policy Implementation

2.5 .1 To achieve these policy objectives government shall:

a) Provide additional resources for PHC in the form of Conditional and Equalisation Grants or other similar mechanisms.
b) Subsidise designated public health and essential clinical services that have visible externalities for the community.
c) Provide national guidelines to ensure that health units are located in those areas considered under-served, and in accordance with the long-term National Health Infrastructure Development Plan
d) Restructure the organisation and management of the National Health Care System and address gender imbalances at all levels;
e) Implement the organisation and management reform of the Ministry of Health in line with its new roles and responsibilities;
f) Strengthen district health services management to reflect the responsibilities devolved from the centre;
g) Decentralise operational responsibilities for integrated health promotion, disease prevention, curative and rehabilitative services below the district level, and build capacity for improved health care delivery and management.
h) Clarify the relationship between the key stakeholders, notably, health related central line ministries, the Health Service Commission, the Local Governments, Donors, Private Practitioners, NGOs and Traditional Practitioners within the decentralised system;
i) Divest clearly defined central MoH functions, as appropriate, to the autonomous and semi-autonomous bodies, namely, the professional councils, the Uganda National Health Research Organisation, the Uganda Blood Transfusion Service, the National Drug Authority and the National Medical Stores;
j) Review and strengthen the existing national drug policy;
k) Review and update the national food and nutrition policy in collaboration with other sectors.

The overall expected outcome would be an effective, efficient, responsive and accountable National Health Care System.

3. HEALTH POLICY PRIORITIES

Government will focus on health services that are demonstrably cost-effective and have the largest impact on reducing mortality and morbidity. The major contributors to the burden of disease at all levels will be given the highest priority. These include malaria, STI/HIV/AIDS, tuberculosis, diarrhoeal diseases, acute lower respiratory tract infections, perinatal and maternal conditions attributable to high fertility and poorly spaced births, vaccine preventable childhood illnesses,

malnutrition, injuries, and physical and mental disability. The cost-effective interventions, which will be implemented in an integrated manner to address these priority health problems, will together constitute the Uganda National Minimum Health Care Package. This package will be reviewed regularly.

4.0 THE UGANDA NATIONAL MINIMUM HEALTH CARE PACKAGE (UNMHCP)

The minimum package will comprise of interventions that address the major causes of the burden of disease and shall be the cardinal reference in determining the allocation of public funds and other essential inputs. Government will allocate the greater proportion of its budget to the package in such a manner that health spending gradually matches the magnitude of priorities within the Burden of Disease.

4.1 Policy Objective:

The Government will assure the provision of a minimum package of public health and clinical services to all its population, with emphasis on the poor, women and children. The package design has been based on data and information on Uganda's national health profile, and on affordable cost-effective interventions.

4.2 Components of the minimum health care package

The minimum health care package consists of the following:

4.2.1 Control of Communicable Disease

a) Malaria:

Prevention and control measures through improved case management, vector control and personal protection from insect bites at the community and household levels, selective chemoprophylaxis, intensified surveillance to help prevent and better manage epidemics, and monitoring the efficacy of existing anti-malarial drugs.

b) STI/HIV/AIDS

Prevention and control of STI/HIV through a program of intensive IEC aimed at promoting responsible sexual and reproductive behaviour. Sexual and reproductive counselling, HIV counselling and testing, wide use of condoms, prompt treatment of STIs, universal blood safety, reduction of mother-to-child transmission, palliative care, promotion of community involvement in the care of patients with AIDS, and mitigation of the socio-

economic impact of the epidemic will constitute the core elements of this component.

c) Tuberculosis:

Strengthening and expanding countrywide, the provision of early diagnosis, prompt and cost-effective treatment.

4.2.2 Integrated Management of Childhood Illness (IMCI)

Promotion and use of the approach of the Integrated Management of Childhood Illness at all health facilities, and at the community and household levels.

4.2.3 Sexual and Reproductive Health and Rights

a) Essential Ante-natal and Obstetric Care:

To ensure safe pregnancy and delivery, improved management of complications of pregnancy and childbirth including spontaneous or induced abortion, and reduce the unacceptably high rates of maternal and perinatal deaths through timely and effective emergency obstetric care provided at strategic and accessible locations.

b) Family Planning

To provide information and services for appropriate modern family planning methods and reduce the wide gap between desired and actual use of family planning services.

c) Adolescent reproductive health

To promote sexual and reproductive health and rights of adolescent boys and girls, including sex education in and out of school, life skills against sexually transmitted infections, unwanted pregnancies and unhealthy lifestyles.

d) Violence against Women

Promote and support agencies and organisations that work to reduce domestic violence, female genital mutilation and other forms of violence against women.

4.2.4 Other Public Health Interventions:

a) Immunisation:

Expand immunisation coverage for the vulnerable population groups co-ordinated through UNEPI.

b) Environmental Health

Government will address the increasing burden of disease resulting from poor environmental health, particularly by placing greater emphasis on rural areas where the population has low access to safe water and poor latrine coverage. This will be achieved through the promotion of personal, household, institutional, community and food hygiene. In addition, Government shall continue to manage health issues that relate to environmental and occupational hazards through enforcing appropriate legislation.

c) Health Education and Promotion:

Intensify information, education and communication activities to improve health awareness, effect desired changes in knowledge, attitude and behaviour (including health-seeking behaviour) directed towards the prevention and control of the major health problems, and in promoting healthy lifestyles.

d) School Health:

Provision of health education, screening for and treating common ailments, improvement of environmental sanitation and personal hygiene, and promotion of appropriate nutrition practices.

e) Epidemics and Disaster Prevention, Preparedness and Response:

In collaboration with the relevant sectors and agencies, develop and institutionalise at the national and district levels, the health sector component of the national policy and plan for preparedness and the capacity to respond to emergencies, including natural and man-made disasters, massive movements of populations (Internally Displaced Persons(IDP), and refugees).

f) Improving Nutrition:

In collaboration with the Agriculture and other relevant Sectors, household food security and healthier eating habits will be promoted to improve the nutrition status of the population, with special attention to young children, pregnant and lactating mothers. Special education and other measures will be undertaken to protect the population against micronutrient deficiencies, obesity, and other nutrition related diseases.

g) Interventions against diseases targeted for eradication

Priority will continue to be given to interventions against diseases internationally targeted for control, elimination or eradication such as guinea worm, river blindness or onchocerciasis, poliomyelitis, neonatal tetanus and measles.

4.2.5 Strengthening Mental Health Services

To address the heavy and increasing burden of mental illness in the country, Government will promote and support a basic Primary Mental Health Programme supported by appropriate referral services at the regional and national levels.

4.2.6 Essential clinical care

Provision of basic care, within the limits of available resources, for injuries and common illness including non–communicable diseases. For instance

a) **Care of injuries and other common conditions including non-communicable diseases.**

b) **Disabilities and Rehabilitative Health:** To increase access to medical rehabilitation services in the districts for persons with disabilities and develop a referral claim for these services;

c) **Palliative Care:** To promote the development of services for the chronically and terminally ill persons in collaboration with organisations dedicated to this field;

d) **Oral/Dental Health:** To ensure availability of basic dental treatment services, with adequate supplies in all district hospitals and upgraded health centres.

4.3 Financing the Minimum Health Care Package

In order to attain greater coverage of the population with the minimum health care package: -

a) Government shall continue to allocate and spend an increasing proportion of its annual health budget (both domestic and external resources) for the provision of the package.

b) In the medium term, government spending at central level and on referral and tertiary hospitals will be held constant in real terms. Any additional resources for the sector will be allocated preferentially, to financing the Minimum Package

c) Efforts will be intensified in the search for supplementary sources of financing the public health sector, including capturing a greater share of the very significant private expenditure on health.

5.0 THE HEALTH CARE DELIVERY SYSTEM

5.1 Organisation and Management of the National Health System

5.1.1 Policy Objective:

To restructure the organisation and management of:

a) The Ministry of Health to assume its new roles and responsibilities;

b) The District Health System to achieve increased capacity and efficiency under a decentralised environment;

c) The national health system to ensure effective harmony and linkages between the centre and districts on the one hand, and the public and private sectors on the other.

5.1.2 The Core functions of the Ministry of Health are:

a) Policy formulation, setting standards, and quality assurance.
b) Resource mobilisation.
c) Capacity development and technical support.
d) Provision of nationally co-ordinated services, e.g. Epidemic control.
e) Co-ordination of health research.
f) Monitoring and evaluation of the overall sector performance.

5.1.3 The District Health Care Responsibilities are:

a) Implementation of National Health Policy.
b) Planning and management of district health services.
c) Provision of disease prevention, health promotion, curative and rehabilitative services, with emphasis on the Minimum Health Care Package and other national priorities.
d) Control of other Communicable Diseases of public health importance to the district.
e) Vector Control.
f) Health Education.
g) Ensuring provision of safe water and environmental sanitation.
h) Health data collection, management, interpretation, dissemination and utilisation.

5.2 Health Service Infrastructure

5.2.1 Policy Objective:

To provide a network of functional, efficient and sustainable health infrastructure for effective health care delivery closer to the people. The functional status and the linkages between the different levels of care, and co-ordination of the various health care providers will be assured, so as to improve access and minimise avoidable waste.

5.2.2. In pursuit of this objective, Government shall:

a) Develop mechanisms to ensure equity in access to basic services for the most important life-threatening health problems, particularly, to avert pregnancy and birth-related deaths and the childhood killer diseases.

b) Build and strengthen capacity of health facilities to improve health service provision, including rehabilitation and equipping of these units, improvement of laboratory and diagnostic services, provision of trained personnel, drugs and other essential supplies, consistent with established standards.

c) Strengthen and rationally expand the national health infrastructure through a medium-term health facility development plan. This plan, to be designed and implemented jointly by the Government, the District Administration and the private health sector (the Religious Bureaux, NGOs and the private-for-profit providers), will put

particular emphasis on affordable lower level and community-based health facilities.

d) Establish an appropriate and efficiently functioning referral system.

5.2.3 Uganda is divided administratively into 45 Districts (LC5), which are further subdivided into Counties, Sub-counties, Parishes and Villages. There are 39,692 Village or Local Councils (LC1), 4517 Parishes (LC2), 893 Sub-counties (LC3) and 167 Counties divided into 214 constituencies (LC4). The health service infrastructure will follow this pattern, with health centres of increasing capacity (designated HCI, HCII, HCIII and HCIV). In addition, most districts have at least one hospital. The Minimum Health Care Package will be delivered through this network.

5.3 The Health Sub-District (HSD)

The objective is to establish and sustain health service zones within each district, to be called Health Sub-Districts. The zone is named health sub-district to emphasise that it is part and parcel of the district health system. The HSDs are intended to be functional subdivisions of the district health system aimed at: -

a) Further decentralisation of the management of routine health service delivery from the District Health Office to lower levels.
b) Improving planning and management of district health services.
c) Increasing equity of access to essential health services.
d) Achieving optimum balance between curative care, disease prevention and health promotion; and
e) Fostering community involvement in the planning, management and delivery of health care.

5.3.1 To achieve the objectives of the HSD: -

a) The office of the District Director of Health Services will be restructured and strengthened so as to enable to concentrate on overall planning, supervision, co-ordination and resource mobilisation for health development in the district.
b) The operational responsibility for health service delivery will devolve to the HSD.
c) The capacity of communities to take responsibility for their own health will be further enhanced.
d) A team of health workers to ensure delivery of Minimum Health Care Package will be built within the Health Sub – District.

5.3.2 The leadership of the HSD will be based at an existing hospital or an upgraded health centre (government, NGO or private) located within the HSD. Upgrading a health centre to HC IV status will involve posting of a resident doctor and core support staff including clinical officer, midwife, anaesthetic assistant, laboratory assistant, and a community health assistant. A small basic operating theatre will also be provided for emergencies, especially those related to pregnancy and childbirth, acute life-threatening childhood illnesses, and accidents.

5.3.3 The HSD will be an almost self-contained sub-system within the District Health System, in which the planning, implementation, monitoring and supervision of all basic health services will be undertaken. Although current Government policy calls for the further decentralisation of social services delivery and management to the Sub-country level (LC III), because of existing financial and manpower constraints, it is, at least over the short-term, considered impracticable for health to immediately decentralise to the Sub-county level, which would require 893 HSDs. However, in the long-term, and as more resources become available, establishment of the HSD at the sub-county level will be considered. Therefore, in the immediate and medium term, the HSD will be created at County level or within its appropriate administrative sub-division where counties are too big for effective management.

5.3.4 Given existing resource constraints, the implementation of this initiative, even at county level (214 HSDs), will be undertaken in phases. Immediate priority will be given to districts without a hospital, areas that are geographically distant from a hospital or upgraded health centre.

6 HEALTH FINANCING

6.1 General Policy Objective:

To develop and implement a sustainable, broad-based national health financing strategy that is geared towards:

i) Ensuring effectiveness, efficiency, and equity in the allocation and utilisation of resources in the health sector consistent with the objectives of the National Poverty Eradication Action Plan.
ii) Attaining significant additional resources for the health sector and focusing their use on cost-effective priority health interventions.
iii) Ensuring full accountability and transparency in the use of these resources.

6.2 To attain these policy objectives government shall:

a) Increase progressively, the level of Government financing to the health sector.

b) Focus the use of public resources (including official development assistance) on health services that are demonstrably cost-effective, have the greatest impact on reducing mortality and morbidity, and/or have a clear bias to protecting the poor and most vulnerable population as well as taking due consideration of the gender related health care needs and concerns.

c) Match all development investments to resources available for recurrent costs; and within recurrent spending, to gradually increase the allocation to non-wage (operational) costs.

d) Develop and support alternative financing schemes such as user fees, health insurance and other community resource mobilisation efforts. However, Government will ensure that such schemes do not unduly discriminate against the poor and vulnerable groups, distort the demand for care, or the provision of health services.

e) Promote the growth of private sector health initiatives.

f) All financial transactions using Government funds (including Central Government and donor transfers to local authorities, and locally generated resources) will be administered strictly within the financial regulations of Government.

7 COMMUNITY EMPOWERMENT

7.1 Policy Objective:

To ensure that communities are empowered to take responsibility for their own health and well being, and to participate actively in the management of their local health services.

7.2 In achieving this Policy Objective, Government shall:

a) Develop guidelines for community capacity building for effective participation in the identification of health problems, planning of health services, in resource mobilisation and in the monitoring of health activities;

b) Promote the establishment of health committees with an appropriate gender balance at each of the different levels of the local government system;

c) Establish Management Boards for all publicly owned tertiary hospitals with extensive delegated authority for their efficient operation;

d) Develop guidelines for the establishment and operation of Management Boards/Committees for district hospitals and other health facilities;
e) Promote and support community-based health services;
f) Establish the National Health Assembly with adequate representation from the district, civil society, donors and other key partners.

8 HUMAN RESOURCES DEVELOPMENT

8.1 Policy Objectives:

a) To address the major constraints of inadequate numbers and inappropriate distribution of trained health personnel.
b) To develop guidelines for optimal deployment of trained health personnel; and
c) To ensure increased productivity in accordance with the Result Oriented Management (ROM) policy of Government through effective and efficient utilisation of health personnel, and the provision of an enabling environment, which meets the special needs of both men and women.

8.2 In pursuit of these Policy Objectives, Government shall:

a) Strengthen human resources management at all levels;
b) Promote equal opportunities for both men and women in the health professions through a gender responsive National Human Resources for Health Development Plan;
c) Develop and promote incentive schemes for equitable deployment and retention of health workers, especially to the rural areas;
d) Establish national guidelines for staffing standards (based on expected workload*)* for all categories of health facilities, and institute effective mechanisms for implementing them;
e) Establish and maintain mechanisms for assuring relevant continuing education for, and supportive supervision of all health personnel;
f) Decentralise in-service training, including its funding to the district level;
g) Develop and update training standards in collaboration with the Ministry of Education;
h) Promote the training and support of Community Resource Persons;

9 PRIVATE SECTOR

The private sector in Uganda consists of NGOs (facility and non-facility-based), private practitioners, the traditional health care system of traditional healers and midwives, and an expanding private pharmaceutical sector. It is collectively responsible for a significant proportion of health care in the country. Each one of these constituent sub-sectors has specific comparative advantages, which must be recognised if they are to be fully harnessed.

9.1 Policy Objective:

To make the Private Sector a major partner in Uganda's national health development by encouraging and supporting its participation in all aspects of the National Health Programme.

9.2 To this end, Government shall:

a) Institute effective means of promoting private sector partnership with full understanding of the nature, scope and scale of its contribution to the National Health Care System;
b) Establish appropriate instruments to facilitate and regulate the private sector in line with existing national laws and regulations;
c) Offer incentives that would attract private health services to all parts of the country;
d) Provide assistance to private providers in areas not effectively served by public facilities, so as to achieve wider coverage of the population, in preference to setting up competing public services;
e) Explore alternative options for improving efficiency within the public health sector such as contracting out clinical and non-clinical services;
f) Constantly monitor and periodically evaluate the effect of privatisation in the health sector;
g) Encourage the participation of private health services in data collection and management; and
h) Provide opportunity for continuing education for health personnel in the private sector.

10 POLICY, PLANNING, MONITORING AND EVALUATION

10.1 Policy Objective:

To provide an effective framework for strategic policy review and formulation, planning, budgeting, monitoring and evaluation.

10.2 To achieve the above policy objective, Government will:

a) Strengthen the capacity of the MoH in policy analysis and formulation, planning, budgeting and in monitoring and evaluation of all health development activities;
b) Strengthen and ensure support for the Health Management Information System and the National Health Data Bank.
c) Generate gender-disaggregated data for effective planning, management and delivery of health services;
d) Strengthen disease surveillance at national, district and community levels;
e) Promote and facilitate gender-sensitive health and biomedical research for the attainment of the policy objectives;
f) Devise or select appropriate indicators for monitoring key programme targets, their impact on health status, and on progress in redressing inequalities in health.
g) Promote effective participation of both men and women in a bottom-up planning process at all levels of the health system;
h) Develop and implement appropriate plans for building capacity of District Health Teams, Health Sub-districts and Health Units in general health planning and management and on the technical aspects of managing integrated health programmes;
i) Establish an appropriate mechanism for periodic Joint GoU/Partners Sector Review of the performance of the National Health Development Programme that will derive from this policy;
j) Generate through periodic surveys, appropriate data for effective planning, management and delivery of health services to people with disability;
k) Facilitate the establishment and operation of a community-based health information system; and
l) Ensure dissemination of information to other stakeholders for purposes of improving management, sharing experience, and upholding transparency.

11 RESEARCH AND DEVELOPMENT

11.1 Policy Objective:

To provide an effective framework for research in the health sector

11.2 To achieve this objective, Government shall:

a) Undertake research on the trends and economic consequences of disease, disability and ill-health;

b) Conduct studies on the content and relative cost-effectiveness of delivering the Uganda Minimum Health Care Package;
c) Promote research on major non-biomedical factors that affect the health and well being of the population;

12 SOCIAL VALUES IN HEALTH CARE

12.1 Policy Objective:

To guide the planning, financing and implementation of all aspects of this policy at all times, and in all circumstances by emphasising the basic principles of equity, fair play, justice and other considerations of ethical importance in the health profession.

12.2 To achieve this objective, Government shall:

a) Give due consideration to the pursuit of national solidarity in a common concern for health-for-all, with special consideration for the welfare of the poor, the most vulnerable and the disadvantaged;
b) Respect the health promotive aspects of the cultures and traditions of the peoples of Uganda;
c) Ensure that the highest standards of ethics are observed at all times in the conduct of medical and health practice, including health research;
d) Reactivate and strengthen professional bodies to ensure continuous monitoring of the practices of health workers, and institute disciplinary measures as necessary;
e) Ensure at all times and at all levels full accountability, especially to the client communities;
f) Promote high standards of ethics among traditional practitioners;
g) Promote campaigns against gender-related issues that lead to health problems such as domestic violence, sexual harassment, rape, defilement, prostitution, female genital mutilation, early marriage and food taboos; and
h) Promote a harmonious working relationship between decision-makers, service providers and beneficiaries.

13 LEGAL ASPECTS OF HEALTH

13.1 Policy Objective:

To review and develop the relevant legal instruments that govern and regulate health and health-related activities in the country, in order to ensure that principles and objectives of this policy are attained.

13.2 To this end, Government shall:

Update, formulate and disseminate laws, regulations and enforcement mechanisms related to:

a) The development and control of the National Health Services;
b) Traditional Medicine, including Traditional Midwifery;
c) The registration, manufacture, importation, storage, sale, distribution and dispensing of pharmaceuticals, vaccines, equipment and appliances, and other medical supplies;
d) The training in and conduct of medical and health research;
e) The importation, manufacture, use and disposal of hazardous materials;
f) The protection of employees against health hazards related to their employment in liaison with relevant organisations;
g) Food hygiene and safety;
h) Government Notice No. 245 of 1961 that governs and regulates the Religious Medical Bureaux;
i) Environmental Health Control, in collaboration with other relevant authorities and agencies;
j) Control of public advertising with negative impact on health and health care;
k) Consumer protection, especially for the vulnerable groups including women, children and persons with disability; and
l) Stigmatisation and denial due to ill health or incapacity.

14 STRONGER DONOR CO-ORDINATION: A SECTOR-WIDE APPROACH

14.1 Policy Objective:

To provide an enabling environment that would allow for effective co-ordination of efforts among all partners in Uganda's national health development, increase efficiency in resource application, achieve equity in the distribution of available resources for health and effective access by all Ugandans to essential health care.

14.2 To this end, Government shall:

a) In collaboration with key stakeholders, develop and adopt a sector-wide approach to health development that is consistent with national sovereignty and aspirations;

b) Reach consensus with all stakeholders on the key national development objectives and the main strategies for attaining them;
c) Promote a common framework to be used by all partners in the health sector for planning, budgeting, disbursement, programme management, support/supervision, accounting, reporting, monitoring and evaluation. On-going programmes and projects will continue and be gradually integrated in the National Health Development Framework.
d) Strengthen capacity at national and district levels for effective co-ordination of all development partners in health.

15. CONCLUSION

The task ahead is formidable, but with good will on all sides, it is not insurmountable. With concerted effort from all actors in the implementation of the National Poverty Eradication Plan, the very significant benefits to be derived from related PEAP components can be realised within the near future. Components such as Universal Primary Education, household food security, improved access to safe water and sanitation and the expected increase in household income all augur well for achieving the overall policy goal of improved health for all the people of Uganda.

The consultative process that was applied in developing this policy document has generated wide consensus on the priority health development objectives and the strategies for achieving them. It is hoped that the same spirit of collaboration will prevail during period of implementation.

The complexities inherent in the very nature of the health sector itself, added to the major challenges of Uganda's highly decentralised system of governance and service delivery, offer an exciting proving ground for new approaches to partnership in development.