THE REPUBLIC OF UGANDA

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT AND HEALTHY AGING

SHARPENED PLAN II

2022/23–2027/28

July 2022

THE REPUBLIC OF UGANDA

Ministry of Health

Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging Sharpened Plan for Uganda

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Table of Contents

List of Figures

List of Tables

List of Acronyms

ADDS	Alternative Drug Distribution System
ADH	Adolescent Health
ADHO	Assistant District Health Office
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARVs	Antiretroviral Drugs
AYP	Adolescent and Young People
BA	Bottleneck Analysis
BDR	Birth and Death Registration
CAPA	Catchment Area Planning and Action
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CCI	Composite Coverage Index
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CH	Child Health
CHEW	Community Health Extension Worker
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organisation
DHIS	District Health Information System
DHO	District Health Office
DPT	Diphtheria Pertussis Tetanus (vaccine)
DSD	Differentiated Service Delivery
EBF	Exclusive Breast Feeding
ECD	Early Childhood Development
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother-to-Child Transmission
EMHSLU	Essential Medicines and Health Supplies List of Uganda
EML	Essential Medicines List
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Programme on Immunisation
ETAT	Emergency Triage and Treatment
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
GH	General Hospital
HC	Health Centre
HDP	Health Development Partners
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HSD	Health Sub-District
HUMC	Health Unit Management Committee
ICCM	Integrated Community Case Management
ICD	International Classification of Diseases
IHRIS	Integrated Human Resources Information System
IMNCI	Integrated Management of Newborn and Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Nets
KMC	Kangaroo Mother Care
KPI	Key Performance Indicator
LBW	Low Birth Weight
LiST	Lives Saved Tool
LLITN	Long Life Insecticide-Treated Nets
LMIS	Logistics Management Information System
LTFP	Long Term Family Planning
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MIYCAN	Maternal, Infant, Young Child and Adolescent Nutrition
MMR	Maternal Mortality Rate
MOES	Ministry of Education and Sports
MOH	Ministry of Health
MPDR	Maternal and Perinatal Death Reviews
MVRS	Mobile Vital Records System
NCD	Non-Communicable Disease
NCF	Nurturing Care Framework
NDP	National Development Plan
NICU	Newborn Intensive Care Unit
NIRA	National Identification and Registration Authority
NMS	National Medical Store
ORS	Oral Rehydration Salt
PAC	Post-Abortion Care
PHC	Primary Health Care
PHP	Private Health Provider
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
PNFP	Private Not for Profit
PPH	Post-Partum Haemorrhage
PPP	Private Public Partnership
QOC	Quality of Care
RBF	Results-based Financing
ROPA	Registration of Persons Act
RRH	Regional Referral Hospital
RUTF	Ready-to-Use Therapeutic Foods
SBA	Skilled Birth Attendant
SBCC	Social and Behaviour Change Communication
SCU	Special Care Unit
SDG	Sustainable Development Goal
SMC	Senior Management Committee
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
STMC	Senior Top Management Committee
THE	Total Health Expenditure
TMC	Top Management Committee
U5MR	Under-5 Mortality Rate
UDHS	Uganda Demographic Health Survey
UgIFT	Uganda Intergovernmental Fiscal Transfer
UHC	Universal Health Coverage
URSB	Uganda Registration Services Bureau
VHT	Village Health Team
WHO	World Health Organization

Foreword

Uganda has made progress toward many Sustainable Development Goals (SDGs) by increasing survival and well-being from pre-pregnancy, childbirth, and post-natal to infancy, childhood, and adolescence. Uganda first developed and launched the Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Sharpened Plan in November 2013 to accelerate the attainment of the Millennium Development Goals (MDGs). The country updated the RMNCAH Sharpened Plan and developed an Investment Case to accelerate progress through five strategic shifts initiated in the 2015–2021 period, building on foundations laid in the previous plan. The five strategic shifts are further consolidated in this current Sharpened Plan as the game changers to achieve RMNCAH Universal Health Coverage.

This Sharpened Plan continues with the bold objectives of ending preventable maternal, newborn, child, and adolescent deaths and safeguarding the health and development of all children, adolescents, and women. This would ensure a Uganda where every woman, child, and adolescent realizes the rights to health and well-being and can harness their social and economic opportunities to fully participate in shaping the prosperous nation.

This plan should drive collective action and call for all stakeholders to align themselves with the national and subnational mutual accountability framework to deliver their commitments. I, therefore, call upon all the stakeholders—government, civil society, development partners, faith-based leaders, cultural leaders, as well as the private sector—who have pledged priority actions to this Sharpened Plan to join hands with the Government of Uganda to implement this plan to prevent the unnecessary loss of mothers and children in Uganda.

Hon. Dr. Jane Ruth Aceng
MINISTER OF HEALTH

Acknowledgement

The Ministry of Health wishes to acknowledge all those individuals, institutions, and organizations that contributed to developing the Reproductive, Maternal, Neonatal, and Child Health (RMNCH) Sharpened Plan. In particular, the Ministry appreciates the technical leadership of the Reproductive Child Health Department for their efforts to bring together various stakeholders while developing this plan. Special recognition is made of the efforts and commitment of the Technical Working Group of the RMNCH Cluster, civil society organizations, cultural and faith-based leaders, District Health Officers, and members of professional bodies, along with the different development partners and other stakeholders. The successful development of this RMNCH Sharpened Plan was made possible with financial and technical support from the World Bank and USAID through the USAID Maternal Child Health and Nutrition Activity. The Ministry of Health furthermore thanks all those individuals, institutions, and organizations that helped review the document as it evolved. Finally, I would like to extend a vote of thanks to the team of technical consultants, led by Dr. Andrew Balyeku, who facilitated the writing.

Dr. Jesca Nsungwa
Commissioner Reproductive Child Health Division

Executive Summary

The country continued to achieve improvements in maternal, newborn, child, and adolescent health for millions of Ugandans. Maternal mortality rate (MMR) declined from 438 in 2011 to 336 in 2016 and infant mortality (per 1,000) improved from 54 to 43 over the same period; but neonatal mortality rate has stagnated at 27 per 1,000 for the last 20 years. In line with the sustainable development goals (SDGs), ending preventable maternal mortality (EPMM) requires Uganda to steepen the rate of MMR decline by greater than 5.5% to achieve less than 140 by 2030, infant mortality rate (IMR) has to be reduced to at least 12 per 1,000 live births and under-5 mortality rate (U5MR) to 25 per 1,000 live births by 2030. The country has set targets in the National Development Plan 2020–2025 (NDP III) to reduce IMR from 41 to 34; U5MR from 62.2 to 30, and MMR from 311 to 211 by 2025.

Despite these achievements, maternal, newborn, and child mortality remain unacceptably high. Disease burden is also still high: more than 6,600 women and 80,000 infant preventable deaths occur every year. Children younger than age 5 disproportionately contribute to almost half (44%) of facility admissions despite being only 17% of the population. Lack of critical services, e.g., for newborns and adolescents; low effective coverage across proven reproductive, maternal, newborn, child, adolescent, and healthy aging (RMNCAH) interventions; poor quality of care; poor client satisfaction; and RMNCAH service fragmentation are among the key issues identified.

For the next five-year period, 2021 to 2026, the National RMNCAH Strategy (Sharpened Plan II) contributes toward the human capital development sub-goal of increasing productivity of the population for better quality of life for all and pursues two broad objectives:

1. Ending preventable maternal, newborn, child, and adolescent deaths
2. Promoting the health and development of all children, adolescents, and women

To achieve these, the Sharpened Plan reinvigorates the following five strategic shifts:

1. **Focusing on districts with the highest maternal and child mortality first** thus increasing efforts to address growing geographical inequities in RMNCAH outcomes in the country. This entails establishing investments in universal coverage emergency obstetric and newborn care (EmONC) and quality of care, strengthening community engagement and service delivery efforts, and improving equity measurements.
2. **Increasing access for high-burden populations** with a focus on addressing specific needs and service barriers especially for the most vulnerable and marginalised subpopulations (including adolescents) within the district health systems. This plan focuses on targeted delivery channels including user community-led or -based engaging and contracting—especially private sector midwives—to increase access and surveillance on inequity and impact of health determinants on RMNCAH outcomes.
3. **Scaling up delivery of evidence-based, high-impact intervention packages** prioritised for each life stage to enable continuity over lifetime. In addition to the basic RMNCAH interventions, this plan emphasises bringing to scale quality of care for (1) birth and first week of life, (2) antenatal care (ANC) initiation in first trimester, and (3) IMNCI/iCCM plus as the main thrust for accelerating survival. It also recognises (4) pre- and inter-conception care that includes FP, nutrition, and adolescent health; (5) implementing the extended nurturing care framework from preconception through adolescence (0–20 years); and (6) RMNCAH social and behaviour change communication as critical for thriving. Implementing this shift will require strong change leadership; national level leadership will drive RMNCAH policy and programmatic integration; district-level leadership will drive population health focus and continuity/linkages; and strong facility-level leadership and governance will ensure transformation toward integrated people-centred RMNCAH services.

4. **Using a multisectoral approach** to enhance development and tackle underlying causes and determinants of poor RMNCAH fatal and non-fatal outcomes that prevent women, children, adolescents, and men from attaining their full health and well-being potential. Implementation will require fundamental change from facility-based output RMNCAH planning to facility catchment population health planning that focuses on increased community engagement on health determinants, increased efforts on sexual and gender-based violence, and primary and secondary school health interventions.
5. **Strengthening mutual accountability for RMNCAH population health level outcomes** by all stakeholders. District RMNCAH accountability is a cornerstone of the revised sharpened plan. Wider engagement is part of this shift toward downward accountability to local communities for service provision and horizontal accountability to peers covering managers as well as public and private providers. The shift also includes public access to budgets and performance information. Other key efforts will include tracking of funding and resource commitments by government and partners, and use of RMNCAH accountability index and community scorecard for citizens' hearings and for civil society parliamentarians' engagement.

Implementation will be within the national long-term institutional framework and key performance indicators will be used to guide strategic performance. The total resource requirement for the RMNCAH sharpened plan implementation is estimated at US$2.7 billion for five years, with per capita cost estimated at $26. An estimated US$2.0 billion is committed by government and partners leaving a funding gap of US$0.7 billion.

01: OVERVIEW

01.1 Introduction

This Investment Case for the RMNCAH Sharpened Plan 2021–2025 is aligned and anchored with key national and global priorities and targets. This Plan defines the broad direction for RMNCAH in Uganda in meeting the key objectives and targets set in the National Development Plan (NDP III) 2020–2025 toward aspirations articulated in Uganda Vision 2040 for sustainable socioeconomic transformation of Uganda. It is built on the progress, challenges, lessons learned from previous planning, and implementation experiences of the first Investment Case for the RMNCAH Sharpened Plan 2015–2020 as well as the new global guidance. This plan continues with the agenda to fast-track impact of services on key priorities toward achieving the Sustainable Development Goals (SDGs) targets within the global Strategy for Women's, Children's, and Adolescents' Health, and within the five strategic shifts started in the previous period. The evidence-based interventions identified in the previous plan remain pertinent and will continue to be pursued for Universal Health Coverage (UHC), building on the foundations laid in the past five years. The development approach in this plan does not provide another list of priority technical interventions but moves the country beyond "doing the right things" to "doing things right."

This plan, like the NDP III, focuses on human capital development and widens the focus of programmes from being largely on survival of children and mothers to health, nutrition, and psychosocial support across the life course, and delivery of comprehensive, integrated, age-, condition-, and context-differentiated interventions and actions at different levels of care. More emphasis is laid on redesigning service organisation and skills toward delivery of RMNCAH family- and adolescent-centred care and services. It continues efforts that are registering reduction in deaths and introduces the broader and longer perspective of the global nurturing care framework (NCF) to spur multisectoral action toward a thrive-and-transform agenda with ongoing efforts to sustain progress survival.

The proportion of deaths among newborn and young infants is increasing, and maternal deaths are stagnating. These groups are the focus of the unfinished child survival agenda in this plan. Reductions in deaths due to malaria and pneumonia in children younger than age 5 must be sustained. The current age structure places prominence on promotion of health, nutrition, and prevention of health risks during the first two decades of life, building on the gains at each life stage to ensure that all 19-year-olds are optimally healthy to contribute socially and economically to society.

01.1.1 Demographic Information

Uganda's population was estimated at 42 million in 2020 and is expected to increase by 5.5 million to reach 48 million by 2025 due to annual population growth rate of 3.4%, among the highest in the world. Almost half (49%) of the population is under age 15, and 70% are less than 25. This predominantly young population and rising life expectancy (male: 62.8 years, female 64.5 years[1]) creates an increasing cohort of mothers, newborns, adolescents, adults, and older people needing more RMNCAH services. Most of the reproductive health (RH) challenges the country faces are concentrated among children, adolescents, and young people (over 75% of Uganda's population). Thus, protecting their health and well-being is critical in controlling the escalating RMNCAH burden in the country, adding significant demands on already stretched RMNCAH services and household health

[1] Uganda Bureau of Statistics. National population and housing census 2014-main report. Kampala (Uganda); 2016. Life expectancy at birth in Uganda increased from 47 and 45 years in 2000/01 for females and males, respectively, to 63 and 64 years by 2015.

care costs. The average household size in Uganda is estimated at five persons, and three in every 10 households (31%) are headed by females. Of the 8.3 million households in the country, 72% are in rural areas. The urban annual growth rate of 5.2%, among the highest in the world, will increase as the country operationalises the 10 newly created cities and over 200 urban councils in the next five years. Hence the need to develop responsive urban RMNCAH services, especially for the urban poor. Uganda is the fourth largest refugee hosting country with the refugee population almost tripling since 2016 to about 1.3 million.

01.1.2 Socioeconomic

Uganda's real gross domestic product (GDP) grew at 2.9% in FY20/21, less than half the 6.8% recorded in FY19 due to COVID-19 pandemic disruption of the country's poverty reduction path. GDP is expected to grow at a similar level in FY21 and slowly pick up over the next three years. Even if GDP growth rebounds strongly by 2022, the level of per capita GDP is likely to remain well below its pre-COVID trajectory. Twenty percent of the population live in poverty, and the absolute number remains high at 8.3 million in 2019/20: one in five persons living in poverty (<USD$1/day). Overall, the incidence of rural poverty is more than double that of urban poverty, but the gap is closing. The literacy rate for people aged 10 and older was estimated at 76%, lower for females (72%) than males (81%). Nine in every 10 children aged 6–12 (91%), eight in every 10 aged 13–18 (79%), and 23% aged 19–24 were currently attending school in 2019/20, therefore amplifying the schools as strong platforms for service delivery for older children and adolescents. Digital use is high with 74% of households owning a mobile phone, 72% household members reporting use of social network internet via their mobile phones, and only 32% owning at least one radio.[2] This provides an opportunity for expanding e-health and m-health to efficiently reach hard-to-reach individuals and address access problems.

01.1.3 Structure of Health Sector in Uganda

The Ministry of Health (MOH) implements clinical and public health RMNCAH programs and activities through a tiered, decentralized health system—primary (health centres), secondary (general hospitals), and tertiary (referral hospitals) levels. Health services are provided by public, private not for profit (PNFP), private health providers (PHPs), and traditional and complementary medicine practitioners (TCMPs). Within the public sector, the national and regional referral hospitals are administered at central level, while general hospitals and health centres are decentralized to local governments (LGs). Nine in every 10 persons (91%) access health care within a 5 km radius. Government of Uganda is undertaking the upgrade of all HC IIs and ensuring an HC III in each subcounty. The private sector plays a critical role, providing 45% of health care, owning almost 70% of the health training institutions in the country, and contributing to the concentration of providers and facilities (45%) in the Central Region where the presence of PHPs is greatest.

[2] Uganda Bureau of Statistics. Uganda national household survey report 2019/2020. Kampala (Uganda); 2021.

01.2 Policy Alignment

01.2.1 Commitments to Global and Regional RMNCAH Agenda

This plan is consistent with global and regional RMNCAH and nutrition-related commitments, strategies, and frameworks of the SDGs. Uganda has endorsed both Every Newborn Action Plan (ENAP) and Ending Perinatal and Maternal Mortality (EPMM) in adherence with the Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) that guides expanding from survival programming to embrace interventions that help thriving ("ensure health and well-being") and transform health and other systems ("expand enabling environments"). It focuses on ensuring person-centred care, and refocuses on improving population health especially addressing multisectoral drivers of poor health outcomes, on community engagement in health, and on community empowerment for co-production of health in line with the revitalised vision for primary health care in the Astana Declaration.

In the drive to "leave no one behind," this plan tackles inequities and emphasises reaching adolescents, minorities, migrants, marginalised, and hard-to-reach subpopulations. It also sets policy groundwork for improving RH services for older people (50 plus) as guided by the Decade of Healthy Ageing (2021–2030), endorsed by the World Health Assembly. It is also informed by the World Health Assembly 2012 Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition global targets related to priority nutrition outcomes to be achieved by 2025. The WHO Redesigning Child and Adolescent Health Programmes report refocuses emphasis on the determinants, causes, and timing of death, and calls for integration of interventions along the life-course and the continuum of care within an extended nurturing framework. At the regional level, aspiration 1, goal 3 of Agenda 2063: The Africa We Want calls for putting in place measures to ensure healthy and well-nourished citizens.

Maputo Plan of Action 2016–2030 is premised on ICPD/MPOA 1994 and ICPD+20 and operationalises the Continental Policy Framework for Sexual and Reproductive Health and Rights (SRHR), which additionally calls for an Africa with a strong cultural identity, values, and ethics, and puts emphasis on women of reproductive age, newborns, children, adolescents, youth, mobile, rural, urban, and cross-border populations, displaced persons, and other marginalized groups. The plan is underpinned by the East African Community (EAC) Vision 2050 and the linked EAC RMNCAH Policy Guidelines 2016–2030.

01.2.2 National Development Plan-Human Capital Development Program

The *Uganda Vision 2040* recognises that good health is a facilitator for socioeconomic transformation. It calls for a paradigm shift from a facility- to a largely community-based health delivery system; prioritises health promotion (including nutrition) and prevention over curative approaches; pushes for a more public-private partnership rather than public-centred delivery; and promotes a service more responsive to health needs of different subpopulations during the vision period. Midway toward Vision 2040 targets, NDP III defines the course for the next five years toward a sustainable socioeconomic transformation of Uganda, prioritising the health sector under Program 12: "Human Capital Development Programme." NDP III shifts from sector to a program-based approach to planning and budgeting, thus integrating gender and social development, education, and health sectors under one program.

01.2.3 Human Capital Development

With a human capital index (HCI) of 38%, a child born in Uganda achieves a paltry 38% of productive potential at age 18 which, unless addressed, puts the goal of increasing productivity of the population for increased competitiveness and better quality of life for all out of reach. High fertility, high levels of maternal and child mortality, and limited access and quality of adolescent health services are some of the key dynamics impeding this HCI. RMNCAH is essential to ensure that the foundation for human

capital development is made before pregnancy and childhood. Ensuring higher birthweight, early-life health, nutrition and development, and adolescent health are critical for human capital accumulation and for long-term economic growth. The stock of human capital of the next generation is determined by the complementarity between health and education attainment, especially for women and adolescents. RMNCAH is essential for sustainable development because of the link to gender equality and women's well-being; the impact on maternal, newborn, child, and adolescent health; and the role in shaping future economic development, fertility reduction, and environmental sustainability. Investment in RMNCAH support is thus critical to foster a more positive human capital accumulation trajectory for the country. Adolescent health services remain extremely limited in access and quality yet improving health of this large age group delivers a triple dividend of benefits for the adolescents now, for their future adult lives, and as a decisive factor for changes in the next generation.

01.2.4 Human-Rights-Based Approach

The rights of children, adolescents, and women are central to this plan to ensure universal availability, accessibility, acceptability, and quality of RMNCAH information, commodities, and services in a way that eliminates discrimination and addresses inequalities. Access rights to health care are laid out in Uganda's patient charter and are in the framework of respectful family-centred care, being inclusive and responsive to RMNCAH needs of different population groups through an integrated and differentiated care delivery approach. Emphasis is placed on health systems strengthening and ensuring community participation and engagement in service organisation and delivery, based on enhanced social accountability mechanisms to monitor and improve equitable access and quality.

01.3 Developing the Sharpened Plan

01.3.1 Planning Process

The Second Investment Case of the RMNCAH Sharpened Plan II follows expiry of the previous plan and is in line with the sector planning process requiring departments to develop Technical National Strategic Plans anchored within the Human Capital Development Program. A top-down and bottom-up mixed approach was used to ensure that strategic guidance provided at the national level is linked to the outputs articulated in the Human Capital Development Program, especially Objective 1: improve the foundations for human capital development; Objective 3: improve population health, safety, and management; and Objective 4: reduce vulnerability and gender inequality along the lifecycle.

The strategic direction specific to RMNCAH was further informed by an extensive consultation process involving the MOH, partners, and civil society. Consultations were done through more than 30 thematic group meetings and four writing workshops. Six thematic groups arranged per life stage included a wide membership of government and partner technical officers, CSOs, and district representatives. A nationwide conference of adolescents was held to gather adolescent health concerns and suggestions. Background analytical work involved discussions on the 12 operational research reports from academia, the midterm and end-term review reports of the First Investment Case for RMNCAH Sharpened Plan, as well as document review. Though the initial task was to update the plan, especially on targets and strategies, the theory of change (TOC) was revised to reflect the new programming and budgeting approach of the country, mapping backward with a focus on the new end results articulated in NDP III. Later, a monitoring and evaluation (M&E) plan was developed to match indicators to outcomes and preconditions. A team of consultants synchronously developed the resource mapping, costing, and gap analysis.

01.3.2 Outline of the Document

Chapter 1 sets the background of the plan; how it aligns with national and global policy environment, past performance, and gaps; how it was developed; and includes key promising innovations considered later in the document. Chapter 2 lays out the road ahead, highlighting the current burden and needs to be covered for each of the five critical life stages. Chapter 3 identifies the current health system bottlenecks hindering effective coverage and establishes mechanisms to overcome them.

Chapter 4 provides the strategic direction for reaching the targets, identifies the theory of change, and explains the required strategic changes (or five strategic shifts carried over from the previous plan) needed to ensure impact. Chapter 5 outlines how the plan will be implemented, describing the various actors, structures, coordination arrangements, planning and budgeting processes, and communication strategies. Chapter 6 provides the performance monitoring framework and sets the Key Performance Indicators. Chapter 7 describes the resources required to implement the plan and provides a forward-looking picture of available resources and current funding gaps that will need to be covered for the next five years.

02: THE ROAD AHEAD

This chapter outlines the road ahead for reaching the 2025 targets in the NDP III and SDGs by 2030.

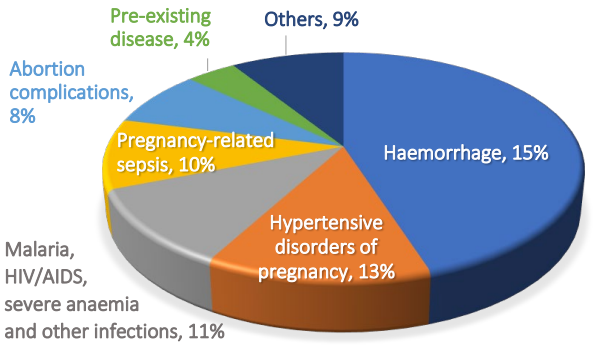
02.1 Improving Maternal and Newborn Health

In line with the SDGs targets, ending preventable maternal mortality (EPMM) requires Uganda to steepen the rate of MMR decline by more than 5.5% to achieve less than 140 by 2030, IMR has to be reduced to at least 12 per 1,000 live births and U5MR to 25 per 1,000 live births by 2030. The country has set its targets within the NDP III to reduce IMR from 41 to 34, U5MR from 62.2 to 30, and MMR from 311 to 211 by 2025.

02.1.1 Ending Maternal Deaths

Though maternal mortality has declined,[a] the pace of reduction is too slow and neonatal mortality remains unchanged. More than 6,600 women continue to die per year (averaging 18 women per day) due to preventable pregnancy-related causes. The Maternal and Perinatal Death Surveillance and Response (MPDSR) 2020 report shows that almost 90% of institutional maternal deaths are due to haemorrhage (45%), pregnancy-related sepsis or abortion complications (21%), and hypertensive disorders of pregnancy (13%) (Figure 1). So, these three remain a priority issue in reducing maternal deaths. Greater emphasis needs to be on post-partum haemorrhage (PPH), which contributes 80% of the haemorrhage-related maternal deaths. The key drivers to these immediate causes of death include inadequate or no antenatal care (ANC) to address possible underlying conditions especially infections, anaemia, and hypertension that account for 75% of maternal mortality indirect causes. Pregnancy-related sepsis and abortion complications are relatively higher among adolescent and young mothers accounting for 39% of deaths and may be a cause of excess mortality in this age group.

Figure 1. Causes of Institutional Maternal Mortality



Source: MPDSR Report, 2020.

About 60% of the maternal deaths in health facilities are attributed to late and critical referrals, and delays to access caesarean section, magnesium sulphate interventions at the referral sites (3rd Delay). Most mothers dying have been referred to hospitals (57%) and delivered by caesarean section (32.4%), implying serious breaks in functioning of the referral system and inadequacies in comprehensive obstetric emergency care. Since more than 80% of deliveries are by midwives and majority of births (75%) take place in health centres (HCs) and general hospitals (GHs), midwifery competences and supports to ensure quality of ANC, intrapartum care, effective referral, and immediate postnatal care (PNC) need to be prioritised to reduce institutional mortality. Functionalising bEmONC (HC IIIs) in all subcounties and cEmONC (HC IVs) in all constituencies and improving maternity care experience and satisfaction to increase uptake will be essential. Even when mothers survive difficult labour, nonfatal health complications (e.g., mental health and fistula) may occur affecting them for a longer duration and yet care is absent in the PNC package. Hence, the

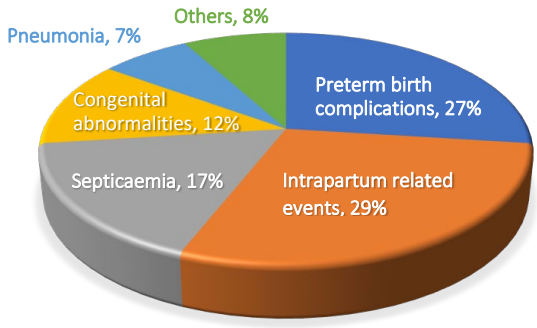
[a] The last Uganda Demographic and Health Survey (UDHS) was done in 2016.

content of not only PNC but also ANC needs to be reviewed. The rapidly growing population, higher service coverage targets toward UHC, and increased frequency of contacts per new clinical protocols will outstrip the public sector sites and necessitate enfolding the private sector.

02.1.2 Ending Preventable Newborn Deaths

Annually, more than 80,000 infants still lose their lives in Uganda due to preventable causes, and neonatal mortality has stagnated over the past decade (27 deaths/1,000 live births). Almost one-third of child deaths are newborns and that proportion is rising. Reducing neonatal deaths remains a big challenge, yet any significant mortality reduction among children is not possible without tackling the newborn deaths. About 75% of institutional early newborn deaths reviewed in MPDSR are directly due to birth asphyxia (49%), complications of prematurity (14%), and septicaemia (12%) (Figure 2). It is estimated that 73% of all neonatal deaths occur during the first week of life, with 36% on the day of birth. It is estimated that low birth weight[b] (LBW) and intrapartum complications account for nearly 70% of neonatal mortality worldwide and share causation with stillbirth worldwide.[3] In Uganda, 12% of infants are born LBW and 14% are born premature. LBW is a significant predictor of neonatal mortality and morbidity as well as future health, and nutritional and developmental status. LBW is a key observable component of a child's initial endowment within the human capital development journey.

Figure 2. Causes of Institutional Newborn Deaths



Source: MPDSR Report, 2020.

To effectively reduce newborn mortality, priority will be on improving survival of preterm and LBW infants as well as management of newborn sepsis. The institutional death burden is highest for preterm babies who account for 0.7% of all hospital admissions in Uganda, and yet these admissions account for 11% of under-5 deaths. A package of interventions that reinforces essential newborn care competencies and investments in newborn resuscitation equipment, kangaroo mother care for LBW babies, intensive/special newborn care units at referral facilities, provision of antenatal corticosteroids for premature labour, and newborn antibiotics need to be implemented to decrease the 42,000 fresh stillbirth and neonatal deaths among LBW babies and 28,000 preterm babies born annually. Meeting the target of reducing LBW by 30% between 2012 and 2025 will require more than doubling the current rate of progress by tackling the modifiable underlying contributors including preconceptual and maternal nutrition, adolescent pregnancies, malaria prevention, family planning, and full ANC. Most of the estimated 100,000 (5% of births) small and sick babies per year would survive with essential care[c] but a considerable number will need special or intensive care or antibiotics—available at HC IVs and GHs—to survive. Follow-up of all small and sick babies with long-term growth and development monitoring is needed for catch-up growth and to combat health consequences such as undernutrition later in life, and to ensure they not only survive but thrive with stronger linkages to early child development (ECD) and child rehabilitation interventions.

[b] Includes those born preterm (<37 weeks' gestation) with intrauterine growth restriction (IUGR), or both.

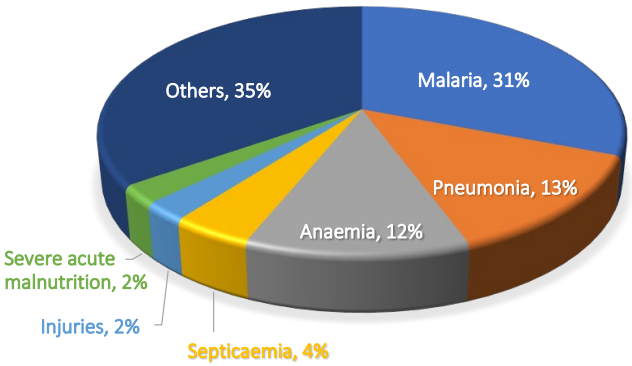
[3] Oza S, Lawn JE, Hogan DR, Mathers C, Cousens SN. Neonatal cause-of-death estimates for the early and late neonatal periods for 194 countries: 2000–2013. Bull World Health Organ. 2015;93(1):19–28.

[c] Such as neonatal resuscitation (helping babies breathe [HBB]), essential newborn care, care of the small and sick newborn (kangaroo mother care, use of oxygen, nasogastric tube feeding with breast milk, use of antibiotics, and phototherapy).

02.2 Improving Child Health

The goal for child health is surviving and being raised as healthy, well-educated children who are mentally and socially ready for adulthood, and enjoyment of health and well-being. Uganda, like the rest of the world, has registered a drop in U5MR with more children now surviving past age 5. The use of survival strategies including immunization, integrated community case management (ICCM)/integrated management of newborn and children illness (IMNCI), paediatric HIV care, long life insecticide-treated nets (LLITNs) must be sustained in the next period to further eliminate preventable deaths and safeguard gains made. This age group represents 30% of Uganda's population. Though Uganda continues to make progress in reducing child mortality, an estimated 60,000 children still die per year. Despite being only 17% of the population, they accounted for 27% and almost half (44%) of outpatients and admissions in health facilities, respectively. More than 167,000 children younger than 5 continue to be lost every year in Uganda[4] mainly due to malaria, pneumonia, diarrhoea, and underlying malnutrition (Figure 3).[5] Diarrhoea-related deaths have declined largely due to improvements in global water, sanitation, and hygiene (WASH), rotavirus vaccine roll-out, and access to oral rehydration salts solution and zinc. Malaria and pneumonia deaths, however, remain high despite vaccines, improved care-seeking behaviour, universal LLITN use, among other measures. Inadequate quality of treatment persists at 23 deaths per 1,000 under-age-5 admissions, driven by increased malaria and pneumonia deaths. Though the vaccine package has been expanded to 12 childhood vaccines, the number of unimmunised children—estimated at 350,000 for BCG and 730,000 for oral polio vaccine (OPV) in 2020—remains very high. Approximately 3.6% of children suffer from moderate acute malnutrition (MAM), while 1.3% have severe acute malnutrition, and these cases remain largely hidden due to difficulty of assessment in these children.[6] Anaemia, which reflects several micronutrient deficiencies, occurs in more than half of children (53%) under 5, higher than the WHO cutoff (greater than 40%). Undernutrition is the underlying cause for about four in 10 deaths of children under 5. The 12–25% mortality among children with severe malnutrition remains unacceptably high[d] and with limited treatment availability.[e] Verbal autopsies show that malaria, injuries (burns, fractures, trauma), and gastrointestinal diseases play an increasing role in the deaths of older children aged 5–9.

Figure 3. Causes of Child (1 Month to 5 Years) Mortality in Uganda (2020)



Source: MPDSR Report, 2020.

Currently, child health interventions in the country are delivered through vertical initiatives such as immunization, ICCM/IMNCI, paediatric HIV care, facility ready-to-use therapeutic foods (RUTF), and LLITN distribution. Accelerating and safeguarding the reduction in child mortality beyond neonatal period will require expanding high-impact preventative and curative interventions; integration of

[4] United Nations Children's Fund (UNICEF). Levels and trends in child mortality: report 2014 estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: UNICEF; 2014.
[5] Liu L, Oza S, Hogan D, Perin J, Rudan I, Lawn JE, et al. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. Lancet. 2015;385(9966):430–40.
[6] Uganda Bureau of Statistics (UBOS), ICF. Uganda demographic and health survey 2016: key indicators report. Kampala (Uganda) and Rockville (MD): UBOS and ICF; 2017. UNICEF Uganda. Nutrition situation analysis: trends in nutrition status, behaviours, and interventions. Kampala (Uganda): UNICEF Uganda; 2018.
[d] Set targets are 5% and 10% by the WHO and Sphere standards, respectively.
[e] Refugee hosting districts: Karamoja and Regional Referral Hospitals.

interventions for healthy, vulnerable, and sick child services across facilities; family/community and interventions by other sectors; and acting on key causes of death and poor growth and development among older children. Attention needs to be given to chronic illnesses such as sickle cell and asthma, and the coordination of long-term primary care delivery systems integrating facility and community/family/self-care.

The WHO redesigned child and adolescent health standards[7] introduces a paradigm shift in programming. The standards expand the focus from age group 0–4 to 0–19 within the extended nurturing care framework, place greater emphasis on preventing emerging mortality in older children (age 5–10) and adolescents including care for chronic physical and mental health conditions, and promote people-centred delivery of comprehensive care and multisectoral services for families, children, and adolescents in all health programmes and health-related sectors.[f]

02.3 Adolescent Health and Well-Being

Adolescent girls and boys (aged 10–19) remain a particularly underserved population by health and social programmes yet they make up 24% (greater than 10 million) of the population. This group—with its unique RMNCAH needs, burdens, and challenges—remains underserved. Yet, investment in adolescent health delivers a triple dividend of benefits for adolescents today, for future adults, and for the next generation.

02.3.1 Adolescent Health Services

Adolescents accounted for 14% of institutional maternal deaths and 7% of facility deliveries in 2020, with complications of pregnancy and childbirth being a leading cause of death among 15- to 19-year-old girls.[8] The median age at sexual debut for girls is 17 years, 43% are married by 18 years, and every one in four 15- to 19-year-old girls is a mother or pregnant, yet not accessing safe contraception.[g] Adolescents are also at an increased risk of mortality and morbidity associated with accidents, violence, HIV infection, drug use, and other preventable or treatable illnesses. Menstruation has emerged as an important cause of school absenteeism. An estimated 20% of young people experience some form of mental illness such as depression, suicidal tendencies, mood disturbances, substance use and abuse, eating disorders, and gender-based violence (GBV). Female genital mutilation (FGM) and child marriage are still practiced in the Sebei and Karamoja regions. Adolescent deaths (per 100 population) between 2010 and 2015 in Uganda were estimated to be 7.3%, higher than the African Region of 6.1%.[9]

In the previous plan, three key health sector investment areas for adolescent health were prioritised: (1) provision of appealing and actionable data/information on adolescent health (ADH) issues to widen and deepen participation and engagement of stakeholders, (2) school-based and school-linked health facilities that provide the full ADH package with adolescent's participation in managing and implementing peer-to-peer education and support, and (3) establishing a pipeline for rapid scale-up on effective local context innovations. Progress has been made on (2) but little on (1) and (3) though efforts started late in 2021. While all adolescents need access to comprehensive sexuality education (e.g., to enhance sexual and reproductive health [SRH], HIV, and sexually transmitted infection [STI]

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[7] World Health Organization (WHO). Standards for improving the quality of care for children and young adolescents in health facilities. Geneva: WHO; 2018. Licence: CC BY-NC-SA 3.0 IGO.

[f] Based on the Social Development Agenda, World Health Organization (WHO), and United Nations Children's Fund (UNICEF) guidance for countries to address the needs of children and adolescents in an integrated manner for their optimal survival, health, growth, and development toward their full potential.

[8] Ministry of Health (Uganda). The annual maternal and perinatal death surveillance and response (MPDSR) report FY2019/2020. Kampala: MOH; 2021.

[g] The Government of Uganda deferred the launch of the 2017 National Guidelines and Service Standards for Sexual and Reproductive Health and Rights mainly due to reactions regarding contraceptives for adolescents aged 15–49 years.

[9] WHO/UNICEF 2016.

knowledge, increase agency and power balance in relationships, promote gender equality, and demand creation), their RMNCAH needs vary by age, gender, and context. With only 26% of facilities having staff adequately trained in adolescent-and-youth-friendly (AYFS) services, too few adolescents can access responsive care. Other gaps include limited reach to boys and the most-at-risk adolescent girls, verticalized and narrow range of available services, contradictions in age of sex debut and national legislation regarding access to services, meaningful engagement and participation of young people in health limited to pilots and incidental rather than structural basis, insufficient service provider competences, and unfavourable organisation[h] of services at health facilities.

Adolescents require access to age and context appropriate information, commodities, support, and integrated services as laid out in the National Adolescent Health policy. To move forward, all adolescents will need access to comprehensive sexuality education whether in or out of school. Ensuring that the 34% of adolescents already in union, and those sexually active (18–19 years and young women) have access to modern contraceptives would drop the unintended teenage pregnancies by 72% in Uganda. Targeting adolescents of all ages, parity, and marital status with self-care RMNCAH commodities and technologies offers enormous prospect.[10] Service delivery to adolescents (and young mothers) requires developing age- and situation-differentiated delivery models with more structural engagements such as peer-led approaches, networks/alliances, innovative platforms for reaching the most vulnerable adolescents, and use of motivational community-based counselling regimes for modern contraception adoption including long-acting reversible contraceptive (LARC). Adolescent service provider competencies, founded on the rights-based approach, need to be integrated in pre-service and continuous professional education.

To increase convergence of multisectoral efforts, adolescent health services will need to change from the current "treatment, prevention, and risk reduction" approach to a more "strengths- and resilience-building" approach within the extended nurturing care framework. The child health redesign for healthy child and adolescent programming sets at least six key domains reflecting the specific needs for each of the five periods from the life course defined in the NDP III: (1) good health; (2) adequate nutrition; (3) responsive relationships and connectedness; (4) security, safety, and supportive clean environment; (5) opportunities for learning and education; and (6) realization of personal autonomy and resilience. Work with families through "adolescent and family-centred" care and a school health platform is needed to shape the supportive and positive parent-child relationships that increase social connections and connections with other sectors.

02.3.2 School Health Promotion

School health programs play a critical bridging role in ensuring comprehensive and cohesive health services for children into adolescence and across the life course. Previous school health interventions have weakly impacted on school health indicators. Adolescent pregnancies remain high and are a big contributor to school drop-out in many parts of the country; sexual violence in primary schools is at 77.7% while in secondary schools at 82%; and almost 22% of adolescents are starting some form of sexual activity. The National School Health Policy 2018–2023 guides the design and implementation of interventions to improve health in school settings through school medical facilities, school-based health clubs and safe spaces, and improved monitoring and tracking.

School Health Promotion (HPS) initiatives and other whole-school approaches to supporting health in education have been implemented for several decades, especially for primary schools. However, numerous gaps limit effectiveness across the education levels based on global standards for HPS

[h] Includes long waiting time, lack of privacy and confidentiality, long queues, multiple registration points, and inappropriate/inconvenient open hours; also facility programs including ANC, delivery, and PNC are generally not attuned for teenage mothers.

[10] Bergstrom K, Ozler B. Improving the well-being of adolescent girls in developing countries. Policy Research Working Paper No. 9827. Washington (DC): World Bank; 2021.

designed to support whole-school approaches in education settings.[11] Areas that require improvement include aligning school health services with health priorities; establishing effective pathways for students and adolescents to contact health providers; establishing surveillance;[g] collecting, analysing, sharing, and using school health data in education and health sector at all levels; and building requisite competences in visiting or dedicated school nurses in implementing the policy. The country will build on existing efforts and adapt the 2020 guidelines with the aim of making every school "a health-promoting school through a standards-driven approach that includes menstrual health and hygiene promotion." Eight core global standards, implementation guidance, and core school health services need to be applied at all school levels, from ECD to tertiary institutions.

Schools offer a unique opportunity to implement effective RMNCAH health services at scale for children and adolescents. Challenges to current school health and nutrition interventions are not being well founded on evidence, not being well implemented, and being underfunded and/or limited in reach and scope. Yet, school-age children and adolescents (i.e., those aged 5–19) experience a range of largely preventable health problems. While efforts will be toward increasing enrolment/attendance, targeting the vulnerable students at all levels remains weak and the quality of learning is very limited.[12] The impact of the high numbers of adolescent unintended pregnancies and child marriages due to prolonged COVID-19-related school closure is likely to cause a significant share of school dropouts. Thus, universal free secondary school and other efforts to reintegrate adolescent mothers remain critical for the education sector.

02.4 Improving Women's Health

Delivering appropriate care, support, and information to women and their families according to needs throughout the life course remains critical to achieving health goals. Strategic reframing of health care delivery to women is needed to accelerate coverage. Priority actions to safeguard reproductive health will focus on family planning, nutrition, and PAC management. For every maternal death, an estimated 20–30 more women experience acute or chronic pregnancy-related maternal morbidities, such as obstetric fistula or depression,[13] and yet these are poorly treated or measured. Cervical cancer is the leading cause of female cancer deaths in Uganda with an estimated 4,607 annually. The country is rolling out HPV vaccines that will reduce the incidence of cervical and other anogenital cancers.

02.4.1 Family Planning

Over the last period, family planning (FP) was a priority intervention with a target to harness the huge, missed opportunities for FP integration at both facility and community outreaches. The target was to increase modern contraceptive prevalence rate (mCPR) for married women from 35% to 42.1% mainly by scaling up community distribution of contraceptives and postpartum long-term and permanent contraception. Though access to FP has significantly improved along with a growing demand for services, the total fertility rate[h] has not changed much. High fertility is driven by low CPR, early sexual debut with over half (54%) of young women beginning childbearing by age 19, persistently high teenage pregnancy rate of 25%, and near universal marital union. Among married women, mCPR rose marginally from 26% in 2015 to 29% in 2020, and the unmet need for FP reduced from 13% in 2015 to 11% in 2020 (short of 10% target in FP CIP indicating very slow progress). Though demand satisfied has progressed slowly from

[11] World Health Organization, United Nations Educational, Scientific, and Cultural Organization (UNESCO). Implementation guidance for health promoting schools draft 2: September 2020. Geneva: WHO; 2020.
[g] This includes ensuring COVID-19 immunisation of teaching and nonteaching staff, as well as the children.
[12] NDP III.
[13] Firoz T, Chou D, von Dadelszen P, Agrawal P, Vanderkruik R, Tunçalp O, et al. Measuring maternal health: focus on maternal morbidity. Bull World Health Organ. 2013;91:794–796. doi: 10.2471/BLT.13.117564.
[h] Declined from 7.4 children per woman in 1989 to the current estimate of 5.4 in 2016 (UDHS).

44% in 2014 to 57% in 2020, mCPR remains low, and women on average still give birth to two children more than they want. Almost 1 million pregnancies per year are unplanned.

The availability and quality of FP services remains inadequate in ensuring effective coverage or in dispelling the perverse negative norms surrounding infertility, particularly given the high childbearing value placed on women in Uganda. As a result, the average annual increase in mCPR for all women is 1.2% over the last decades. Fertility rates are still very high, and even with an increasingly larger population group reaching childbearing age, unmet need remains high. This is too slow and necessitates significant changes in FP programming and service delivery. Delaying birth beyond adolescence,[i] preventing rapid pregnancies (spacing births by at least three years), and engaging partners offer promise of reaching coverage. Repositioning FP in a wider and nonmedicalised framework that brings together appealing interventions for women before and after pregnancy (e.g., adolescent and maternal nutrition, ECD, prevention of nonfatal maternal disorders) will have a more significant, longer-term impact on demand and uptake.

02.4.2 Post-abortion Care

In Uganda, an estimated 54 unsafe abortions per 1,000 women of reproductive age occur annually, with an estimated 300,000 induced abortions that account for 14% of all pregnancies or 39 per 1,000 women aged 15–49.[14] Although an estimated 77% of abortions treated in the public health system are induced, unsafe abortions account for almost 40% of admissions to emergency obstetric care units. They are responsible for significant morbidity and mortality, especially among adolescents and young women. The unsafe abortion rate among adolescents is estimated to be 26 per 1,000 for ages 15–19 in Africa, and in Uganda. Uganda has restrictive abortion laws, making post-abortion care (PAC) critical to saving lives and protecting the health of thousands of young women per year. Maternal deaths due to abortion complications are mainly at HCIIs and HC IIIs; none at higher levels. Thus, a comprehensive PAC package (based on the national guidelines, April 2015) will be strengthened at HC IIIs and above with skilled and MVA-equipped midwives as the main providers of basic PAC. Overall quality of PAC services is "poor" with more than two-thirds of patients not receiving postabortion FP counselling, modern contraceptives, and other reproductive health services. Meeting women's contraceptive needs will remain a critical strategy to help women avoid unintended pregnancies. Safeguarding equitable and good-quality PAC in the country still requires an enabling law.

02.4.3 Periconceptual and Maternal Nutrition

National anaemia rates among women of reproductive age (26% in 2019/2020) have persistently remained high regardless of economic status. An estimated 28.5% of women aged 15–49 have anaemia, which affected more than half of children (53%) under age 5 in 2016.[15] The prevalence of underweight and stunting among women aged 20–49 is 6.9% and 1.3%, respectively. Women's nutrition has not received sufficient program attention due to the narrow focus on nutrition during pregnancy, yet many women do not enter ANC until second or third trimester. Within this window, much of the focus has been on infants and children and, to a lesser degree, on periconceptual[j] and maternal nutrition status, despite implications for maternal, birth, infant, and child outcomes. Several evidence-based strategies exist to improve maternal nutrition during pregnancy; however, key gaps remain in program implementation and equity. The previous plan targeted a full spectrum of approaches for improving nutrition that were to be implemented through a multisectoral response.

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[i] Contraception among adolescents will be reviewed to provide compelling evidence on the current gaps and align with WHO 2014 guidance.

[14] Moore MA, Kibombo R, Cats-Baril D. Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion. Health Policy Plan. 2014;29(7):893–901.

[15] Sserwanja Q, Mukunya D, Habumugisha T, Mutisya LM, Tuke R, Olal E. Factors associated with undernutrition among 20- to 49-year-old women in Uganda: a secondary analysis of the Uganda demographic health survey 2016. BMC Public Health. 2020;20(1644). doi: 10.1186/s12889-020-09775-2.

[j] Any intervention provided to women and couples of childbearing age before pregnancy—regardless of pregnancy status or desire—to improve health outcomes for women, newborns, and children.

The Uganda Nutrition Action Plan (UNAPII) 2018–2025 and Uganda Maternal, Infant, Young Child, and Adolescent Nutrition Action Plan (MIYCA) 2020–2025, were developed in the previous period to guide multisectoral actions and RMNCAH nutrition priorities. More effort will be put on adolescents' and women's nutrition across the continuum of preconception to pregnancy, which is critical for ensuring positive pregnancy and long-term outcomes for mother, child, and family. Many synergies exist to program periconceptual care alongside FP.

02.5 Older People

Uganda's life expectancy has gradually increased past the 60-year-old mark,[16] from 50 to 63 over the past 10 years.[17] This ageing population is mainly due to the reduction of mortality among children and falling fertility rates. Older people have accumulated financial capital, possess institutional memory for society, and are guardians of cherished societal norms, values, and standards. Harnessing the longevity dividend has immense opportunities for socioeconomic development. In line with global trends, the absolute number of older people in Uganda increased from 840,000 in 1991 to an estimated 1.7 million in 2020. The percentage of older adults is expected to rise above 5% (greater than 2.2 million) of the national population by 2025.[18] As people age their physical and mental capacities decline. Their health issues become more chronic and complex, and they have unique long-term multimorbidity health and social needs.

The decade of 2020–2030 has been declared the decade of healthy ageing.[19] Healthy ageing is defined as "the process of developing and maintaining the functional ability that enables well-being in older age."[20] The International Conference on Population and Development's Beyond 2014: International Conference on Human Rights recognised older people as one of four key population groups that has been marginalised and excluded in ensuring their rights and access to sexual and reproductive health (SRH).[21] The Uganda NCD Alliance Strategic Plan 2016–2019 identified the common health problems of older people as physical, primarily noncommunicable diseases (NCDs) and SRH malignancies; and mental, mainly dementia and depression. However, SRH services for older people remain minimal. Menopause, andropause, cumulative impact of pregnancy and childbearing during the reproductive age, impact of NCDs and their medications on libido, erectile dysfunction, and energy levels. Evidence shows that more than 80% of men and 65% of women remain sexually active in old age.[22] The minimal perception of STI risk among older people means less protection during sexual activity with evidence of rising new HIV infections in this group. The proportion of PLHIV aged 50 and older is expected to rise from 17% in 2019 to 41% by 2030, contributed to by increased survival and new HIV infections.[23] More women who survive reproductive age—with serious injuries or disabilities due to childbirth and other health issues—suffer from conditions such as severe anaemia, incontinence, damage to the reproductive organs or nervous system, chronic pain, and infertility.

The primary health care system is not designed to meet or address issues of older people, including lack of health management information system (HMIS) data on SRH of older populations and ageistic attitudes by health providers. Challenges exist with the availability, accessibility, acceptability, and

[16] World Health Organization (WHO). Global strategy and action plan on ageing and health. Geneva: WHO: 2017. Defines age 60 and above as "older" people.
[17] Uganda Bureau of Statistics (UBOS). National population and housing census 2014—main report. Kampala (Uganda):UBOS; 2016.
[18] Ajwang M, Muliira JK, Nankinga Z. Continuing education in geriatrics for rural health care providers in Uganda: a needs assessment. Afr J Health Prof Educ. 2010;2(2):3–8.
[19] United Nations. Decade of healthy ageing: 2020–2030. New York: United Nations; 2020. Available from: https://www.who.int/initiatives/decade-of-healthy-ageing.
[20] WHO. World report on ageing and health. Geneva: WHO; 2015. p. 28.
[21] Aboderin I. Sexual and reproductive health and rights of older men and women: addressing a policy blind spot. Reprod Health Matters. 2014;22(44):185–90.
[22] Nicolosi A, Laumann EO, Glasser DB, Moreira ED, Paik A, Gingell C. Sexual behavior and sexual dysfunctions after age 40: the global study of sexual attitudes and behaviors. Urology. 2004;64(5):991–7.
[23] AIDS Control Programme. The 2019 HIV epidemiological surveillance report for Uganda. Kampala (Uganda): Ministry of Health; 2020.

quality of health care for older people. The attention of this plan extends the life course approach to tackling SRH services in post-reproductive years. Uganda's health care system should be strengthened to provide long-term care to older people with chronic conditions, especially continuing care at HC IIIs.

Aligning health and long-term care systems to the needs of the older population requires a transformative approach. Systems will need to respond to individuals whose status can be described as: (1) capacity is high and has stable level, (2) capacity is declining, and (3) capacity has fallen to the point where care and support are required from others. Priority actions needed:

1. Developing SRH service standards for older people and their needs based on a client-focused approach of tailored medical checkups as well as a diagnostic assessment and counselling sessions. Uganda's primary health care system should be strengthened to provide long-term care for older people with chronic conditions, especially continuing care at HC IIIs. The establishment of community outreach or home care services for disabled older people could also solve the challenges of access.
2. Conducting advocacy campaigns to raise awareness of health and multisectoral needs and rights of older people, and ageism and elderly abuse.
3. Combating ageism and integrating capacity-building for health workers, facilities, and caregivers within the existing system to address older people's needs and ensure a life cycle approach to cope with the complexity of Uganda's ageing population.
4. Improving information management systems for healthy ageing in Uganda.

02.6 Cross-Cutting Issues

02.6.1 WASH

In the previous planning period, access to sanitation facilities (improved toilet, unimproved and shared) increased by only 4%. Though many initiatives are currently on the ground to improve WASH, almost 61% of Ugandans lack access to safe water and 81% do not have the required improved toilets. Hygiene is still poor with more than 58% of the population not practicing basic hygiene of hand washing with soap. Almost all (95%) health facilities have some usable sanitary facilities with 64% having limited sanitation services (at least one improved sanitation facility, but not all requirements for basic service are met). School sanitation is also poor with high pupil-toilet ratio of 72:1 against the standard of 45:1 for day schools and 25:1 for boarding schools. Only 21% of schools had facilities to cater for menstrual hygiene. Hand washing coverage in schools was at 57%.

02.6.2 HIV/GBV Linkages

Over the past five years, Uganda has progressed in the fight against HIV and AIDS and fully achieved the 90–90–90 targets with a drastic reduction in number of new infections from 66,000 in 2015 to 38,000 in 2020. The HIV prevalence among adults (15–49 years) in Uganda is 5.4%, higher among females, and the number of PLHIV has reached 1.4 million. For ages 15–24, HIV prevalence among females is three times that of males (0.8% males, 3.3% females). Among adolescents aged 10–24, females have the largest burden, more than 70% of new infections.

National Policy on Elimination of GBV[24] calls for specific promotion of male involvement as a strategy to enhance community participation in prevention and response to GBV. Despite multisectoral efforts, high levels of GBV persist. The Uganda Police Annual Crime Report 2020 raises a concern over the increase of defilement, domestic violence, and rape cases, among others. GBV is still socially justified

[24] Ministry of Gender, Labour and Social Development (MGLSD). The national policy on elimination of gender-based violence in Uganda. Rev. ed. Kampala (Uganda): MGLSD; 2019.

by half of women and 41% of men. The policy places drivers on unequal power relations, poverty, misuse of ICT and media, HIV and AIDS, alcohol abuse, polygamy, unemployment, limited education, biases in socialization, poor parenting practices, and impunity. The Uganda Demographic and Health Survey (UDHS) 2016 shows prevalence of GBV at (51%) of women and 52% of men who have ever experienced physical violence since age 15. Over half (56%) of ever-married women and 44% of ever-married men have experienced spousal violence with FGM prevalence at 6.4% in Karamoja and 2.6% in Sebei regions.

Linked together in a complex cycle of causes and consequences, poor SRH including HIV and AIDS, and sexual and gender-based violence (SGBV) remain major public health concerns for Uganda. Among young women aged 15–24, 15% have experienced sexual violence at some point in time. Policy efforts include the National SRHR/HIV Integration and Linkages Strategy, establishment of a technical platform under the leadership of the MOH, and various assessments and studies on integration including SRH/HIV integration in Global Fund programming. Despite this progress on policy, integration is still beset by inadequate training of health workers; lack of integrated SRH/HIV and GBV services delivery; inadequate referrals; inadequate service delivery organisation; and lack of proper infrastructure space, which compromises privacy and confidentiality for provision of integrated HIV/SRH services.

The expanded elimination of mother-to-child transmission (eMTCT) interventions have reduced the numbers and proportion of children contracting HIV from their HIV-positive mothers. Still, mother-to-child transmission accounts for 14% of all new infections and about 90% of newly identified HIV-positive cases in (PMTCT) sites from mothers younger than age 24. Adolescent girls and young women (AGYW) have higher rates of unplanned pregnancy, suboptimal uptake of ANC and PNC; and, among women living with HIV, poorer adherence to treatment and lower viral load suppression. Despite these outcomes, AGYW and women living with HIV receive less attention for preventing pregnancy and managing pregnancy and parenthood in maternal health services that treat women the same, regardless of age or HIV status.

To plug the gaps, the country will need to strengthen delivery of integrated SRH/HIV and GBV care packages that also include cervical cancer screening. Collaboration among SRH, HIV, and SGBV services will be moved toward actual implementation. Despite the availability of policy guidelines, identification, assessment, treatment, documentation, referral, and follow-up are still inadequately addressed at facility levels.

02.6.3 Equity

Underlying the persistently high levels of maternal and newborn death and disability in Uganda is the failure to assure women's rights and gender equality. Women's low status and lack of power, poor access to information and care, constrained movement from home, early age of marriage, and the low priority and resources given to adolescent health all contribute to high mortality rates. Overcoming these factors means challenging the religious, cultural, and political norms and legal frameworks that limit access, independent informed choices, and space for appropriate actions to ensure, healthy sexual and reproductive lives for all.

Although government has expanded health services for poor and vulnerable populations, health inequity remains widespread impacting maternal, reproductive, neonatal, child, and adolescent health outcomes. Uganda is still marked by vast social inequalities between rich and poor, high and low levels of education, urban and rural populations, and dominant and minority ethnicities. Most of the differences are typified in neonatal, infant, and under-5 mortality disparities along geographical locations, mother's wealth and education; more so than rural or urban residence. Some regions have higher burdens and rates of this mortality and poor child nutrition including lower RMNCAH service utilisation. Very traditional communities; ethnic minorities or strong tribal communities (e.g., Batwa,

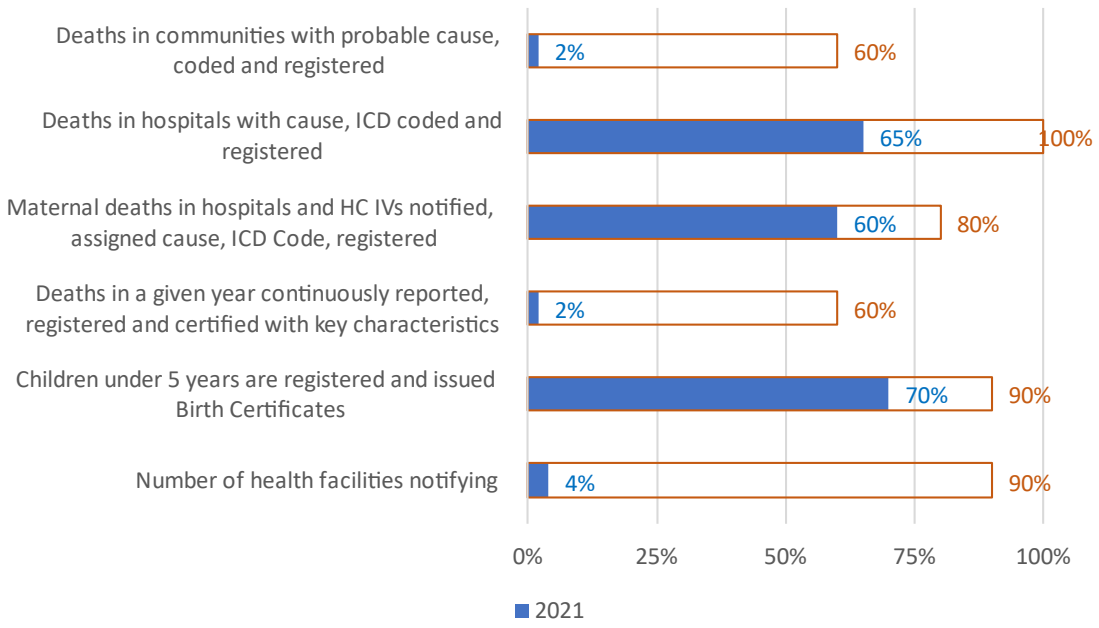
Karimajong); and people of lowest socioeconomic status, those with refugee backgrounds, young unemployed in urban areas, prisoners, and sexual minorities all have fewer health-promoting behaviours and higher RMNCAH-risk activities.

Thus, efforts are needed to prioritise these communities first. One major challenge in addressing RMNCAH inequities in Uganda is the lack of systematic collection of data disaggregated by socioeconomic status to better monitor health equity trends beyond the UDHS. For example, people with disabilities remain unseen in data, with their special needs largely unmet. Identifying bottlenecks and reaching vulnerable and marginalized adolescents will require increased effort if greater equity is to be achieved. Operational research is needed to provide key information on how to better identify and target such population groups having the worst health outcomes.

02.6.4 Birth and Death Registration

Systematic registration of births (30%) and deaths (1%) was virtually nonexistent in 2015; the previous investment case called for building a functioning civil registration and vital statistics (CRVS) system in the country. Until January 2016, the registration of births and deaths in Uganda was regulated by the Births and Deaths Registration (BDR) Act Cap 309, Laws of Uganda (1970). The new law Registration of Persons Act (ROPA) 2015 provided for immediate and compulsory registration of all births and deaths and tasked all medical facilities to record these events and file returns to the local National Identification and Registration Authority (NIRA) officer, including declarant reports for events occurring outside medical facilities. The ROPA 2015 combines registration of births and deaths and national identification system, using a unique national identification number (NIN) shared by the national identification card and recorded on birth registers and certificates.

Figure 4. Coverage of Birth and Death Registration against Target Set for 2021



The previous plan set out to strengthen the CRVS system through strengthening the civil registration authority to carry out its mandate and scale up BDR across the country. It focused on developing and disseminating CRVS strategy and communication steps; developing registration documents; establishing a monitoring and evaluation (M&E) system for CRVS; and scaling up BDR services at health facility and community level.

Progress was made in early 2021 to communicate the new law. The low-cost Mobile Vital Records System (MVRS) has been scaled up at facility level to 63 districts and its use has rapidly increased birth registration coverage and reduced turnaround time. BDR has been incorporated in the HMIS, and hospital providers trained in International Classification of Diseases (ICD) 11 coding of death. Facility-level collection of information and reporting of causes of death is slowly improving, and BDR performance has been included in the results-based financing (RBF). However, information and M&E linkages between NIRA registration, UBOS, and HMIS remain undeveloped.

Improvements have been registered in hospital and HC IV birth and death registration but number of facilities notifying deaths is very low (4%), and deaths continuously registered and certified with key characteristics remains at only 2% (Figure 4). Birth notification through the Mobile Vital Registration System (MVRS) is operational in 135 hospitals. NIRA currently has 117 registration centres for births, deaths, and adoptions but at the current CRVS coverage level, the BDR system is not yet able to count every maternal and perinatal death nor provide universal birth registration. Strengthening health worker capacity in notification at health facility and community (in VHT registers) levels, including providing causes of deaths, remain central to expanding BDR coverage, quality, and reporting.

02.7 COVID-19 Impact on RMNCAH

The pandemic and actions taken to address it adversely interrupted provision and use of essential RMNCAH health services in the country and led to additional maternal, newborn, and child deaths, and stillbirths. Though children, adolescents, and women less than 35 years old had no or milder symptoms, they were severely affected by disruptions in essential health, education, and other social services, and an increase in inequality. Use of RMNCAH services plummeted so much that maternal and neonatal deaths and stillbirths indirectly caused by the lockdown exceeded deaths due to COVID. The country noted a 29% (28,939) reduction in recorded facility deliveries in March compared with January 2020, 28% less than the 12-month average for 2019. Over the same period, recorded maternal deaths increased 82% (from 92 to 167 women). Many health facilities noted additional mortality burden as a result of the COVID-19 lockdown period. This exposed alarming gaps in the national primary health care system and the need for greater investment in health centres and community service delivery, including maintaining the function of the HMIS, to ensure resilience of essential care for all while responding rapidly to emergencies.

During the lockdown, the country prepared and implemented a national plan for continuing essential lifesaving RMNCAH services as part of country preparedness and response for COVID-19, adapted from global and regional guidelines and standard operating procedures (SOPs). During the period, new innovations—especially digital technologies—helped improve outreach; multisectoral action along with private sector partnerships were quickly reinforced, and the role of village health teams (VHTs) in resilience and reach was appreciated, with a call for government to start their remuneration.

Post-COVID-19 surges are likely to be seen in stunting rates due to factors related to maternal nutrition during pregnancy and nutrition during infancy, worsened by increased poverty.[25] The prolonged school closures (more than two years) resulted in surges in adolescent pregnancy and sexual and GBV that might also impact mental health, especially among adolescents and young people. As schools reopen, the already overcrowded education system will heighten the need for functionalising a school health system in the country. Disadvantaged families were disproportionally affected, which calls for the need to target the inequalities.

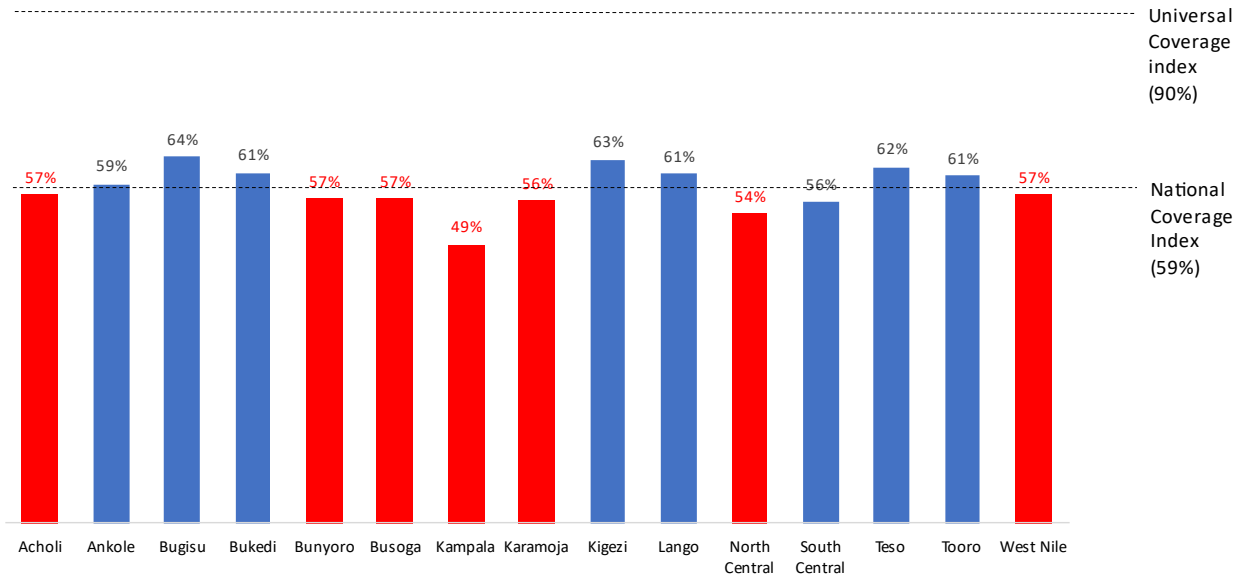
[25] Galasso E, Wagstaff A. The aggregate income losses from childhood stunting and the returns to a nutrition intervention aimed at reducing stunting. Econ Hum Biol. 2019;34:225–38.

03: ACHIEVING EFFECTIVE COVERAGE

03.1 Coverage of RMNCAH Interventions

Despite improvement, current data on use illustrates that countrywide 41% of people are at risk due to ineffective coverage of RMNCAH care services and inequities. Unless the bottlenecks are identified and addressed, efforts to strengthen health systems will be unsuccessful. This section identifies barriers impeding effective coverage and priority actions for system strengthening.

Figure 5. Composite RMNCH Coverage Index by Region DHIS2 2020



The composite coverage[k] index (CCI) in Figure 5 shows an overall 59% at the national level but regional disparities exist with six of 15 regions registering wider coverage gaps than the national. A list of forty (40) priority districts with CCI less than the national average is included (Annex 1). This index will be used to assess progress in RMNCAH service utilisation. Key drivers of overall coverage are immunization, early initiation of breastfeeding, and malaria treatment (higher than 80%). Perinatal and FP interventions are still low-performing areas as indicated by facility use service indicators, and thus need more effort to progress toward RMNCAH universal coverage in light of the regional differences. The indicators pulling down coverage are HPV vaccination (16%), postpartum FP (29%), ANC-1 in first trimester (33%), perinatal death notifications (35%), full immunization (50%), and intermittent preventive treatment pregnant women (IPTp) three doses (55%).

[k] Ideally should use UDHS data but most current is 2016. This measures utilisation data and will be updated as coverage data becomes available, but now used for comparative purposes.

03.2 Key Health System Support to Overcome Bottlenecks

To achieve coverage with equity and quality, the previous plan prioritised inputs toward infrastructure development and human resource capacity to advance RMNCAH coverage in Uganda. The inputs aimed to maintain successes observed for interventions with high coverage and plug gaps in lagging intervention areas especially perinatal care, care of the small and sick baby, child health services, adolescent health services, and FP.

03.2.1 RMNCAH Governance and Leadership

Leadership and management issues—identified in the previous plan—continue to be a critical bottleneck to success. In the previous period, human resource gaps at the MOH were filled by restructuring. Some RMNCAH-related technical policy instruments were developed or updated to further improve the country's RMNCAH strategic framework.[l] Though the policy environment was considered adequate in the previous plan, implementation of the additional policy instruments is still weak. This is hindered by segmented development of policy guidelines, tools, and support to districts including piecemeal introduction, inadequate use of tools and levers[m] for implementation, ineffective technical oversight, insufficient corresponding budget allocations, and weak accountability for required system and delivery modifications.

At lower levels, health/social service committees of local governments and facility management committees are the key mechanisms for participatory governance. However, their stewardship is ineffective and without adequate guidance to enhance the health of the population in their area including building trust and ownership of the services. Consequently, they focus more on facility functioning than on community health and well-being for all.

RMNCAH is still in the challenging position of aligning donors, partners, and stakeholders behind a unified and systematic RMNCAH approach due to segmentation of supports and programming. Integration and a continuum-of-care approach are still curtailed by the vertical approach of RMNCAH component interventions. Health sector governance structures are adequate but weak at subnational levels. Progress has been made on strengthening national level coordination, partnerships, and coalition building over the last period through the extended Maternal and Child Health (MCH) Cluster.[n] However, low staffing at the Reproductive and Child Health Department (41%) and the proliferation in number of districts (50% or 65) that lack substantive Assistant District Health Office (ADHO)-MCH critically strained oversight of the decentralised governance of service delivery. District and health facility leadership and management are the most decisive factors for bringing about changes in RMNCAH service delivery and overall improvement. These mid-level health managers are swamped with district and facility leadership responsibilities and yet have limited competences and resources. These leadership weaknesses, along with disempowered professional bodies, partly limit enfolding the private sector that caters 45% of health care.

Thus, efforts in the next period will be to:

1. Harmonise, align, and consolidate the various RMNCAH policies and programming and develop a comprehensive RMNCAH manual/SOPs; should be done in partnership with individuals, families, communities, and frontline service providers.

[l] Public Health Act, Community Health Policy, Migration of Health Worker's Policy, Nursing and Midwifery Policy, National Adolescent Health Policy, Palliative Care Services in Uganda, Reproductive Health Policy, Assistant Reproductive Health Technology, Uganda Medical Internship Policy, Human Organ Donation and Tissue Transplant Bill. Some policy documents such as the National Health Policy 2020/21–2029/30 (NHP III), UHC Roadmap 2020/21–2029/30, National Health Professions Authority (NHPA) Bill, and Urban Health Strategy are being finalised.

[m] These include regulation and legislation, standard setting, budgeting, incentives, and organizational design and change.

[n] Membership landscape includes public; CSO platform; private, bilateral, and multilateral agencies.

2. Regionalise technical oversight and performance improvement across the public and private sector around the regional referral hospitals.
3. Develop training, job aids, and tools for improving district and facility RMNCAH leadership in management, change management, building partnerships with local communities, and achieving people-centred and integrated care.
4. Develop tools for the various subnational health governance[26] committees for implementing the alterations in service delivery design to people-centred RMNCAH care and population RMNCAH management, inclusive of services and accountability.
5. Reanalysis of the legal, policy, and regulatory framework to identify gaps and barriers to RMNCAH extended nurturing care framework and developing a redress strategy.
6. Develop guidelines, implementing tools, and mechanisms—together with professional bodies and associations—for effective engagement of the private sector, especially midwifes/nurses in RMNCAH delivery, particularly for adolescents and hard-to-reach subpopulations.
7. Hold annual meetings involving professional councils, associations, and regional teams to review in-service training/continuing medical education (CME) related to RMNCAH, performance data, and supervision/mentoring reports.

03.2.2 RMNCAH Financing

Persistent low public expenditure on RMNCAH identified in the previous plan still hampers transformation in the health of women and children. Uganda's total health expenditure (THE) has averaged UGX 5.16 billion and a current health expenditure (CHE) average of UGX 4.995 billion between 2016 and 2019. Thus, government budget allocation for the health sector in the last five years stood at 7.8% (below Abuja Declaration of 15%) and a THE per capita of US$36.9 (below WHO recommended US$86).[27] Government expenditures increased faster than domestic revenues, increasing the fiscal deficit in 2019, largely financed through external borrowing with current debt at 43.6% of GDP in 2019. Donors continue to contribute the largest share (42%) of THE, followed by private sector (inclusive of households) at 41%, The portion from government or public resources is the least (17%). Mandatory health insurance does not exist in Uganda, and voluntary health insurance is almost non-existent with a coverage of only 4% of people aged 15 years or older. Implementation of the mandatory National Health Insurance Bill has been delayed numerous times since 2007 when it was initially drafted, and the NDPIII anticipates an increase in health insurance coverage to an estimated 25% by 2025. Financial protection in the country remains low with out-of-pocket payment accounting for 37% of THE, far above the 10% threshold for pushing households into impoverishment due to health reasons.

Innovative financing in the past period saw the transition of small-scale "maternal vouchers" into countrywide results/performance-based funding (RBF/PBF) mechanism under the Uganda Reproductive Maternal and Child Health Service Improvement Project (URMCHIP).[o] Government, under the Uganda Intergovernmental Fiscal Transfer (UgIFT) project is integrating this PBF approach into the country's public financial management systems. This US$1 billion initiative will build on lessons from the URMCHIP and improve adequacy, equity, and resource management by local governments. These additional funds disbursed within the conditional PHC facility grants from government will be for operating costs and health output/performance-based indicators covering RMNCAH, nutrition HIV, TB, and NCDs. An additional annual budget for repairs and maintenance of

[26] Outlined in Ministry of Health guidelines for governance and management structures. Kampala (Uganda): MOH; 2013.
[27] Uganda Ministry of Health. National health before pregnancy accounts 2016–2019. Kampala (Uganda): MOH; 2020.
[o] Implemented under financing from the World Bank and the Global Financing Facility (GFF) in support of Every Woman Every Child.

health facilities and equipment will be disbursed to ensure functionality of the upgraded facilities. Given the limited fiscal space, this RMNCAH plan aims to identify and use new innovative financing options. Priority will be toward:

1. Improving efficiencies through integration of RMNCAH program implementation, management, training, and supervision activities; and increasing domestic resource mobilization for RMNCAH
2. Developing multi-department activities with HIV, malaria, and TB to implement health system strengthening within the Global Fund[p] and especially community health systems
3. Continuing to track national and district level expenditure, and reduce off-budget financing of RMNCAH services currently at 79% (UGX 129 billion)28
4. Aligning RMNCAH/N partner funding toward service delivery at community, HC III, and HC IV levels; establishing measurement and tracking mechanisms in light of the high (65%) household total expenditure on health used in seeking services through hospitals

03.2.3 Health Workforce

The previous plan identified staff shortage, maldistribution, absenteeism, and insufficient skills as long-standing and important health workforce bottlenecks. Addressing this situation is critical due to the labour-intensive nature of health service delivery. Over the last period, the filling rate for approved staffing positions improved from 48% in 2008 to 74% in 2020,[q] driven mainly by recruitment, training, and deployment of critical cadres; deployment and bonding of trained staff in hard-to-reach areas/districts with staffing below 50%; and ongoing infrastructure improvements in facility work environment, equipment availability, and staff accommodation. Despite this progress, workforce density remains suboptimal with midwife-to-pregnant woman ratio of 1:311 far below the WHO threshold of 1:200 for the region. Maldistribution continues with the staffing level for largely rural HC IIs only 55% compared to the national average level of 74%, and more than 70% of doctors and 60% of midwives and nurses located in hospitals, which mostly serve urban populations.

The inequitable staff distribution persists with about half of health facilities in the more urban central region[r] masking the gross shortage in rural areas. In addition to shortages, health worker productivity remains low, driven by working "rotational midwifery shifts," 50% of staff not available[s] due to chronic absenteeism (especially at lower-level facilities),[29] and deficits in critical skills and competence in management of emergencies, small and sick neonates, adolescents, and older people. The multiple, small-scale, and disjointed trainings fomented by the narrow focus of project, partner, and researcher-driven results contribute to the sanctioned high absenteeism, low uptake of new approaches or clinical protocols, and inefficiencies sometimes with delivery contradictions.

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[p] RMNCAH interventions included in the HIV, malaria, and TB Global Fund modular frameworks that could be integrated in Uganda's funding request include: (1) HIV: eMTCT, pre-exposure prophylaxis in high-risk women, screening for intimate partner violence, differentiated HIV testing in male partners, and early infant diagnosis; (2) Malaria: LLINs distribution, IPTp during ANC and iCCM; (3) TB: screening, diagnosis, and treatment in pregnancy, iCCM-plus.

[28] MOH, UNICEF. Tracking off-budget financial resources in the health sector FY2019/2020. Kampala (Uganda): MOH and UNICEF; 2020. The Uganda equity atlas and Aid Management Platform (AMP) were used.

[q] Public facility midwives increased by 1,830 (from 4,607 to 6,429); anaesthetic officers by 73 (from 215 to 288), and doctors by 480 (from 936 to 1,415) but were still short of the target. About 730 targeted bursaries were awarded including Certificate in Theatre Techniques (176); Diploma in Anaesthesia (117); Diploma in Clinical Nutrition (14); Diploma in Nursing-Paediatrics (18); Diploma in Child and Adolescent Mental Health; Bachelor of Science Anaesthesia (40); Fellowship in Neonatology (10), among others. Still, staffing levels for doctors (53%), anaesthetic officers (28%), and dispensers (43%) are lowest among critical cadres and too low to address the sector priority of reducing maternal and perinatal deaths.

[r] Distribution of the health workforce continues to be aligned to health facilities; the central region hosts 45% of total health facilities in the country, all five NRHs, two of the RRHs, and 76% of private facilities; majority of PFP health facilities are in more urban regions.

[s] Unsanctioned absenteeism has been reduced to 11%, authorized absenteeism to 38%.

[29] Zhang H, Fink G, Cohen J. The impact of health worker absenteeism on patient health care seeking behavior, testing and treatment: a longitudinal analysis in Uganda. PLoS ONE. 2020;16(8):e0256437.

Village health teams (VHTs) remain an informal voluntary health workforce operating at national scale. Long-standing challenges—identified in the previous plan but not addressed—persist. Government is developing the first "community health strategy," which is expected to formalize VHTs support and accountability framework, link them to the integrated human resources information system (IHRIS), and provide incentives within RBF and other funding arrangements by government and partner mechanisms or allowances. Currently, only 58% of districts have an active VHT system, mainly in integrated community case management (ICCM). The increased focus on population health in this plan, expansion of VHT scope of work, and scale up to countrywide coverage will increase both community RMNCAH delivery volumes and supervision burden. The very high number of VHT-per-supervisor ratios (average is 600:1) demands retooling and digitizing their training, support supervision, and reporting.

To further influence the longer-term national 10-year human resources for health (HRH) development strategic plan, additional efforts are needed to speed up health worker retention, productivity, competence, and responsiveness toward RMNCAH priorities to achieve set targets. The priority RMNCAH cadres for recruitment to fill critical staffing gaps in the next five years are: anaesthetic officers (200), dispensers (200), anaesthesiologists (70), neonatologists for RRH (20), critical care neonatal nurses (60), FP specialists (60), geriatric medicine specialists (35), paediatricians (300), and obstetricians and gynaecologists (180). These positions are necessary to support development of PHC essential services, optimise EmONC quality, and provide vital tertiary care. Lower-facility level (HCs and general hospitals) midwives/nurses and community-level VHTs as frontline workers are prioritised since an estimated 95% of RMNCAH services in the country are delivered by this group.

In the next period, priority system strengthening actions to improve health worker productivity, competence, and responsiveness to RMNCAH needs are:

1. Create a pool of RMNCAH-trained health workers
2. Develop a comprehensive training needs assessment and training plan hinged on the comprehensive RMNCAH manual/SOPs[t]
3. Configure and build capacity for continuously tracking RMNCAH training information to determine district- and facility-level progress and deficits based on an electronic IHRIS[u]
4. Train mid-level managers (especially ADHO-MCH and nursing officers) in implementation of RMNCAH nursing and midwifery performance improvement management[v]
5. Digitize RMNCAH training materials and tools including for adolescent peer providers, school health, and self-care
6. Train 17 regional teams of trainers/supervisors/mentors with integrated biannual, short on-site courses; provide peer support for frontline workers organised within districts; and develop information and communications technology (ICT)-enabled distance-learning schemes
7. Update midwifery and nursing pre-service national training curriculum and cover new RMNCAH competence requirements and rural health issues to improve competence and interest in rural practice
8. Develop and roll out training module on expanded RMNCAH package (including use of digitized technologies) for VHTs, and incentivize VHTs to meet RMNCAH performance standards within the expanded community package (ICCM-plus, commodity distribution, pregnancy mapping, etc.)

[t] Also include urban health care delivery, geriatrics and sexual health, comprehensive guidelines for humanitarian situations, and adapt the WHO recommendations on child health redesign and school health policy.
[u] The ability to link records by a single license number to identify individuals and link multiple trainings to a single identifier will ensure that the HRIS remains up to date and is utilised by both private and public sector providers.
[v] Changing from personnel administration to a more comprehensive HRH development approach, addressing staff supply, performance management, and personnel relations.

03.2.4 RMNCAH Infrastructure and Equipment

Massive medical equipment procurement and rehabilitation were previously initiated including furniture, instruments, and critical devices such as blood refrigerators, theatre equipment, neonatal units, ultrasound machines, and electricity generators to be distributed to 700 health centres across the country. Of the targeted 315 HC IIs, 186 have been upgraded to HC IIIs; the remaining 129 HC IIIs will occur in 2022. So far, ultrasound machines for 20 HC IVs out of 218, NICU equipment for 42 high-volume HC IVs, and assorted medical equipment for 400 HC IIIs are targeted under the Uganda Intergovernmental Fiscal Transfers (UgIFT) program. Under Global Alliance for Vaccines and Immunisation (GAVI) funding, 5,213 vaccine carriers and 1,155 cold boxes were procured, and 996 refrigerators for storing vaccines as well as oxytocin were installed. The disconnect between equipment and available personnel is being addressed in the staffing strategy, and maintenance budgets have been increased through the UgIFT PHC grants. This significant investment in health infrastructure allows the government to establish and equip at least one HC III in each subcounty toward delivering UHC in Uganda.

The remaining infrastructure bottlenecks relate to geographical maldistribution of referral facilities, inadequate staff accommodation at health facilities (only 32% [6,590] fully staffed), and a critical lack of equipment for inpatient neonatal care even though more than two-thirds of newborns require specialised inpatient care (NICUs and SCUs). Also, the physical structure, equipment, working space, and environment at most health facilities do not meet clients' expectations,[30] implying that more maintenance on existing older facilities is needed.

Additional priorities for the next period are:

1. Procurement of targeted equipment: (a) low-cost portable obstetric ultrasound machines with training package for midwives for all HC IIIs and HC IVs to enhance patient care and experience, (b) NICUs for general hospitals, (c) SCUs for 100 high-volume HC IVs, general hospitals, (d) Kangaroo Mother Care (KMC) beds for all HC IIIs and HC IVs
2. Establishment of blood storage facilities at all HC IVs to ensure timely availability of blood supply and other products such as fresh frozen plasma and platelets
3. Procurement of smartphones for VHTs to contact health facilities for referrals, use mobile phone-based alerts and audit services, and report using rapid SMS
4. Establishment of facility digital asset inventory system to track equipment availability, functionality, and servicing requirements
5. Provision of training aids/simulators at 16 regional hospitals to serve as pre- and in-service competence training hubs
6. Renovation of a few grossly dilapidated health facilities in selected districts
7. Equipping and strengthening the regional equipment maintenance workshop to maintain all equipment being procured and distributed to districts

03.2.5 RMNCAH Commodity Security and Technologies

03.2.5.1 Commodity Security

The previous plan recognised weaknesses in the health supply chain as an important bottleneck in service delivery. These included shortage of pharmacy staff, weak coordination of different commodity funding streams especially FP items, lack of cold chain equipment for oxytocin, and lack of storage space at some health facilities resulting in commodity stock-outs and overstocking. Availability of RMNCAH commodities has improved through increased government and partners

[30] Ministry of Health (MOH). Client satisfaction survey for the health sector 2020/2021. Kampala (Uganda): MOH; 2022.

funding. Many challenges still exist in the national supply chain management system such as inadequate and late deliveries from the national medical stores and the inability to respond to emergency orders. As a result, stock-outs of essential medicines and health supplies at many facilities persist with only 49% having more than 95% availability of essential medicines and health supplies.[31]

In the last period, long-term infrastructure developments to improve storage capacity began; cold chain storage refrigerators for oxytocin were procured with GAVI support. District-level pharmacists have been recruited to support integrated supply chain and management at lower-level health facilities and conduct health facility audits to improve drug stock cards, prescriptions, and facility ordering practices. Stock delivery times have improved, but health facilities still experience stock-outs and overstocking with 45% reporting stock-outs in the last three months of 2020.[32] The government has developed a 10-year health commodities supply chain road map and redesigned the community-level medicines supply chain system for RMNCAH commodities[33] within the revised National Medicines Policy.

03.2.5.2 Digital Interventions

Digital technologies provide quick, efficient, and effective enhancement in the coverage and quality of RMNCAH practices and services. The WHO introduction and scaling guideline specifies nine recommendations on select digital health interventions[w] that involve the use of a mobile phone or device.[34] Already, digitization of logistics management information systems from the national to the community level has been started through scaling up NMS+ CSSP and DHIS2 ordering app for public and private, not-for-profit (PNFP) facilities, and through health facilities using eLMIS including HMIS and Rx Solution. Currently, all 275 HC IVs and above are ordering commodities using NMS+ CSSP, and RRHs are using HMIS. The NDPIII places priority on ICT especially for reducing data and smartphone costs. The rapid increases in connectivity to mobile phones and the Internet creates opportunities for improving access.

Over the next period, priority will be on improving quantification and forecasting critical lifesaving RMNCAH commodities at facility and community levels; refining commodity flow, tracking and accountability; and promoting RMNCAH self-care commodities and technologies through:

1. Integrating the alternative, private sector distribution strategy (ADS) especially for FP and self-care commodities to increase access points
2. Developing comprehensive RMNCAH self-care commodity security and safety strategy
3. Establishing and supporting an effective government-led regulatory and stewardship subcommittee to steer and monitor the digital health development partnership among government health services, private IT platforms, and public and private sectors to harness the enormous ICT potential
4. Researching the use of new technology under m-health and e-health in supporting service delivery improvements and community engagement with less focus on answering “what” and more on addressing “how” in operations and implementation

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[31] Ministry of Health. Annual health sector performance report (AHSPR) 2019/20. Kampala (Uganda): MOH; 2021.
[32] Ministry of Finance, Planning and Economic Development (MOFPED). Health sector annual budget monitoring report-FY 2019/20. Kampala (Uganda): MOFPED; 2020.
[33] Government of Uganda (GOU)-Health Supply Chain Program. Community health supply chain systems strengthening strategy 2016. Kampala (Uganda): GOU; 2017.
[w] Defined as a discrete functionality of digital technology that is applied to achieve health objectives and is implemented within digital health applications and ICT systems, including communication channels such as text messages.
[34] World Health Organization (WHO). WHO guideline: recommendations on digital interventions for health system strengthening. Geneva: WHO; 2019.

03.2.6 Service Delivery Emphasising Evidence-Based, High-Impact Interventions

The previous plan introduced packages of high-priority interventions and mechanisms needed for their delivery. It highlighted key cross-cutting, poor-service-delivery challenges of service fragmentation, limited application of clinical protocols at service delivery, inadequate basic diagnostic and care equipment, and a poorly functioning RMNCAH referral system.

During the past implementation period, many quality tools were developed to improve health care quality and support the provision of services according to clinical guidelines. Currently, the country has adapted the WHO standards for quality of care over the life course, placing mothers, newborns, children, and adolescents at the centre by addressing provision and patients' experience. However, efforts have been mostly focused and designed around supply-side clinical indicators of quality even as the country digitises the e-Health Facility Quality Assessment Tool using DHIS2. RMNCAH service delivery at all levels remains poorly coordinated, episodic, fragmented around intervention/funder project, uneven, and centred on providers. Current RMNCAH conditions are managed at all levels of care due to insufficient referral gatekeeping and the public's perception that quality and scope of care is poorer at lower-level facilities, which defeats the purpose of the national tiered-care system. Care is sought outside local public facilities regardless of cost and distances involved.[35] Community-level delivery remains underfunded with low coverage and being unincentivized, leading to low utilisation.

Client satisfaction with the public health care system is low with only 31% expressing full satisfaction with services provided at health facilities or in the community. The least satisfaction is among clients attending public HCs, and the leading quality disincentives are poor responsiveness related to promptness (long queues), respectful/courteous/dignifying care, and provision of services at all times (24-hour services).[36] While facility deliveries have progressively improved, institutional maternal deaths soar at 100 per 100,000 live births, far above the ideal of less than 41, and perinatal deaths at 20, far above the ideal of less than six,[x] implying that lifesaving interventions are still not provided with sufficient quality. Though indicated in the essential health care package, small and sick newborns, adolescents, and ageing service packages are not as well institutionalized as part of routine services compared to child health, maternal health, and FP services. With 72% of deliveries occurring in HC IVs and below (55% in HC III and below), continuing to improve EmONC functionality in HCs will remain critical in reducing emergency care and mortality in RRHs. Weak emergency referral persists due to insufficient integration in the newly created regionalised ambulance system, under the emergency medical service program, boosted during the COVID-19 response.

Within the next period, priority will be on strengthening quality of care at all levels within the PHC approach of health promotion for the majority and quality, respectful, people-centred care provided closest to home. Continuing to improve technical quality is needed but also redesigning service organisation toward promoting acceptability, experience, responsiveness, and trust to drive service demand and utilization. This will be achieved by the following steps.

1. Develop guidelines, pilot, and scale up a system for remodelling facility and community RMNCAH service delivery organisation toward integrated people-centred services across the continuum of care and differentiated care.
2. Support development of a centrally coordinated system of regionalized RMNCAH care services integrated with coordinating RMNCAH care, HRH training, regional service delivery ambulance network, multilevel quality improvement, and simplified effective referral pathways. Efforts will entail developing guidelines, scoping study, procurement of mentoring

[35] Parkhurst JO, Ssengooba F. Assessing access barriers to maternal health care: measuring bypassing to identify health centre needs in rural Uganda. Health Policy Plan. 2009 Sep 24(5):377–84. doi: 10.1093/heapol/czp023.
[36] Ministry of Health (MOH). Client satisfaction survey for the health sector 2020/2021. Kampala (Uganda): MOH; 2022.
[x] Based on HMIS in 2019 since data for 2020 and 2021 were distorted by COVID-19 response.

and training aids, and supporting supervision to establish 17 RRH skills hubs in line with the national regional support policy guidelines.

3. Training regional mentoring teams and supporting quarterly mentoring visits (five) for training, support supervision, and management for VHTs to: (a) rationalise VHTs initial and continued training including adolescent/young people VHTs, (b) retool and procure critical VHTs equipment, (c) mobilize, train, and integrate adolescents and young people (AYP) as peer educators and providers through the AYP Constituency in the RMNCAH CSO coalition.
4. Use differentiated service delivery (DSD) in response to the increasing diversity of needs of demographic groups, building on decentralization, task sharing, integration, peer support, patient and community empowerment. DSD will result in an increase in the number of people served per formal health worker. It will optimise a mixture of home, community (including school and workplace), and facility-based delivery of services.[y] Develop guidelines, training, and mentoring, and adjust existing RMNCAH data systems to meet the variety of delivery approaches.
5. Enhance school health promotion services including stronger linkages of health services within the schools, or partnerships between schools and nearby HCs for offering RMNCAH services.

03.2.7 Health Management Information

HMIS has progressively developed from a paper-based system to partial electronic or computer-based system integrated in the DHIS2. The HMIS is not uniform at all levels, with community centres, HCs, and general hospitals still paper based whose summaries are entered in the DHIS2 at district level. Combining community and facility HMIS has been difficult with community reporting rates stagnating at 40%, a similar figure reported for the private sector.

The previous plan identified weaknesses in data analysis, report generation, dissemination, and use. Though timeliness, completeness, and generation of reports and scorecards has improved, recent studies show the critical deficit is that data are not used by the health facilities that collect them, so there is no impetus for data quality at the source.[37] Currently, health facilities in Uganda do not keep patient records/files beyond patient cards or facility registers, and this curtails any longitudinal follow-up or implementation of family-centred care. The increasing data burden during service provision along with increased demand for more health indicators and more disaggregated data has caused concern about the amount of time health workers spend on recording and reporting data at the potential cost and risk to quality service provision, taking up over one-third of consultation time.[38]

Progress made in migrating to electronic medical records has been limited to HIV and TB programs. Since its initiation in 2011, the UgandaEMR[z] has expanded to more than 1,000 hospitals and high-volume HC IVs and contains components linked to maternal and child health that could be expanded for wider RMNCAH. The assessment in 2020 showed the system is moderately secure but could be improved in line with the Uganda Data Protection and Privacy Act 2019. Inclusion of RMNCAH care in the EMR system could enable tracking starting from preconception through pregnancy, newborn, child, adolescent, to adulthood, and allow sharing of health information between outpatient clinic and the hospital, and between clinical and public health services to inform decision-making. It thus offers

[y] Examples include health care worker or peer-led community groups, leverage of existing self-help groups, community outreach, decentralized pickup points for RMNCAH commodities, youth/adolescent models, home care, and key population models.
[37] Wandera SO, Kwagala B, Nankinga O, Ndugga P, Kabagenyi A, Adamou B, et al. Facilitators, best practices and barriers to integrating family planning data in Uganda's health management information system. BMC Health Serv Res. 2019;19:327.
[38] Siyam A, Ir P, York D, Antwi J, Amponsah F, Rambique O, et al. The burden of recording and reporting health data in primary health care facilities in five low- and lower-middle income countries. BMC Health Serv Res. 2021;21:691.
[z] UgandaEMR is a customization of OpenMRS for Uganda and is used following guidelines issued by the Ministry of Health under the Health Management Information System (HMIS) manuals.

the best foundation for a holistic national EMR system for the country in the longer term. Linkage with the CRVS system, community, and other digital apps capturing additional data on stillbirths (not captured in CRVS) and correlation with health determinants for equity measurements and data use at source are further added value.

Priority for the next period will thus be on use of indicators that measure quality of integrated activities based on characterized population groups and building capacity to implement integrated RMNCAH M&E data use in guiding programs. Steps will include:

1. Develop and tailor reporting tools and configuration of RMNCAH reporting
2. Roll out RMNCAH dashboard embedded in DHIS2 to the remaining 10 regions
3. Digitalize and operationalize the Community Health Information Systems with simplified mobile application dashboard
4. Implement home-based record of history of health services
5. Together with Division of Health Information and NITA-U, develop a platform for national and district health managers to access interlinked data from RMNCAH-sensitive sectoral information systems
6. Deploy the RMNCAH Equity Assessment building on existing sentinel sites and efforts[aa]

03.2.8 Community Engagement[39] for RMNCAH

The previous plan highlighted that social and behaviour change communication (SBCC) interventions have hardly been implemented. Community health, an integral part of the Uganda health system, has been operationalized more through direct community health care service delivery (through VHTs and outreaches) than health promotion activities (home visits) or strategic SBCC interventions. Support for community health remains almost solely from external funding. Government support will increase in FY2020/21 if local governments dedicate 20% of PHC budget to disease prevention and health promotion.

The increased programmatic focus on RMNCAH promotion, and action on social determinants, self-care, equity, and rights makes community engagement pivotal. Many unlinked initiatives are being implemented but addressing immediate short-term campaigns (e.g., child health days) are determined by specific intervention or campaign targets (e.g., FP, EPI, male engagement). Government, with support from partners, is developing a comprehensive, costed community health strategy and has created a coalition[40] to steer the active engagement of communities in health at policy and management levels.

To improve community engagement, this plan prioritises a revised Health Facility Catchment Area Planning and Action (CAPA) as a long-term strategy for sustainable improvements in nurturing care. The WHO estimates that 70%–90% of all health care takes place in the home[41] and the people-centred model, pushed by this plan, indicates a large role for families and communities in the co-production of health.[42] The CAPA approach moves planning from conformity with centrally derived "demand creation" and targets more flexibility and responsiveness with a community-led PHC focus that drives

[aa] Adaptations for deployment will be made from the WHO's "Health Equity Assessment Toolkit (HEAT)," UNICEF's "Equitable Impact Sensitive Tool (EQUIST)," and USAID's "Maternal and Child Survival Equity Toolkit."

[39] World Health Organization (WHO). WHO Community engagement framework for quality, people-centred and resilient health services. Geneva: WHO; 2017. Community engagement is defined as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes."

[40] Uganda's National Community Health Learning and Improvement Initiative (NACHLII).

[41] USAID. Acting on the call: ending preventable child and maternal deaths: a focus on health systems. Washington (DC): USAID; 2016.

[42] World Health Organization (WHO). WHO global strategy on people-centred and integrated health services: interim report. Geneva: WHO; 2015.

population RMNCAH&N improvements, including changes in service design and quality of care. Positioning CAPA at HCIII harmonises with the parish and subcounty development model in the NDPIII[bb] by engaging local structures, networks, and social supports toward effective and inclusive local service delivery, strengthened local accountability, and increased household nurturing care practices and action on health determinants. Behaviour change, community engagement, demand for services, harmful social norms, and social accountability have long been central to RMNCAH improvement but continue to lack clear unified initiatives and strategies. An SBCC framework is thus needed to initiate and align efforts necessary to achieve national RMNCAH priorities and align to the intersectoral coordination required for achieving results. Priority actions include:

1. Developing, digitizing, and disseminating the RMNCAH CAPA manual
2. Training in implementation of CAPA
3. Harmonising and disseminating a comprehensive RMNCAH SBCC strategy that incorporates information and communications technology (ICT) and practices on health determinants
4. Launching extensive awareness campaigns on RMNCAH self-care commodities and technologies
5. Reaching and engaging underserved, disadvantaged, and marginalized populations (see Shift 2)

[bb] Subcounty as the unit of development planning (with the parish chief as the focal person in coordinating supervision of health service delivery) and parish level where people are organized and supported to increase health production.

04: REACHING TARGETS FOR 2025

04.1 Strategic Direction of the Revised Sharpened Plan

The strategic direction of this sharpened plan is drawn from the NDP III 2020–25 Vision and Goals that link to the SDGs. The objectives of the plan further relate to Every Woman Every Child strategy, focusing on "Survive" and "Thrive/transform" objectives.

National Development Plan 2020–25

National Vision: A transformed Ugandan society from peasant to a modern and prosperous country by 2040

National Development Goal: To increase average household incomes and improve the quality of life of Ugandans

Human Capital Development Sub-Goal: To increase productivity of the population for increased competitiveness and better quality of life for all

Goal: To improve the health and quality of life of women, newborns, children, adolescents, and men, as well as older people.

Broad Objective: To accelerate movement toward Universal Health Coverage with focus on Primary Health Care and improve population health, nutrition, well-being, safety,[cc] and management[dd] by 2025.

Specific Objectives:

1. To end preventable maternal, newborn, child, and adolescent deaths
   - This objective maintains the commitment to addressing the unmet needs and remaining inequities in maternal, newborn, and under-5 survival.
2. To promote the health and development of all children, adolescents, and women
   - This objective looks beyond survival and addresses health and development needs of all people across the various life stages.

Strategic Shifts

These objectives will provide the framework for streamlining and directing government, private sector, and civil society and development partners' investments toward the following shifts in service delivery:

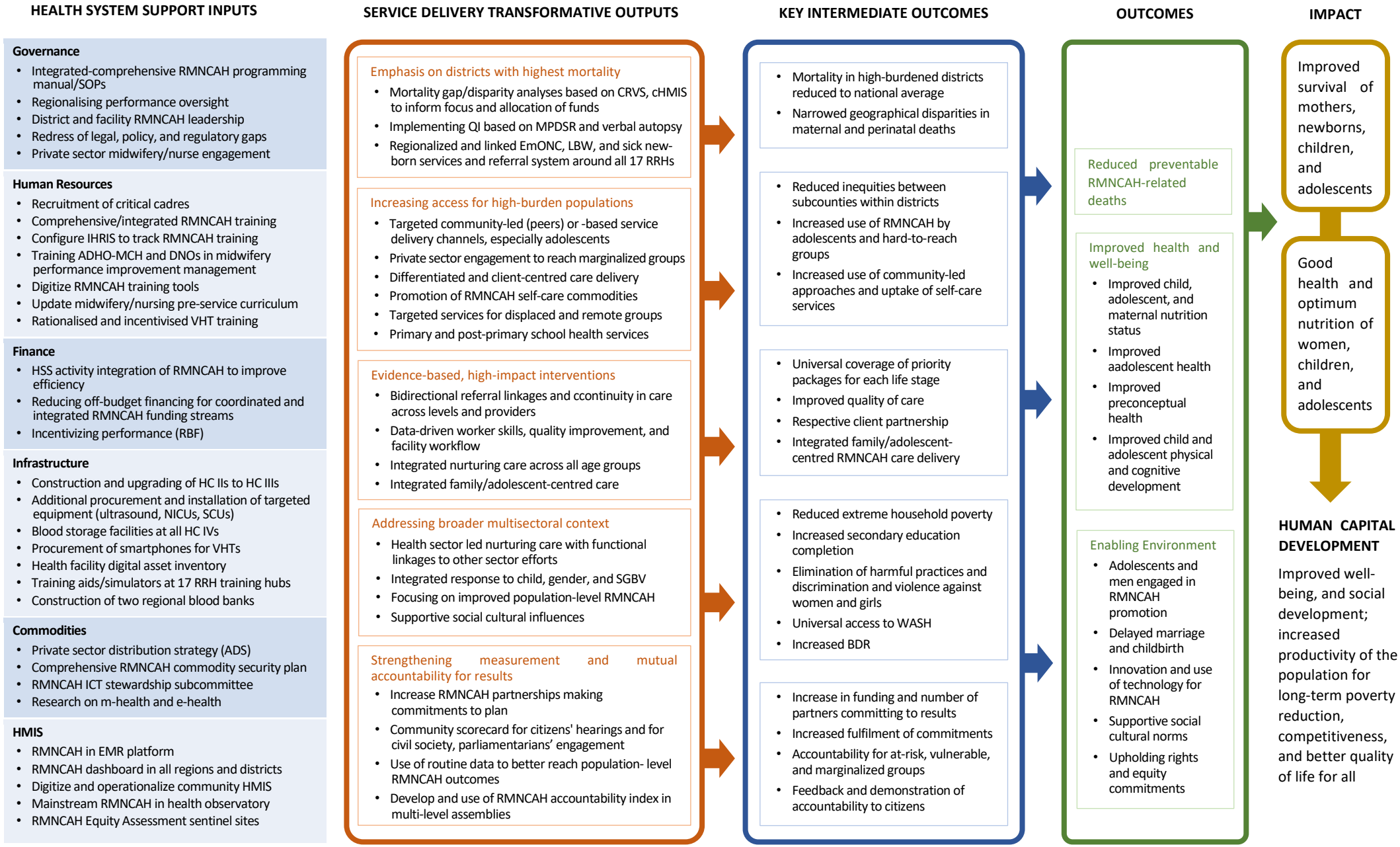
Shift 1:	Shift 2:	Shift 3:	Shift 4:	Shift 5:
Focusing first on districts with highest maternal and child mortality	Increasing access for high-burden populations in each district	Scaling up delivery of evidence-based, high-impact intervention packages	Addressing the broader multisectoral context	Strengthening mutual accountability for RMNCAH outcomes by all stakeholders

04.2 Theory of Change

For health system performance to sustainably accelerate improvement in people's health and well-being, critical inputs for each system block need to contribute toward the provision of people-centred care services. Critical inputs are interlinked in health system supports.

[cc] Tackling issues of sanitation, ventilation, pollution, use of clean cooking energy, and reduction of road traffic accidents.
[dd] When families are able to feed, clothe, educate, and provide health care for their children and themselves.

Theory of Change



04.2.1 Assumptions Related to Inputs

- Strong RMNCAH leadership and support at central, district, and facility levels is the most important factor for implementation of the transformative processes toward improving outcomes. Multi-stakeholder collaboration through existing mechanisms is anticipated to focus efforts on overcoming the current segmentation in RMNCAH policies, planning, budgeting, and implementation across all levels of the health system. Functionalising the regionalised health approach, anchored on regional referral hospitals (RRHs), assumes that additional training and supervision capacity is built to drive quality of facility care to peripheral health units. Strengthening district and facility RMNCAH leadership is anticipated to help mobilisation of the private sector, especially midwives and clinics, to cover service gaps created by increased utilisation to meet set coverage targets.
- Human resources for health has remained a persistent problem but continuing recruitment of critical cadres developing a comprehensive digitized RMNCAH training approach monitored through IHRIS will improve competencies. Trainings will be aligned to be cumulative rather than the current vertically driven and competitive approaches that contribute to the high levels of sanctioned absenteeism. Strengthening human resource leadership, especially in midwifery and nursing performance, will target the highest numbers of RMNCAH providers. This comprehensive training will also rationalise and incentivise VHTs.
- Integrated implementation of RMNCAH, leveraging health system strengthening (HSS) support from the Global Fund, and reducing off-budget financing will improve efficiencies and align RMNCAH/N funding to community PHC, which is incentivised through PHC grants.
- Longer-term massive infrastructure development will continue but with the addition of critical RMNCAH equipment such as ultrasound devices, NICUs, SCUs, blood storage facilities at all HC IVs, smart phones for VHTs, and training aids/simulators at 17 RRH training hubs.
- Commodity availability will be improved through implementing the comprehensive RMNCAH commodity security plan and expanding the private sector distribution strategy (alternative distribution system [ADS]). ICT developments will remain critical for performance improvement and research steered by government.
- The move toward electronic records along with longitudinal sharable family RMNCAH within HMIS will drive continuity in care, linking a digitized community HMIS with facility services and mainstreaming RMNCAH in the ongoing sector reforms. Due to the lack of routine equity data, short-term sentinel sites will produce equity measurements to facilitate regional and district efforts to reach marginalised populations.

04.2.2 Assumptions Related to Shifts

- Districts with higher morbidity and mortality burden have lower service availability, more socioeconomic barriers, and require more considerable health resources to obtain the same level of population health as others.
- Populations with higher burdens are not adequately identified and reached by the current delivery system; more tailored, community-led approaches will be required.
- Evidence-based packages, quality, and equity will best be delivered through remodelling patient flow to ensure continuity, reorganizing provider-client communication toward family/adolescent-centred care, continuously focusing on improving performance, and increasing the role of the community in managing provision of RMNCAH services.

- Regional referral hospitals, also teaching hospitals, can provide a leading role in setting high-quality clinical standards and an effective referral system. It is assumed that the best quality of care in the country should be found at teaching hospitals.
- Broader multisectoral action will be driven by (1) focusing on age cohorts through the extended nurturing care framework driven by health worker contacts, (2) catchment area planning and action, and (3) focusing on population health planning.
- Mutual accountability for results will be strengthened.

04.2.3 Assumptions Related to Transformative Service Delivery

Changing how the system fundamentally operates in delivery of services is the only way health system inputs can support sustainable improvements in access, quality, equity, and effective coverage. Making this transformation is not a single step but an overarching approach. The five strategic shifts will be realised through the various actions shown under each shift but with the following key catalytic improvements in service delivery.

- Transformation to family and/or adolescent-centred care is a long-term process with a minimum set of operations involving remodelling from acute episodic and individually focused care toward people-centred, multidisciplinary team-based work, providing health worker training in new skill sets in communication and improvement in patient linkages, and building new leadership skills among administrators to help plan and manage these changes that foster an increasing role of the community in provision of RMNCAH services. It is anticipated that an integrated people-centred care approach will lead to coordinated/integrated RMNCAH services delivery at facility and community levels as well as strengthening multisectoral action at population and individual levels in practice. This assumes that adequate response to adolescent and/or family-centred needs is carried out in a way that interacts with other sectors related to nurturing care beyond the health system.
- Differentiated RMNCAH care delivery with a stronger community component and peer approaches will reach the diversity of age groups, contexts, gender, sexuality, family and marital status, level of education, poverty, and different needs of people for whom the services are targeted. The approach is expected to enable facilities to spotlight specific barriers, sociocultural issues, and needs of different populations— especially vulnerable groups—and implement effective interventions to close disparities.
- Implementing the child redesign within the extended Nurturing Care Framework is expected to reduce nonfatal disease, tackle social determinants, establish the continuum of care to buffer adversities, build resilience across the life course, and promote delivery of integrated strategies and services.
- Health facility Catchment Area Planning and Action (CAPA) will be implemented with fidelity and drive the change toward a population health focus. It will heighten the community's active interest in the design and organization of the RMNCAH system and empower people to make healthy choices and actively engage in building healthy communities, including tackling health determinants and barriers to health and well-being. CAPA should increase formal involvement of local communities in population- and individual-level development decision-making. It should impact alterations in the district health system toward better harmonisation of multisectoral planning and service delivery processes at the community level (especially within the area wide concept of the subcounty and parish development models prioritised under the NDPIII). It is also assumed that the scope and content of CAPA

will counteract the sectoral "silo-approach" and provide linkages for increased developmental effectiveness based on real community issues or problems.

- Preconception care (PCC) lifestyle behaviours affect maternal, paternal, offspring, and transgenerational health outcomes. Uganda has not started a comprehensive package of services. Thus, women seek health care before pregnancy only when they are unable to conceive despite trying or to obtain contraceptives. Greater success is expected if holistic PCC is initiated and promoted, and includes self-care and individual- or population-level interventions for prevention and management of infectious diseases, and screening for and managing chronic and genetic conditions. This will enable many RMNCAH risks to be detected early, reduce newborn and maternal mortality, and improve family health and well-being

04.3 Implementing the Five Strategic Shifts

The five strategic shifts introduced in the previous RMNCAH Sharpened Plan remain the interdependent strategies driving transformation. The endline review showed that the previous strategic period (2015–2020) provided preparation and a platform for this revised Plan to consolidate with these five shifts remaining pertinent. Fulfilling these five strategies cumulatively will build more effective and equitable RMNCAH services; shortage of progress in any one will weaken others. The five interdependent strategies are: (1) focusing first on districts with highest maternal and child mortality, (2) increasing access for high-burden populations, (3) emphasising evidence-based, high-impact interventions, (4) addressing the broader multisectoral context, and (5) strengthening mutual accountability for RMNCAH outcomes by all stakeholders.

Shift 1: Focusing First on Districts with Highest Maternal and Child Mortality

Improving child and maternal survival remains one of the most significant health challenges in the country. The reduction in child mortality needs to be accelerated from 7.7% to 12% per year and maternal mortality from 3.3% to 6% if the country is to meet its NDP III and global SDG targets by 2030. Relatively faster reduction in mortality among high-burdened districts will contribute to an overall acceleration in national reduction. Progress in improving birth outcomes is occurring at the national level but subnational inequalities, though prioritized in the previous plan, still receive limited attention and were inadequately tackled. Significant geographical disparities[ee] in pregnancy outcomes have been consistently shown in past demographic and health surveys (UDHSs) and HMIS, hence the need to reduce these disparities remains urgent. Numerous structural factors including social, environmental, biologic, genetic, behavioural, local government leadership and governance, as well as health care factors may play a role in these severe morbidity and mortality disparities requiring a concerted multipronged approach to sustainably reduce their occurrence.

A few regions, districts, and communities account for half of the national burden of under-5 newborn and maternal deaths. Outside Kampala, the subregions with highest under-5 mortality rate (U5MR) are Busoga, Bunyoro, Karamoja, Northern central, Tooro, and West Nile compared to the other nine regions.[43] The districts with highest U5MR (more than 120 deaths per 1,000 live births) include Zombo, Bullisa, Kyegegwa, Kamwenge, Rubirizi, Buhweju, Lyantonde, and Rakai. Regions with highest maternal mortality are Karamoja, Kigezi, Northern central, and Acholi with more than 400 deaths per

[ee] Looked at as differences that result in difference in occurrence of maternal and newborn deaths closely linked with geographic regions.

[43] Agiraembabazi G, Waiswa P, Adong H, Kirunda KA, Doughman D, Kamau L, et al. Leaving no woman or child behind (Uganda): Countdown to 2030 policy brief [Internet]. April 2019. Available from: http://countdown2030.org/wp-content/uploads/2019/04/Uganda-policy-brief-April-2019_Final.pdf.

100,000 live births.[44] Data also show that the reduction in child mortality rate is slower among the urban poor population (more than 6.8 million), hence the need to develop targeted interventions as urban population growth accelerates in Uganda. A significant proportion of severe maternal morbidity and mortality events are preventable and efforts to do so may have higher success among these communities. Reducing mortality in these regions will require improving access to and quality of emergency obstetric and neonatal care (EmONC) and addressing health system deficits (e.g., staffing, infrastructure, equipment, referral failures, guidelines, non-use of clinical protocols).

In addition to system inputs, priorities to reduce severe morbidity and mortality in these regions include:[ff]

1. Establishing functioning bEmONC in 1,200 HC IIIs and cEmONC in 200 HC IVs within a coordinated referral system of regionalized RMNCAH service to improve access to critical lifesaving interventions in the continuum of care.
2. Instituting quality of care initiatives that elevate and standardise RMNCAH&N care delivery at all health facilities and effective use of scaled MPDSR and community verbal autopsy in all facility catchment areas (i.e., 2,184 subcounties)
3. Establishing a comprehensive community delivery (VHTs) system, engaging communities to address existent access barriers, and implementing data-driven community-led actions in all 70,626 villages
4. Measuring disparities continuously through strengthening of the BDR through NIRA and DHIS2,[gg] community HMIS, and use of composite indices as a means of identifying overburdened districts/regions and tracking progress in reduction of disparities.

Shift 2: Increasing Access for High-Burden Populations

At the heart of the 2030 agenda for sustainable development is the pledge to leave no one behind by focusing particularly on, among others, the poorest, most vulnerable, and those furthest behind. Districts face inequities in health care access and outcomes. Relatively faster increases in coverage among subpopulation groups falling behind will accelerate district success.[45] Proactive, pro-equity interventions to respond to the needs of vulnerable groups and communities with poor access is needed at the district level.

Districts need the right level of information to fully identify and characterize vulnerable groups and communities and prioritize them in service planning, implementation, and institutional arrangements for targeted service delivery. These groups may be in geographical communities (e.g., islands, far-to-reach villages, refugees) or dispersed in the general population (e.g., small and sick newborns, adolescents in union, marginalized groups). Three general methods will be used by districts and health facilities to identify these groups: (1) apply existing nationally defined priority groups, (2) use composite coverage index to compare subcounties, and (3) conduct additional district contextual assessments that include using proxies such as low birth weight (LBW), anaemia in pregnancy, and couple years of protection (CYP) rates for community RMNCAH burden.

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[44] Uganda Bureau of Statistics (UBOF). Health status and associated factors: thematic series based on the national population and housing census 2014. Kampala (Uganda): UBOF; 2017. Available from: https://searchworks.stanford.edu/view/13588685.

[ff] Annual targets are set in the work plan and monitoring framework.

[gg] Only 20%–35% of deaths are currently reported through the HMIS.

[45] UNICEF. Narrowing the gaps: the power of investing in the poorest children. New York: UNICEF; 2017.

RMNCAH encompasses the life cycle of an individual from birth to old age provided along the continuum of care to all who need services. However, members of populations and groups who are often difficult to reach face significant barriers when services are provided through routine service delivery. They need RMNCAH services delivered through community-led, targeted outreach or satellites in locations with client-centred differentiated service delivery and effective referral mechanisms. These groups also need strong preventive interventions, especially FP and behavioural interventions. To recognize progress in closing intra-district equity gaps, districts need to monitor outcomes of their efforts using routine and valid qualitative measurements, adjust interventions based on data, and set up systems for continuous qualitative feedback.

National Priority Groups

a) Adolescent and young mothers
b) Small and sick newborns
c) Children from birth through age 5
d) Adolescents
e) Vulnerable populations including the urban and rural poor; adolescents; people with disabilities, HIV, or sickle cell disease; indigenous groups; islanders; refugees; migrants; minorities; marginalized; socially excluded

Priority actions include:

1. Changing to targeted delivery channels through task-shifting to community-led (peers) or community-based (VHT, outreach, and satellites) service delivery to assure universal access to and benefit of quality services that are coproduced according to specific needs of the marginalised and disadvantaged. These groups will be identified in the annual facility CAPA within each of the 2,184 subcounties and districts.
2. Engaging and contracting private health care midwives (CSOs, PNFPs, and PHPs) especially through district-level RBF to expand access concurrent with regulation efforts.
3. Setting up three RMNCAH HCIII sentinel sites per region to provide more detailed surveillance data on inequity and on impact of health determinants on RMNCAH outcomes.

Shift 3: Emphasising Evidence-Based, High-Impact Interventions

Survival, health, and well-being for women, children, and adolescents does not depend on a single intervention, but on packages of interventions delivered at all levels of the health system. The goal thus remains to get all essential RMNCAH packages that are already part of the health system to high quality and high coverage rather than choosing between packages. Evidence-based packages of RMNCAH interventions have been defined and published,[46] but implementation remains suboptimal as seen from the composite coverage index (see Figure 5). The endline review showed very limited implementation of these packages primarily due to insufficient dissemination of the plan and tools to guide systematic implementation at each level. Recognizing that resource and capacity still constrain integration of the full RMNCAH package, an incremental approach to expanding access to interventions within each package will be continued in this period to ensure that complete packages are delivered by appropriate care levels and received at each life stage.

[46] World Health Organization (WHO). Packages of interventions for family planning, safe abortion care, maternal, newborn and child health. Geneva: WHO; 2010. Available from: https://apps.who.int/iris/handle/10665/70428.

The endline review showed inadequate investment in ensuring delivery of packages. This plan does not change or create new interventions from the previous one but focuses on components prioritised to bring about progress in the survive, thrive, and transform agenda of women, children, and young people and, consequently, improved human capital development. This approach also ensures confluence with other sectors in the human capital development program on harnessing the demographic dividend; focusing on children and young people maximises investment returns across current and next generations.

Shift 3 Top Five Priorities

Survival

- Care at birth and first week of life (EmONC and care for sick and small newborns)
- IMNCI and ICCM

Thrive/Transform

- Preconception and interconception care (family planning; maternal, infant, youth children and adolescent nutrition [MIYCAN]; and adolescent health)
- Extended nurturing care from preconception through adolescence
- Comprehensive RMNCAH social and behavioral change

a) Priorities for Survival

These are interventions that reduce maternal and newborn deaths by saving more lives rapidly by focusing on immediate causes of maternal deaths (i.e., obstetric haemorrhage, hypertensive disorders of pregnancy, and abortion/pregnancy-related sepsis) and newborn deaths (i.e., birth asphyxia [48%], complications of prematurity, and septicaemia). Priority interventions are:

1. **Care at birth and in the first week of life**: care for small and sick newborns and EmONC will give a triple return on investment by saving maternal and newborn lives and preventing stillbirths and disability.
    - *Functionalise basic and comprehensive EmONC* to manage obstetric haemorrhage, hypertensive disorders of pregnancy within two hours,[hh] and post abortion. Annually 311,880 mothers require critical care for maternal complications, 25% do not have access to skilled services. This will help about 40% of pregnant women who experience delivery complications and about 15% who develop sudden onset and unpredictable potentially life-threatening obstetric complications.[47]
    - *Establish NICUs and SCUs:* More than 200,000 newborns require inpatient care; 135,315 do not have access to skilled neonatal care services including specialised care in NICUs.
    - *Provide essential and inpatient maternal and infant care* including kangaroo care, facility-based care of small and sick newborns, and emergency triage, assessment, and treatment plus tertiary admission care (ETAT+) for severely ill infants and children. The addition of special and intensive care services for small and sick newborns will reduce newborn mortality by almost half.
2. **ANC** initiation in first trimester and reaching at least eight visits may have lower impact on maternal and newborn mortality but is prioritized because it remains the only entry point into formal health care services for most mothers. The package of quality ANC interventions increases outcomes and effectiveness of care during childbirth and PNC.

[hh] MPDSR Report 2020 shows that among women aged 20 and above, haemorrhage was the leading cause of death at 48% (≥25 years) and 31% (20–25 years). For mothers less than 20 years, hypertensive disorders of pregnancy was the leading cause at 21%, followed by pregnancy-related sepsis at 20%, and haemorrhage 19%.

[47] World Health Organization (WHO). The world health report 2000: health systems: improving performance. Geneva: WHO; 2000.

3. **IMNCI and Integrated Community Case Management** (ICCM Plus):[ii] in addition to case management, nutrition and safety, bonding, and breastfeeding to promote parent-child relationships and learning opportunities will be added to increase cognitive and socioemotional development. Ready-to-use therapeutic food (RUTF) will be provided at hospital and HCIV level for severe acute malnutrition.

b) Priorities for Thrive/Transform

Fostering the next generation's development begins prior to conception and must continue through pregnancy, ensuring the health and well-being of adolescents and young women prior to childbearing.[48] Priority interventions are:

1. **Preconception and interconception care**
    - *Family planning*: need to de-medicalize FP to other sector efforts, upstage persistently high teenage pregnancy rate, and counter misconceptions and norms for preference of large families. Review and align current laws and policies related to contraception among 15- to 19-year-olds; scale up selected high-impact interventions, postpartum FP, self-care, and other innovations to attain better achievement of the new FP 2020 commitments.
    - *Maternal, infant, young child, and adolescent nutrition (MIYCAN):* attention needed due to rising anaemia rates among women, high stunting rates and high LBW among newborns, and intermittent iron and folic acid supplementation to improve iron status in menstruating rural adolescent girls and women living in high-prevalence districts.[jj]
    - *Adolescent health:* emphasis on school health, age-differentiated RMNCAH services, and building an enabling environment.
2. **Extended nurturing care framework (NCF)** from preconception through adolescence (0-20 years).[kk] Investment in individual- and family-centred care will be a critical first step toward realizing the full potential of Uganda's cross-sectoral NCF.
3. **Comprehensive RMNCAH social and behaviour change communication framework** The interventions are spelled out in the service delivery section (see 3.2.6).

[ii] Crucial in reducing catastrophic household expenditure on health since malaria, respiratory infections, and diarrhoea are most common among children and account for 20% (over UGX 50 billion) of OOP for health.

[48] Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB, et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet Commissions. 2016;387(10036):2423–78.

[jj] Anemia in women of reproductive age (15–49) reported at 38.9% in 2019 (>20% threshold for interventions).

[kk] Organized into five developmental periods: preconception/prenatal, newborn, 0–3 years, older children, and adolescence to receive the five inter-related and indivisible components of nurturing care (good health, adequate nutrition, safety and security, responsive caregiving, and opportunities for learning).

Table 1. Delivery Platforms for Priority Intervention Packages

Direct Provision	Key System Supports
Community and HC II	
1. Short-term FP 2. Child: (ICCM, immunization) 3. Newborn: (KMC, assess and refer sick newborns, nurturing support) 4. Maternal: focused antenatal care 5. School health package 6. Adolescent package 7. Health education 8. ECD and parenting support 9. Menstrual health management 10. KMC and care of the sick newborn 11. Identification and referral of SGBV 12. Older persons package	• Community-based RMNCAH surveillance • Referral mapping and support • Adolescent peer VHW • VHT incentives • CAPA
HC III	
All above, plus 13. FP: LARC 14. Maternal/newborn: (SBA, PAC, bEmONC, IMNCI, essential newborn care package, daily static immunisation) 15. Voluntary medical male circumcision 16. Integrated outreaches 17. Growth monitoring and promotion 18. RUTF 19. ADH friendly package 20. Fistula screening and referral 21. Screening: (for RH cancers and preventive treatment, sickle cell trait)	• Support supervision • Area-wide (subcounty and parish level) microplanning–this should be CAPA • MPDSR • Portable ultrasound machines
HC IV and GH	
All above, plus 22. Maternal/newborn (cEmONC) 23. Permanent contraception 24. Continuation of chronic care for NCDs 25. Post-abortion care 26. Nutrition wards	• Maternal perinatal death surveillance and response • Regional referral network • CAPA • Blood storage • High dependence units • SCUs

Shift 4: Addressing the Broader Multisectoral Context

Though some multisectoral strategies like nutrition, WASH, and teenage pregnancy exist, most intersectoral work has been in groups where multiple departments and even sectors meet to assess efforts, align actions, and monitor implementation, with or without the integration of sector activities. Despite efforts for decades to bridge areas of mutual concern under multisectoral actions, the endline review showed that multisectoral partnership in RMNCAH is still weak, fragmented on vertical issues, and not systematically implemented across all levels. Up to 50% of the gains made in reducing child mortality are a result of health-enhancing investments in other sectors—such as education, women's participation, the environment, governance, and poverty reduction.[49] Current coverage of the nonhealth sector UHC tracer indicators is low; much effort is still needed as shown in Table 2.

Table 2. Non-Health Sector UHC Tracer Indicators

Indicators	2020	Ideal
Households appropriately treating water (%)	52	>90
Improved toilet coverage (%)	19	>90
Hand washing with soap and water (%)	34	>90
Use of clean energy (access to electricity) (%)	29	>90
Undernourishment (population) (%)	40	<5
Housing floors made of cement screed (%)	52	<90
Alcohol abuse	5.8	<1
Average years of schooling	6.1	11
Gender gap index	0.52	0.8
GBV prevalence	56	<10

Adopting the extended version of the NCF promotes equity and reduces threats of poor health, food insecurity, illiteracy, neglect and cruelty, inadequate resources, and limited social freedom for women, children, and young people. The extended NCF will provide the road map for child, adolescent women, and family multisectoral elements of the thrive and transform agenda. It defines the synchronised linkages with other sectors related to the needs and demands of people at different life stages. This NCF embeds adolescent health and well-being, nutrition, FP, male involvement, and other components the previous plan inadequately addressed in the multisectoral shift, avoiding over-medicalization and harms related to overuse of clinical interventions.

The health sector, with its many contacts from before pregnancy through early childhood and the after-school period, is central to the NCF introduction and establishment, especially within the human capital development program under NDP III. The country has already developed several lower-level intersectoral action policy documents and structures at national and district levels and uses technical working groups (TWGs) targeting adolescent health, nutrition, WASH, maternal health, school health, GBV, and ECD, among others. Placing the NCF framework at the district level will entail a new approach to sector convergence within the district NDP III programming guidelines by aligning and harmonizing different sector processes, and providing information to and encouraging engagement of the private

[49] Kuruvilla S, Schweitzer J, Bishai D, Chowdhury S, Caramani D, Frost L, et al. Success factors for reducing maternal and child mortality. Bull World Health Organ. 2014;92(7):533–44.

sector. This plan focuses on intersectoral actions on social determinants of health at the community level within the facility catchment area actions (see community engagement section on page 27). At the community level, guidance will be provided to facility CAPA to merge health delivery with social, WASH, education, and community development services. This level also allows integration with traditional and complementary medicine systems that are geographically peculiar and strengthens local structures for preparedness and response in health crises such as the COVID-19 pandemic.

Priority actions are:

1. Strengthening clinical response to child, gender, and sexual-based violence through cascaded training of health care providers (facility and community levels) on management of sexual and gender-based violence survivors/victims, based on adapted WHO tools piloted in the country from 2014 to 2018
2. Health-sector-led nurturing care with functional linkages to other sector efforts
3. CAPA and community engagement for improved population-level RMNCAH
4. School health interventions

Shift 5: Strengthening Mutual Accountability for RMNCAH Outcomes by All Stakeholders

The emphasis on population health in this plan demands that improvements consider all factors that influence and are affected by RMNCAH. Population-level improvements are a shared responsibility of health care providers, governmental public health agencies, and many other community institutions. Accountability remains an important factor for success and acts as a motivator to concentrate focus on commitments and allocated roles or responsibilities. Mutual accountability means that stakeholders agree to be held responsible for obligations and commitments they make to each other in achieving the intermediate results. Over the last strategic period, the country moved toward establishing joint RMNCAH accountability mechanisms at national level and progressively initiated regional reviews that are currently being strengthened. The mechanisms are established at national level and in three regions; in the next period the process at national level will be strengthened and regional health assemblies will be scaled up.

District RMNCAH accountability remains a cornerstone of the revised plan, but the system is weakly developed at this level. This is in recognition that centrally funded and directed reviews evoke little action at district and facility level, hence renewed forms of accountability are needed that are driven from the community upward.[II] Strengthening local accountability at the health facilities level will involve training health and facility management to increase their responsiveness to consult with and report back to local communities they serve with RMNCAH services. This emphasis on community engagement is part of the shift in thinking of accountability based on improving catchment area population health and on institutionalising inclusiveness, complaint mechanisms, and feedback loops as well as openness, transparency, and access to budgets and performance information. Mechanisms to link facility RMNCAH outputs, service delivery, and community HMIS on population health coupled with a community score card will be introduced to ensure services retain community support and respond to local perceptions of needs and priorities.

District and facility managers will collectively be fully accountable for results and for ensuring quality measures are implemented in a way that gradually holds each provider accountable for high-quality care delivery with every patient so that clients see them as competent, caring, and responsive. The people-centred care approach in this plan extends a provider's accountability beyond current

[II] Monitoring and reporting the extent of public engagement through meetings of the health facility management committee is done through HMIS reporting but not well analysed or followed up to ensure their effectiveness.

answerability to local government employers (district and subcounty) or professional associations (upward accountability). The new dimension is the downward accountability to local communities (e.g., on disrespect, negligence) for service provision and horizontal accountability to peers (e.g., on unnecessary or late referrals, harm).

To track progress and ensure accountability for RMNCAH outcomes, improvements in availability and quality of data and reporting from community HMIS, MPDSR, HFQAP, RMNCAH score cards and BDR will be critical. As the MPDSR coverage increases, use of "near miss" should be scaled up, especially in HCs. For effective social accountability, transparent and inclusive mechanisms involving RMNCAH assemblies at regional and national levels and facility-level catchment area review meetings/barazas are needed to improve responsiveness to community needs and demands. Covering both public and private sectors will be critical. Tracking of resource commitments by government and partners will be through the "System of Health Accounts 2011," which provides detailed expenditure data on RMNCAH to ensure accountability to improve quality of care and equity. Priorities to strengthen accountability are linked to political engagement, attracting more or improving use of financing, responsiveness to user needs, and rallying multistakeholder approaches toward achieving universal access to services.

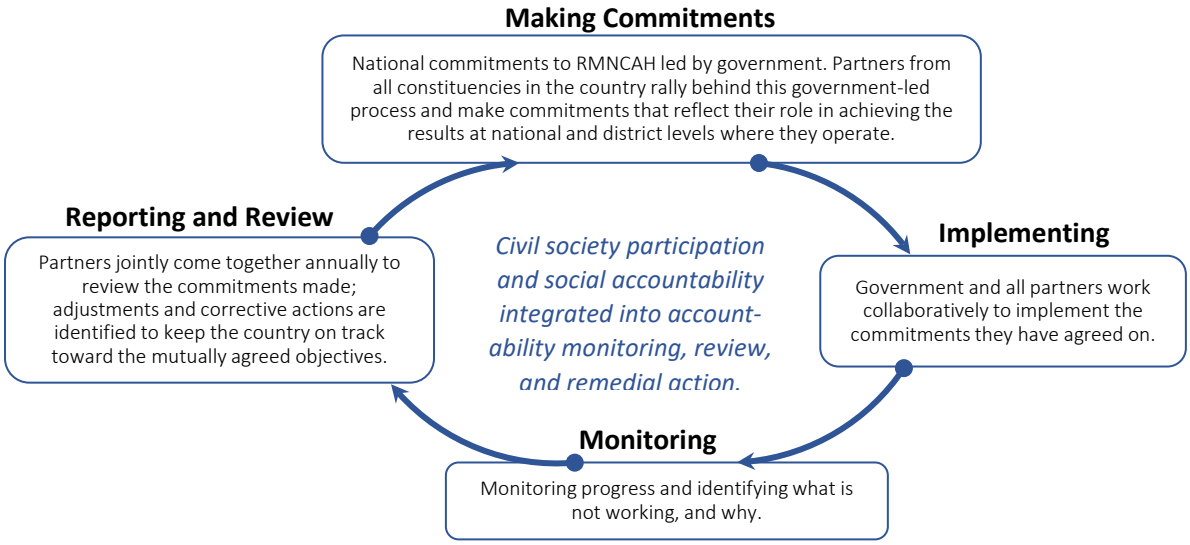
Priority actions include:

1. Support 17 annual regional RMNCAH reviews and one national one incorporating results from community score cards and patient satisfaction surveys.
2. Develop facility management committee guidelines and tools for inclusiveness, community feedback-reporting-action follow-up, and an IT-based RMNCAH community score card for use in social accountability (mutual accountability between provider and user).
3. Develop and use RMNCAH accountability index in national and subnational level joint review assemblies.
4. Use a community score card for citizens' hearings and for civil society, parliamentarians' engagement.
5. Increase RMNCAH partnerships with commitment to the plan and to the extended nurturing care framework.[mm]

The mutual accountability mechanism is anchored on human rights and accountability processes. All partners commit to specific, measurable, achievable, realistic, and time-bound actions that set out their own contributions to the achievement of the targets and results of this plan and consequently to the SDGs.

[mm] This plan expands accountability work to include monitoring critical underlying determinants of RMNCAH outside the health sector, e.g., education, gender, and justice, law and order (JLOS). Indicators for this will be developed based on routine data from respective sector information systems.

Figure 6. Accountability Framework Applied at National and Subnational Levels



05: IMPLEMENTATION STRATEGY FOR THE PLAN

This plan focuses on reorienting RMNCAH services and sets the stepwise targets and transformative strategic shifts that will deliver universal coverage of high-quality, people-centred care and integrated RMNCAH services. This change will not be quick and will require concerted and unceasing commitment from government (central and local), partners, private sector, and all stakeholders. The MOH will take the lead role in collaboration with all partners at the national and subnational levels. Implementation will adhere to the set sector institutional mechanisms for governance, management, and decentralised implementation. Operationalization of this plan will involve five broad strategies.

1. Printing, dissemination, and distribution of the plan starting with national launch, followed by cascaded dissemination and orientation meetings at regional, district, and health facilities levels. Adequate copies of the plan and an abbreviated version will be printed and distributed to all the targeted stakeholders.
2. Harmonising and developing national integrated RMNCAH policy tools, manual/SOPs in collaboration with stakeholders, and training district leadership.
3. Building capacity for regional and district teams through developing the integrated regionalized technical support supervision, training, and mentoring capacity and process. Selected members of the MOH Reproductive and Child Health Department and other related departments such as clinical services; community health; standards, compliance, accreditation, and patient protection (SCAPP); specific disease programs; and partners will form the national team of trainers. The training of trainers/mentors (TOT) will be at national and regional level, creating 17 regional teams of master trainers for RMNCAH who will cascade the training to district and facility levels.
4. Developing integrated implementation annual work plans to ensure alignment and harmonisation of efforts with the plan objectives and targets. All changes to improve RMNCAH implementation processes will be routed through the institutionalized continuous quality improvement structures and processes[50] at the regional, district, and health facility levels, and address data-evidenced gaps at each of these levels. Each level will develop annual work plans for implementing the RMNCAH sharpened plan depending on its mandates. Efforts will be toward ensuring participatory approaches starting with facility catchment area planning and raising awareness of and engaging health governance structures on the redesign of RMNCAH services to the integrated, people-centred delivery and renewed accountability to local stakeholders.
5. Strengthening RMNCAH M&E to provide adequate monitoring information for decision-making at all levels; tracking progress on access, quality, equity, learning, and health determinants; and maintaining the focus on the objectives and results.

[50] Ministry of Health (MOH). 5S-continuous quality improvement-total quality management implementation guidelines in Uganda. Kampala (Uganda):MOH; 2019 and MOH. National support supervision guidelines for health services. Kampala (Uganda): MOH; 2020.

05.1 Levels of Implementation

05.1.1 National Level

The MOH through the Reproductive and Child Health Department maintains oversight on actions of implementers within their mandate to ensure attainment of strategic plan objectives. This plan provides agreed upon RMNCAH performance indicators to be achieved by all stakeholders through collective attribution. Comprehensive RMNCAH annual operational plans reflecting all interventions and costs will be developed and anchored on the RMNCAH Sharpened Plan. Understaffing at the centre will require short-term technical assistance (TA) support. Prioritised areas for TA include M&E, newborn care, service integration, nurturing care, private sector engagement, advocacy/SBCC, and other demand-driven TA to cover emerging gaps and priorities in implementation of the strategy in collaboration with HDPs.

The plan will use the structures aligned with the health sector organizational framework and health partnership.[nn] The specific structures for health sector governance and management under the long-term institutional arrangements include Senior Top Management Committee (STMC), Top Management Committee (TMC), Health Policy Advisory Committee (HPAC), and Senior Management Committee (SMC). The quarterly expanded MCH Cluster (Country Platform) and the monthly MCH TWG will be the overall coordinating organs for this RMNCAH plan. The MCH Cluster will be responsible for resource mobilization, coordination, monitoring of implementation, and holding actors accountable for delivery of results as stated in this RMNCAH plan. Subcommittees of MCH TWG may be constituted or recomposed to focus on priority elements or the operational and monitoring implementation of the new transformational interventions in the plan. These subcommittees will link with the other MOH TWGs[51] to ensure that the requirements of this plan are integrated in the agenda and decisions made around health system inputs and provide a monthly progress briefing to MCH TWG.

05.1.2 Regional Level

The sector is establishing regional health systems through which the centre can provide its oversight mandate for health service delivery. This is to be achieved through strengthening capacity of 17 RRHs in providing technical oversight, managing data, serving as regional centres of excellence in providing comprehensive health care packages, strengthening systems for patient referral, establishing and operationalising accredited teams that provide high-quality continuing medical education and professional development, and transferring skills from RRHs to lower-level facilities within which transformational change can be managed and measured. Within the RRHs, the departments of obstetrics and gynaecology, paediatrics/neonatal, and community health will form the RMNCAH regional mentoring team and be capacitated to steer and implement the regional RMNCAH technical support to district health facilities. This will include technical supportive supervision/mentorship/coaching visits to the districts/telemedicine, including performance reviews, developing research agenda, quality improvement, pooling regional trainers, creating supervision and on-site mentoring teams, generating localised CME topics, and strengthening regional RMNCAH-related HMIS, among others. Each region will develop a team of regional TOTs, supervisors, and mentors.

05.1.3 District Health System

The Constitution and the Local Governments Act 1997 (with Amendment Act 2001) provide the legal mandate for local governments in decentralised service delivery that includes: management of GHs and all HCs, implementation/enforcement of the various Health Acts, community mobilization and

[nn] Outlined in the MOH Guidelines for Governance and Management Structures, 2013.
[51] The TWGs are outlined in: MOH. Guidelines for governance and management structures. Kampala (Uganda): MOH: 2013.

education, supervision and monitoring within the local government. Establishing functional ADHO-MCH staff in every district will be critical for quality, effective, and efficient RMNCAH management and service delivery at the local government department level, the health sub-district (HSD) level, lower-level HFs, and the community. These focal points will ensure adaptation of the national RMNCAH sharpened plan in district health activities making sure that the priorities are incorporated in the integrated district annual work plan, mobilising the health management structures to drive local implementation, and rally needed local multisectoral action. Much of the implementation reforms in this plan will depend on strengthening the functionality of ADHO-MCH in every district, starting with the poor performing ones.

All health facilities will work toward not only improving the facility performance, but also developing annual catchment area plans that include RMNCAH activities based on population health characteristics. The VHT implementation will be incorporated within the facility performance system. Of critical importance will be community engagement in the service reorganisation demanded by this plan to ensure delivery of people-centred care, inclusion of hard-to-reach people through differentiated care approaches, and implementation of the nurturing care framework. Services to older children and adolescents need to be developed hinged on each facility. This will include provision of school health services, developing adolescent networks, and inclusion of young people in facility management.

05.1.4 Integrated Training and Supervision Approach

Training and development of HRH is a critical aspect of this strategy. Integrated training, a comprehensive approach, will be used in implementing this plan to improve all components needed for performing at the highest level. The individual and family-centred work environment requires skilled workers to perform tasks encompassing multiple interventions during the same client visit.

Rather than in-service training in silos, all HRH training and development will be linked to competency and knowledge performance by developing positive attitudes at their stations, increasing care integration, improving overall job satisfaction, and building teamwork.

05.2 Key Promising Innovations

In the next five years and beyond, the country will accelerate "game-changing innovations" to increase survival, and thriving and transformative innovations. Innovations that reduce complexity, streamline service delivery, minimize human resource workload, offset infrastructural demands, and promote home care will be critical. A number of digital innovations have been piloted in RMNCAH and found promising for ICT-based health promotion, prevention, and treatment.[oo] Over the next period, priority will be on strengthening SMS-based applications like *FamilyConnect,* which targets community health with information on what families can do to keep themselves in good health; self-care apps such as the Digital Fertility-Awareness one that allows women and couples to take control of their lives, and ones for training health workers; and connecting routine facility outputs to treatment outcomes and changes in population health by digitising community HMIS. Innovations for reaching marginalised populations have been developed within the HIV arena, and efforts will be made to leverage these to promote RMNCAH care coverage for key populations RMNCAH shares with such programs.

[oo] The ICT sector, within the NDP III framework, is working toward doubling Internet penetration from 25% to 50%, expanding connectivity to districts, reducing cost of ICT devices and services (unit cost of 1Mbps/month for Internet service on the retail market from USD$237 to USD$70, unit cost of low-entry smartphones from UGX 100,000 to UGX 60,000, and cost of a computer from UGX 1,600,000 to UGX 800,000), and providing 80% of government services online.

Innovations for scale-up include treatment of presumed sepsis and pneumonia among infants aged 2 months and less using the newly simplified oral antibiotics, Sayana Press and other contraceptive devices, heat stable carbetocin and tranexamic acid (TXA) for addressing postpartum haemorrhage at lower-level facilities, and formulated ready-to-use MgSO4 packs for preeclampsia. Other sector-wide efforts will be toward inclusion of VHT workers in the health workforce system (IHRIS) digital registry as well as using performance-based funding to incentivise them within the wider Uganda Intergovernmental Fiscal Transfer (UgIFT) Program for Results (PforR).

Digital Applications Prioritised for Scale-Up

- Birth notification to NIRA through the Mobile Vital Records Systems (MVRS)
- Institutional maternal and perinatal death notification with MPDSR context through DHIS2
- Stock notification and commodity management through mTrac
- Provider-to-provider telemedicine, e.g., consultation, referral communication
- Targeted client communication (TCC) across five population groups, e.g., *FamilyConnect* providing information via SMS to pregnant women and mothers linked to VHT services, ADH, service point awareness, service use feedback, self-care support
- Provision of training to health workers and VHTs via mobile devices (mLearning) and IHRIS tracking
- Health worker decision support (CDSS) for ICCM/IMNCI, use of lifesaving commodities and procedures, FP services
- VHT digital health tool

05.3 RMNCAH Partnership

The partnership's purpose is to maintain policy dialogue, promote joint planning, and drive effective implementation and monitoring of the revised sharpened plan. Partners include health development partners (HDPs), private not-for-profit organizations (PNFPs), private health practitioners (PHPs), and civil society organisations (CSOs); collectively referred to as RMNCAH implementing partners.

05.3.1 Aligning Partners

This partnership will work toward resource mobilization and allocation and aim at ensuring transparency and accountability between the Government and partners and to citizens in the implementation of the plan.

Efforts will be made to align the various existing technical subcommittees, RMNCAH CSO coalition, private sector coalition, RMNCAH Research Network, RMNCAH Assembly, and other related partnership platforms to ensure consistency of purpose and contributions to success. Many groups have been operating with little relationship to each other or to the Sharpened Plan and yet their operations put the shifts into action. The RMNCAH Monitoring and Communication Group will be created to improve coherence, monitoring, reporting, awareness, and advocacy. It will bring efficiency to all RMNCAH communication activities and play a vital role in engaging with more partners, other sectors, and communities on the themes important to RMNCAH, using a unified visual image, innovative digital tools, and strategic media partnership building. Among the activities will be keeping stakeholders fully informed about their roles and responsibilities and progress in the implementation.

05.3.2 Key Stakeholder Roles in Maximising Impact

Strategic responsibilities and their outputs are assigned so that stakeholders understand their core roles within the plan, make their commitments, and set targets for accountability for commitments in the following areas:

Individuals, households, and communities

- Individuals and households: Adoption of appropriate health practices and health-seeking behaviour; co-production of health, self-care; active participation in management of local health services
- Community: Community and home-based self-help interventions, ownership of and commitment to community-level actions, peer-to-peer communication

Central government

- Parliamentarians: Making RMNCAH supportive laws and allocating budgets
- Office of the Prime Minister (OPM): Leadership for coordination and implementation of UHC across ministries, departments, and other public institutions
- Ministry of Lands, Housing and Urban Development: Stewardship for multisectoral action on urban health[52]
- Ministry of Education and Sports: Sectoral interface on RMNCAH within Human Capital Development Program, age-appropriate sexuality education in school, school health
- Ministry of Gender, Labour and Social Development: Prevention of teenage pregnancy, early child development, nurturing care and parenting; SGBV prevention; mobilising male involvement; empowering young people and youth leaders
- Judiciary law and order: Identifying legal and regulatory gaps and instituting reforms; implementation and enforcement of laws
- Ministry of Health: Policy guidance, funding, coordination, oversight for quality assurance, ensure availability of human resources for health, M&E function, protect and fulfil human rights for all, regulate professionalism, functioning of all service delivery platforms
- Ministry of Finance, Planning and Economic Development: Resource mobilization and allocation to the sectors including health sector

Local government

- District Health Management Team (DHMT): Population health planning, coordination, public-private service mix, local leadership engagement, universal community health services, increasing domestic WASH coverage
- HSD Management Team: Community action planning, quality reviews, functional referral mechanisms
- Health Unit Management Committee (HUMC): Planning facility service delivery, linking facility with service users, and ensuring local cultural responsiveness
- Health facilities: Delivering quality and responsive health services to the population
- Local Government Councils: Local resource mobilization and allocation to sectors including health, supervision, and monitoring of service delivery in the district

[52] Ministry of Lands, Housing and Urban Redevelopment. The Uganda national urban policy: transformed and sustainable urban areas. Kampala (Uganda): Republic of Uganda; 2017. The Urban Authorities Association of Uganda (UAAU), and The National Slum Dwellers Federation of Uganda.

Community

- Opinion leaders (including cultural, social, and religious): Community voices for RMNCAH, influencing social and cultural gender and male engagement norms, nurturing, and parenting
- Faith-based service organizations: Service delivery to remote and underserved populations
- Civil society organizations (including community-based organizations, local and national nongovernmental organizations [NGOs], networks): Have ear to the ground, provide voice of the people, education on rights,[pp] advocate for marginalised populations, agitate for change, litigation, raise discussion on sensitive RMNCAH issues, promote social accountability,[qq] functional RMNCAH&N CSO platform

Private sector

- Private providers: Provision of quality person-centred care, working within district health systems, provision of health promotion services and information
- Commercial/business: Cooperate with RMNCAH social responsibility, implement RMNCAH SOPs for employees and their families, assist with production and social marketing of RMNCAH promoting commodities and information, social entrepreneurship
- Academia and research organizations: Build the evidence base to shape effective and equity-oriented policies and programmes, promote knowledge exchange, influence discourse about development, conduct targeted in-country research
- The media: Promote health literacy and self-care; mobilise for male engagement; target unhealthy social norms including SGBV
- Traditional health practitioners: Complementary RMNCAH services

Partners

- Multilateral and bilateral organizations and funders (UN, bilateral development partners): Mobilise financing, technical support for country-identified priorities, bridge-building between sectors, capacity strengthening, technical assistance, scaling up innovations and best practice, international human rights laws, accelerating services for marginalized populations, define evidence-based norms, regulations, standards, and guidelines
- Regional organizations: Standard setting, regional consensus, lobbying for unsupported RMNCAH services, collaboration around priority issues such as cross-border cooperation and regulations, knowledge and technology transfer
- Global funds, programmes and partnerships: Financing RMNCAH gaps, health system strengthening, capital financing, mobilize resources to fill funding gaps at country level including through innovative financing mechanisms
- International NGOs: Innovation, accountability, service delivery, and advocacy for social inclusion, create transparency and mutual accountability among partners for results, resources, and rights

[pp] Educate people about their rights and entitlements in the health system, care options, right to competent care, respect, information, privacy, consent, and confidentiality; and provide options for redress when care falls below the quality standard.
[qq] Through citizen report cards, community monitoring, social audits, participatory budgeting, patient charters.

06: PERFORMANCE MONITORING

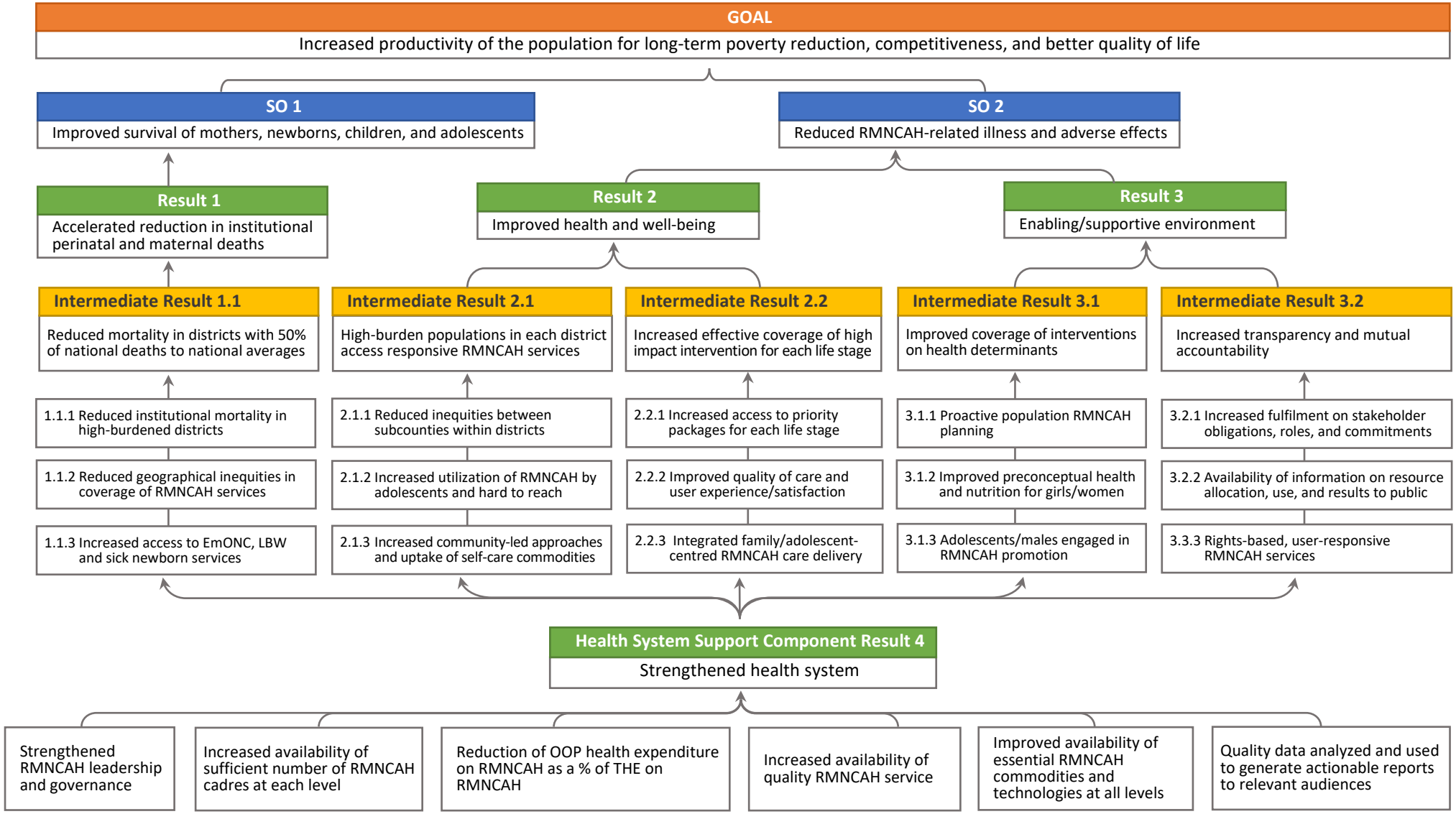
Performance monitoring will be regularly and systematically used to track progress of implementation based on the theory of change and aligned to the national human capital development in NDP III and international RMNCAH reporting obligations over the medium term (output, outcome, and impact monitoring). The Reproductive and Child Health Division will need to establish a Management and Monitoring Unit to improve management, monitoring, and evaluation systems of RMNCAH Strategic Plans. This Unit will be incorporated in the planned "Health Observatory" of the overall health sector. The Unit will produce quarterly and annual Program Implementation Reports to feed into the program reviews and advise on essential steps to take with respect to overall improvement of implementation actions.

The purpose of performance monitoring is to manage implementation of the Sharpened Plan and all RMNCAH Operational Plans, and promote evidence-based decision-making. It also monitors utilization of fund allocation and disbursement, and provides assessments of performance. It will strengthen the monitoring capacities within the RMNCAH division, regions, and districts to efficiently use routine data systems for decision-making. It will also assist in improving routine health management information systems so that critical monitoring and evaluating information needed is routinely available, and that this information is complete and of good quality. This section also sets the monitoring and evaluation framework, with a set of well-defined and commonly agreed upon indicators to track progress in specific areas.

06.1 The Results Framework

The results based on the complete set of indicators at different levels of the health system—service delivery, service improvement, and systems strengthening/reforms—over the next five years of implementation will generate a chain of evidence of program performance aligned to the theory of change. It lays out three main results through which five intermediate results (IRs) (based on the five strategic shifts) collectively contribute. The sub-results under each IR are based on transformative service delivery actions implemented at the different levels. The critical inputs needed to overcome the health system bottlenecks are also included as key results in this plan.

Figure 7. The Results Framework



06.2 The Performance Indicator Framework

06.2.1 Key Performance Indicators

These strategic key performance indicators (KPIs) will play a vital role in managing the transformation toward Population Health Management. The KPIs cover multiple levels of performance information:

1. Strategic KPIs measure combined progress toward achieving the high-level targets set for the two Strategic Objectives
2. Implementation KPIs track specific progress on each of the five strategic shifts needed to achieve the three top-level result areas as well as the critical inputs in the health system supports for RMNCAH. They include operational inputs for the health system supports.

Ten strategic KPIs will be used to measure progress toward the RMNCAH objectives and targets set for the next five years in line with the NDP III Human Capital Development Program Implementation Plan. These KPIs are aggregate of several implementation indicators, generally from routine HMIS or quarterly reports and act as collective proxies for annual performance reporting. While some KPIs rely on survey-based data, mostly routine health information system data will be used together with document reviews (supervision reports and other studies) as well as data mining especially for community (community HMIS and CAPA) and population level data. Ten KPIs have been selected with the aim of informing and determining whether strategic governance is succeeding, and more elaborate performance measures used to focus on areas of poor performance that need deeper review to improve operations.

Table 3. Strategic Key Performance Indicators and Targets

Indicator	Base-line	Target					Data Source	By Whom
		'20/21	'21/22	'22/23	'23/24	'24/25		
KPI 1: Tracks performance against mortality targets (SO 1)								
• Institutional neonatal mortality rate per 1,000 live births	18	15	14	14	13	12	HMIS	DHI
• Institutional maternal mortality rate per 100,000 deliveries	102	80	75	70	65	60	HMIS	DHI
KPI 2: Tracks performance against health and development of all children, adolescents, and women (SO 2)								
• Full immunization coverage by 1 year							HMIS	DHI
• Prevalence of under-5 stunting	29%	27%	25%	23%	21%	19%	HMIS	DHI
• Adolescent birth rate (age 15–19 years)	132					125	HMIS	DHI
• Couple years of protection (millions)	3.2	4.5	5.7	7	8.2	9.5	HMIS	DHI
KPI 3: Tracks efforts on prioritizing district with highest maternal and child mortality first								
• Gap in perinatal mortality between the highest and the lowest quintiles among districts	TBD					50% base-line		
• Gap in RMNCAH composite coverage index between districts with highest and lowest newborn and maternal mortality rates	32	27	22	17	12	5	HMIS	DHI

Indicator	Base-line	Target					Data Source	By Whom
		'20/21	'21/22	'22/23	'23/24	'24/25		
KPI 4: Tracks coverage of services for high-burden populations								
• Human papilloma virus vaccination coverage for 10-year-old girls	40%	50%	65%	60%	65%	70%	HMIS	DHI
• Uptake of FP self-care RMNCAH services (Sayana) among young women	TBD					Double baseline	UDHS	MOH
• Facilities offering adolescent and youth responsive SRH services	26%	32%	39%	47%	57%	70%	UDHS	MOH
• RMNCAH service coverage for displaced populations	TBD					Double baseline	UDHS	MOH
KPI 5: Tracks coverage of evidence-based, high-impact intervention packages along age groups against set targets at levels of coverage and quality required to cause impact								
• Proportion of maternal deaths due to PPH, hypertension, and maternal sepsis/post abortion	90%	78%	68%	59%	52%	45%	MPDSR	
• Proportion of newborn deaths due to complications in premature birth, birth asphyxia, and septicemia	75%	66%	58%	51%	45%	40%	MPDSR	DHI
• Proportion of expected live births that have postnatal contact at six days	36%	41%	47%	54%	61%	70%	HMIS	DHI
• Proportion of facilities by level scoring >75% in the HFQAP tool in RMNCAH module	TBD					50% increase		
KPI 6: Tracks performance of multisectoral efforts								
• Prevalence of stunting among children under 5 years	29%	27%	25%	23%	21%	19%	HMIS	DHI
• Attendance in early childhood education	37%	43%	49%	57%	65%	75%	Countdown 2030	UNICEF
• Basic sanitation coverage (improved latrine coverage)	19%	50%	55%	61%	68%	75%	HMIS	MOH
• Quality adjusted years of schooling	4.5	4.6	5.0	5.3	6	7	Educ MIS	MOES
• Proportion of births by adolescents (%)	25%	22%	20%	18%	16%	15%	HMIS	MOH
• Children under 5 years registered and issued Birth Certificates	40%	70%	75%	80%	85%	90%	CRVS	NIRA
• GBV prevalence	56%	50%	45%	40%	35%	30%	GBV IS	MOGLSD
KPI 7: Tracks performance of mutual accountability for RMNCAH outcomes								
• % commitments met annually								
• Percentage of deaths in a given year continuously reported, registered, and certified with key characteristics	2%	10%	40%	50%	60%	70%	CRVS	NIRA
• Proportion of users very satisfied with provider family–communication and shared decision-making	31%	36%	41%	47%	54%	62%	Client satisfaction survey	MOH

Indicator	Base-line	Target					Data Source	By Whom
		'20/21	'21/22	'22/23	'23/24	'24/25		
KPI 8: Tracks health systems inputs to maximize impact of RMNCAH service delivery								
• % health facilities with 95% availability of 41 basket of EMHS, including lab, vaccines, and blood transfusion supplies	46%		60%		75%	80%	SARA	MOH
• % approved staffing levels filled by qualified health workers	73%	80%	82%	84%	85%	86%	HRIS	MOH
• % RRHs with functional ICUs/HDUs	20%	100%	100%	100%	100%	100%	Administra-tive reports	MOH
• Number of functional National and Regional Call Centres with EmONC referral streamlined.	0	2	5	10	14	17	Administra-tive reports	MOH
• Proportion of facilities with functional EmONC-based level of care	19%		33%		57%	75%	SARA	MOH
• % health facilities with newborn care corners (NBCCs)	4%		12%		35%	60%	SARA	MOH
KPI 9: Tracks financial performance								
• Out-of-pocket health expenditure as a % of THE	37%	28%	22%	17%	13%	10%	NHA	MOH
• Proportion of RMNCAH off-budget support	58%	50%	44%	38%	33%	29%	Annual off-budget tracking report	MOH
KPI 10: Tracks delivery of the transformative interventions								
• Proportion of facilities implementing Health Facility Catchment Area Planning and Action	0%	10%	30%	40%	60%	70%	Administra-tive reports	MOH
• Proportion of primary and secondary schools having or being linked to health facilities	14%	20%	28%	40%	57%	81%	Administra-tive reports	MOH
• Anaemia rates among women of reproductive age	26%	21%	17%	14%	11%	9%	UDHS Studies	MOH

06.2.2 Thematic Reporting Indicators

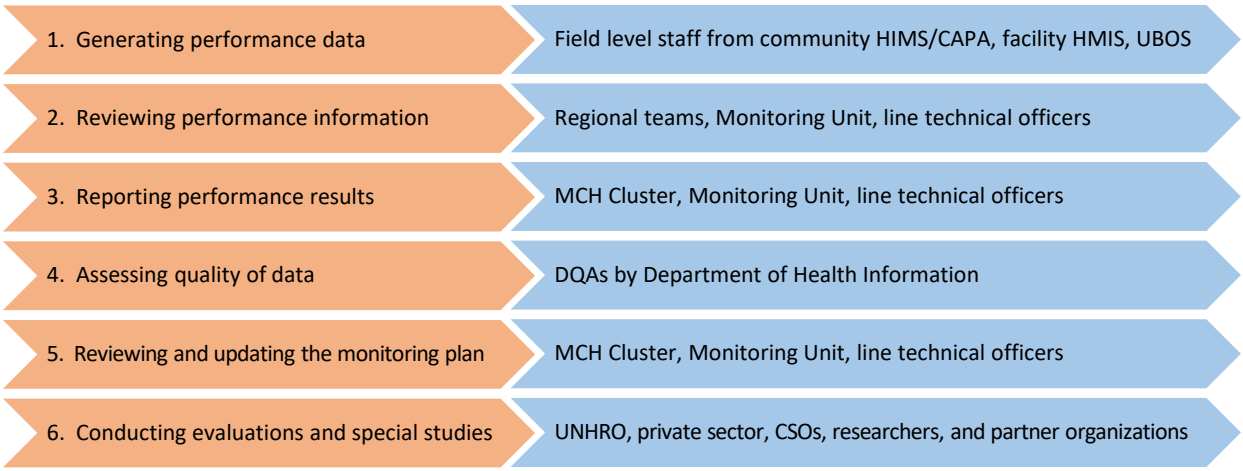
Thematic reporting is part of the comprehensive monitoring system at facility, district, regional, program, national, and international levels. It is intended to improve the knowledge focus in RMNCAH integration, staff learning and skills development, and providers strengthening external knowledge partnerships and promoting good feedback. Thematic reporting indicators will focus on progress against the intermediate targets in the results framework and annualised operational milestones in the annual implementation plans using quantitative and qualitative methods. They will complement and clarify interpretation of the strategic KPIs and inform correction.

Though also useful for performance monitoring, the strategic Results Framework for the Sharpened Plan does not include collection of data at the operational level. Thus, these data will be found in individual Operational Plan Progress reports that feed into performance reporting. The Department of Health Information and the Division monitoring unit will provide much of the data with the latter taking lead in completion of quarterly annual data quality assessment (See Table 6).

06.3 Managing for Results

Ministry of Health and partners of RMNCAH have specific roles and responsibilities in the overall performance monitoring system. Managing for results will also work toward establishing effective communication and better information/data-sharing mechanisms among the MOH, agencies in the National Human Capital Development Program, partners, and other key stakeholders for proper monitoring and implementation of the Plan. Figure 8 outlines responsibilities for each of the major steps in the monitoring process, which are further discussed in detail in this section.

Figure 8. Steps and Responsibilities for Managing Results



06.3.1 Decision-Support Tools and Approaches

Data should be presented in usable formats to allow policy makers to make well-informed decisions within the limited timeframe. A variety of decision-support tools and approaches such as data dashboards, summary bulletins, RMNCAH status report cards, and colour-coded data presentation techniques will be used depending on the audience.

- Health summary bulletins to disseminate data in the Joint Assemblies to provide an overall picture of RMNCAH status in the country.
- Health status report cards used to report on HSDP core indicators or program areas to compare current progress to a target or to past report card trends.
- Policy briefs used for conveying specific evidence-based policy recommendations arising from the M&E system, including operational research findings.
- RMNCAH data dashboards visually present critical data (including strategic KPIs and thematic reporting) in summary form for different health system levels so that decisions can be made quickly. This will enable users to identify problems and target specific follow-up activities to improve services and provide feedback.

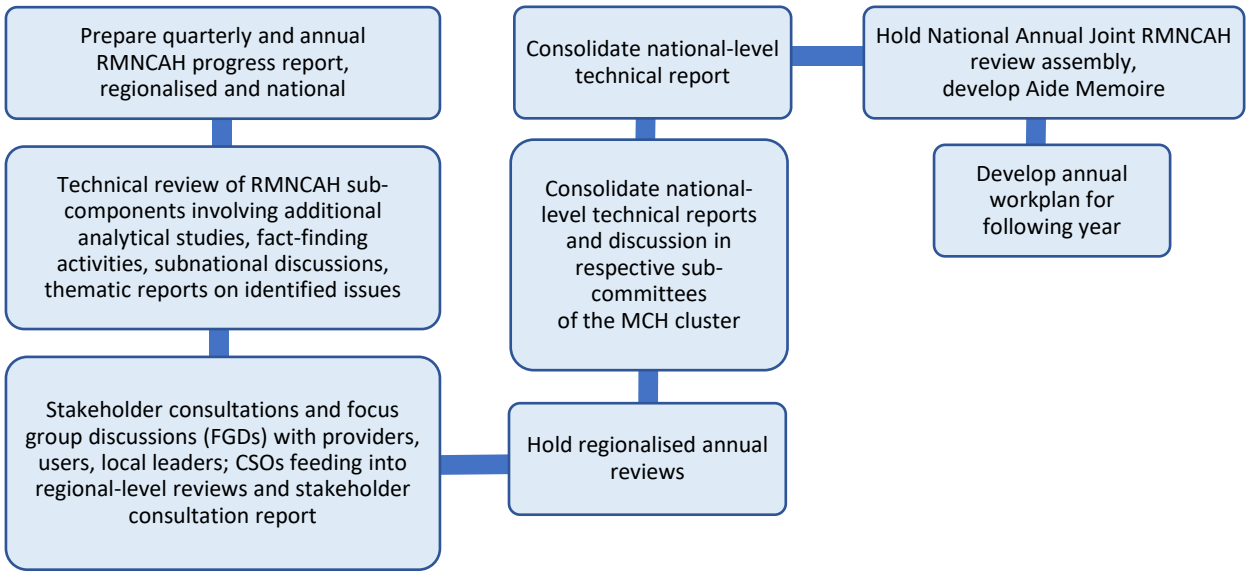
06.3.2 Quarterly and Annual Joint RMNCAH Performance Reviews

The Line Technical Officers and Development Partners together will be monitoring performance data during the financial year based on annual program implementation reports prepared by the Monitoring Unit. Depending on the results of these reviews, the Line Technical Officers may need to adjust their programming and implementation activities. The RMNCAH Monitoring Unit will also conduct quarterly and annual program reviews and develop review reports at both national and district/regional levels.

The annual Joint RMNCAH Performance Review of the RMNCAH-SP will be a management instrument, designed for both government and RMNCAH partners, to monitor implementation progress and to verify that management, policy responsibilities, and commitments are met. It will focus on implementation of shifts, service delivery reforms, and resource tracking to suggest a course of action related to achieving the RMNCAH-SP goals and objectives; and provide recommendations on risk management strategies and financing. It will have the following specific objectives:

1. To review the implementation of the RMNCAH-SP and take stock of quantitative and qualitative progress and achievement of goals, targets, reforms, and fund utilization; and recommend revisions to these for the remaining period of the program.
2. To review the financing arrangements and assess how well MOH and partner support meets the priorities and requirements of the RMNCAH-SP.

Figure 9. Annual RMNCAH Performance Review Process



06.3.3 Evaluations and Special Studies

Performance indicators only "indicate" progress and cannot be used to determine "why" a certain result occurs or not. Qualitative data will be used to support the causal relationship between activities implemented and the impact achieved with the intended beneficiaries. Furthermore, the quarterly and annual progress reviews will emphasize the voice and perspective of the community in different aspects of RMNCAH efforts, taking into account feedback information and report cards from users and community leaders.

Evaluations and special studies/surveys to collect data at the population level will complement routine performance monitoring efforts with more rigorous, in-depth analysis on topics of special interest determined along the implementation cycle. The major surveys to inform this plan are shown in Table 4.

Table 4. Major Surveys to Inform RMNCAH Sharpened Plan

Surveys and Special Nationwide Studies	Responsibility	Timing
Service Availability Readiness Assessment	MOH Quality Assurance Dept	Every 2 years (May-June)
Efficiency Analysis	MOH Planning Dept	Annual (April-June)
National Health Accounts	MOH Planning Dept	Annual (July-December)
National Client Satisfaction Survey	MOH Quality Assurance Dept	Every 2 years (January)
Uganda Demographic Health Survey	UBOS	Every 5 years
Panel Survey	UBOS	Annual (July-December)
National Household Survey	UBOS	Every 3 years
National Service Delivery Survey	UBOS	Every 5 years
Countdown to 2030	MUSPH	Annually
Track20/FP2020	MUSPH	Quarterly

06.3.4 Reviewing and Updating the Monitoring Plan

This monitoring plan serves as a "living" document to guide RMNCAH-SP performance monitoring and management efforts. As such, it will be updated as necessary to reflect changes in strategy and/or activities in consideration of the following issues:

- Are the performance indicators measuring the intended results?
- Are the performance indicators providing the information needed?
- Are the performance indicators requiring improvement?

06.3.5 Reporting

Reporting will be on a monthly, quarterly, and annual basis providing a link between data collection, analysis, and use. It will further provide a basis for assessing progress against targets and strategic plans.

Table 5. Type, Schedule, and Responsibility for Reports

Type of Report	Scope	Responsibility
Activity-Based Reports	These will include workshop/training reports, field reports, consultancy reports, etc.	Activity Managers
Quarterly Report	The report will include programmatic and financial information. Each active division will prepare quarterly reports highlighting key achievements, challenges, lessons learned, and planned activities for the next quarter. A consolidated report for the entire department will be desirable in the long term.	Designated M&E Person
Annual Report	This will serve as the key communication tool for the department at the end of each year. The annual report will provide highlights of key achievements for the year against set targets.	Designated M&E Person/ Commissioner
Annual Workplan	At the end of each year, each division will develop an operational plan that outlines keys activities and deliverables, expected outputs, timelines, and budget. These will be consolidated into an organizational workplan.	Designated M&E Person/Program Officers
Evaluation Reports	These will include baseline, mid-term, and endline evaluation reports.	External Consultant
Financial Reports Monitoring	Resource mapping and finance monitoring for accountability and reporting purposes, as well as for measuring financial efficiency (maximization of outputs with minimal inputs).	Finance

Table 6. Activities to Strengthen Performance Monitoring

Item	Location	Quantity	Frequency
Rolling Out the Sharpened Plan			
1. Central level orientation on the Sharpened Plan (targets and indicators)	MOH CH	1	one off
2. District level (DHT) orientation on the Sharpened Plan (targets and indicators)	District	136	one off
3. Health facility level orientation on the Sharpened Plan (targets and indicators)	Targeted health facility	3000	one off
4. Consultancy support to MOH Department of Reproductive and Child Health for plan roll-out activities	MOH CH/ District	4	one off
Routine Data Collection			
5. Qualitative data collection—community level	Community	20	quarterly
6. Quantitative data collection—HF level	Health facility	20	quarterly
7. Targeted data quality assessment/audits	Health facility	20	quarterly
8. Performance review meetings	District	20	quarterly
9. Annual population-based survey	District	5	yearly
Data Use Activities			
10. Trainings/mentorships in data quality improvements, analysis, and use	District/HF-based		quarterly
11. Establishing RMNCAH data repository	MOH		
12. Annual M&E system performance reviews	MOH CH	5	yearly
13. Training on use of scorecard	District		yearly
Dissemination			
14. Quarterly bulletin	MOH CH	20	quarterly
15. Abstracts and manuscripts writing and approval	MOH CH	20	semiannually

06.4 Programmatic Risks

06.4.1 Risks

- **Failure to build systems by focusing on targets:** This plan requires fundamental changes, especially in integrated comprehensive programming and reorganization of service delivery with a new emphasis on people-centred care to optimize processes, improve value for money, and attain targets. Furthermore, incremental improvements need to be sequenced toward set annual targets rather than the end. Sporadic lessons guiding delivery of new international guidelines contribute to the fragmentation of training, donor driven funding, and shifting priorities to subcomponents of RMNCAH. Many of these new guidelines do not work toward integrating and strengthening the system and thus impede delivery of integrated service packages services.
- **CSOs as direct implementors:** Many of the NGOs have become direct implementing partners even duplicating interventions thus weakening their role as representatives of their

constituencies and making them unable to promote advocacy and social accountability needed to drive this plan.

- **Suboptimal engagement of district and facility level in strategy development** limits to recipient roles resulting in poorly understood, owned, contextualized, or aligned with and relevant to stakeholder priorities at the community and local government level. In most cases, strategies and shorter-term projects have a vested interest (achieving numbers) and are disseminated without the support and resources to effect the changes needed to implement them or achieve post-funding sustainability.
- **Inadequate M&E or poor data quality characterized by** slow progress in CRVS hinders identification and targeting highest-burden populations groups and areas. Non-standardized and ad-hoc N&E products provide 'soft' indicators on progress output numbers instead of impact and outcome indicator analysis. Inadequate data to measure quality of care and equity—critical components of the Plan—make it difficult to measure performance of RMNCAH interventions. Lack of facility patient records make it very difficult to fit them within the continuum of care advocated for in the Plan. Population-based community health data is not integrated within the facility HMIS data and hence not used to adequately plan and address population health and identification of unreached populations within the catchment areas. Many critical RMCAH indicators/data elements remain unreported. Most catastrophic is that HMIS data is not used at source, which deleteriously impacts quality.
- **Regulatory weakness by private sector** councils leaves private sector outlets inadequately regulated on quality, over-concentrated in urban areas, technically unsupported, not fully integrated in the district health system, and not attuned to government priorities. Major emphasis for RMNCAH should be on engaging and promoting the private sector midwifery and missing critical cadres.
- **Failure to harness cultural and religious values**/norms, poor interpersonal communication, and cultural insensitivity (including open hostility) of providers to certain populations especially adolescents, minority groups, and older people actively limit effective utilisation.
- **Heavy dependence on external funding** limits sustainability of health interventions.

06.4.2 Risk Mitigation Measures

- Ensure effective coordination, system management, and channelling of resources to priorities of the RMNCAH plan including focusing on effective management of health workers at all levels and providing mid-level managers with support, clear guidelines, adequate salaries, and other incentives to use health records and establish realistic expectations.
- Strengthen joint government donor collaboration and coordination mechanisms at all levels such as joint annual programme reviews, and development of joint donor working groups.
- Establish a healthy balance between delegation of responsibilities and accountabilities with clear communication to facilitate timely decisions that prevent service disruptions, provide flexibility to encourage innovation, and reduce wastage.
- Establish a system that measures accountability and performance at all levels, especially for inclusive health governance through strengthening cultural competence.
- Provide public access to information about health budgets, policies, disbursements, standard pricing, patient rights, and health worker responsibilities to promote accountability and sound data analysis, including information on marginalized populations.

07: RESOURCE REQUIREMENTS, FINANCING PROJECTION, AND GAPS

The RMNCAH Sharpened Plan resource requirements were estimated using OneHealth Tool (OHT) while the resource commitment was carried out using Resource Mapping and Expenditure Tracking (RMET). The Resource Mapping and Expenditure Tracking tool helps map both retrospective and prospective resource projections from the government, key implementing partners, and donors. It provides an overview of resources spent on RMNCH programmes and the estimated upcoming resource commitments as reported by the stakeholders. The basic assumption used in the RMET exercise was that the high case financial resource commitments scenario for the first three years was used to estimate annual average financial commitments for the five years. The limitation was that reported financial commitments from partners are not disaggregated by interventions, and out-of-pocket (OOP) expenditures from household estimates were not included in the resource mapping.

07.1 RMNCAH Sharpened Plan Estimated Cost

The resource requirement was estimated using OneHealth Tool (OHT) based on: (1) the accessed information on RMNCAH profiles documented as part of the Sharpened Plan, (2) official figures for base year population demographics, (3) national protocols and expert opinions used for clinical practices, and (4) expansion targets set to meet the standards as based on population figures and other set criteria. The unit costs for human resources, commodities, and investment requirements were extracted from recent HSDP II costing exercises, and each unit cost was verified by the data collection team. The system priorities and targets were set by the team, and unit costs were verified by the team to be used in this resource requirement. The unit costs for human resources, commodities, and investment requirements were also informed by GOU Procurement and Disposal Guideline rates for 2020–21.

Overall, the total resource requirement for RMNCAH Sharpened Plan implementation is estimated at US$2.7 billion for five years. Of this, the significant share (93.4%)—about US$2.5 billion—goes to sustaining evidence-based, high-impact interventions in the form of service delivery. The second highest share goes to system strengthening with only 6.4%, about US$174 million. The least is investment on strategic shifts (Table 7). The per capita cost of RMNCAH services is estimated to be $26.

Table 7. Total Estimated Cost of RMNCAH Sharpened Plan (000 US$)

	2020–21	2021–22	2022–23	2023–24	2024–25	Total	Share
Strategic shifts	847	1,196	1,149	1,102	1,102	53,952	0.2%
Systems strengthening	119,646	11,281	11,652	14,400	16,784	173,763	6.4%
Service delivery	419,381	456,745	503,737	559,213	594,5128	2,533,588	93.4%
Total	**539,874**	**469,222**	**516,538**	**574,714**	**612,398**	**2,712,746**	

The strategic shifts are a major area of focus, and implementation cost is estimated at about US$5.4 million (Table 8). The highest share—82%—is related to the fifth strategic shift: strengthening mutual accountability. This allocation is likely to have resulted from under-costing of strategic shift 1 and 3 as their detailed strategic interventions are going to be developed as part of the plan implementation. If reaching the underserved geographic areas and population groups require different service delivery approaches with additional investments, this is not reflected in this costing estimation.

Table 8. Estimated Costs by Strategic Shifts (US$)

Strategic shifts	2020-21	2021-22	2022-23	2023-24	2024-25	Total	Share
1. Focusing first on sub-regions with highest maternal and child mortality	273,968	79,634	82,023	82,023	82,023	599,671	11%
2. Increasing access for high-burden populations	91,584	83,617	8,015	8,015	8,015	199,245	4%
3. Emphasizing evidence-based, high-impact interventions	53,509	41,134	-	-	-	94,644	2%
4. Addressing the broader multisectoral context	39,595	10,937	11,265	11,265	11,265	84,329	2%
5. Strengthening mutual accountability for RMNCAH outcomes	388,105	980,346	1,047,911	1,000,444	1,000,444	4,417,250	82%
Total	**846,761**	**1,195,669**	**1,149,214**	**1,101,747**	**1,101,747**	**5,395,137**	**100%**

The RMNCAH Sharpened Plan is pushing for universal coverage of six types of services to be delivered at different levels of care (Table 9). In estimating service delivery costs by levels of care (not including system strengthening costs, see Table 10 below), three types of cost elements were considered:

human resources, commodities, and program strengthening support. Human resource cost was estimated based on the person-days that each service takes from the total time of each cadre—through OHT—and using the estimate to apportion the cost based on annual salaries. The commodities are based on the targets set and the required types and unit of drugs and medicine required per intervention to reach the targeted population in need. Program strengthening costs are estimated with the assumption that there will be a monthly coordination meeting at all levels, preparing and implementing TV and radio communication twice a year, undertaking two national-level coordination meetings per year, and undertaking an annual review and planning for each of the service areas. The total service delivery costs of all programs are estimated at US$2.53 billion, of which 38% is estimated to finance the requirement of MNRH services, 21% for child health services, and 20% for nutrition services. As shown in Table 9, 55% of the estimated resource requirement is for procuring and distributing health service commodities (medical supplies, vaccines, etc.), while 41% is for financing human resource salaries of providers at different levels of care. Specific program system strengthening costs account for only 4% of the total service delivery cost.

Table 9. Cost by Types of Services and Major Cost Components (000 US$)

	Service delivery		Program strengthening	Total	Share
	HRH	Commodities			
MNRH Services	574,471	365,659	33,009	973,139	38%
Child Health Services	197,423	98,093	25,282	520,798	21%
Immunization Services	10,899	330,577	27,227	368,705	15%
Nutrition Services	235,422	272,112	9,573	517,108	20%
Adolescence Health Services	10,432	14,802	8,862	34,096	1%
School Health Services	10,215	103,658	5,869	119,742	5%
Total	1,038,863	1,384,902	109,824	2,533,588	
Share	41%	55%	4%		

The dimension of the costing exercise was to estimate the share of different levels of service provider platforms as outlined in Table 10 from the total cost of the service delivery. The basic assumption is to use the service utilization share of each of the services at different levels of care. The highest share of the total service delivery cost is HC III at about one-third (US$829 million). This is followed by GHs with a share of 19%. Overall, PHC service providers (community, and HC II, HC III, and HC IV) account for 47% of total service delivery cost. The share of higher-level care (national and super-specialized national referral hospitals) is about 21%.

Table 10. Cost by Levels of Service Delivery and Major Cost Components (000 US$)

	Service delivery		Program strengthening	Total	Share
	HRH	Commodities			
Community and Health Centre II	94,700	126,244	10,011	230,955	9%
Health Centre III	339,884	453,098	35,931	828,913	33%
Health Centre IV	49,874	66,487	5,272	121,634	5%
General Hospital	197,381	263,127	20,866	481,374	19%
Regional Referral Hospital	144,633	192,809	15,290	352,731	14%
National Referral Hospital	141,594	188,758	14,969	345,320	14%
Super-Specialized Hospital	70,797	94,379	7,4844	172,660	7%
Total	1,038,863	1,384,902	109,824	2,533,588	100%
Share	41%	55%	4%		

The other area of focus for this costing process was system strengthening. The unit costs of most of the system strengthening interventions are based on the GOU Procurement and Disposal Guideline rates for 2021. The targets were taken from the Sharpened Plan.[rr] The total cost for interventions aimed at removing system bottlenecks is estimated at US$173.8 million. Of this, the major share goes to infrastructure and RMNCAH equipment at 63% of the total (US$109.5 million). The major cost driver in this intervention is the planned construction of 138 HC IIIs in subcounties. The costs for health infrastructure development—health facility construction and maintenance, medical equipment purchases and maintenance, and transport—are planned to be completed in the first three years of implementation. The second highest share of the estimated cost goes to human resources (upgrading skills and filling RMHNCAH human resource gaps) accounting for 25% (US$43.3 million). For detailed costs of each intervention and their share of the total cost, see Table 11.

Table 11. Estimated Costs of System-Strengthening Core Priorities (US$)

	2020-21	2021-22	2022-23	2023-24	2024-25	Total	Share
RMNCAH Leadership	1,911,013	2,488,653	2,293,166	2,216,121	2,118,244	11,027,197	6%
Infrastructure and Equipment	109,473,210	-	-	-	-	109,473,210	63%
Health Workforce	6,601,327	6,720,823	7,450,097	10,195,379	12,350,654	43,318,280	25%
RMNCAH Financing	39,692	39,692	40,883	40,883	40,883	202,032	0%
RMNCAH Commodity Security	870,376	1,026,253	1,259,962	1,462,884	1,665,806	6,285,280	4%
RMNCAH Service Delivery	351,383	339,344	197,631	197,631	197,631	1,283,621	1%
Community Engagement	171,123	208,842	176,257	176,257	176,257	908,736	1%
Health Management Information	227,524	457,524	234,350	110,750	234,350	1,264,496	1%
Total	**119,645,647**	**11,281,130**	**11,652,346**	**14,399,904**	**16,783,824**	**173,762,852**	**100%**

[rr] The exchange rate used for this estimation is US$1=UGX 3,650.

07.2 Resource Mapping and Projections

The resource mapping exercise carried out in developing this Sharpened Plan sets forth the commitment of all development partners for the plan period. Total resources available are estimated to be US$2.1 billion. The highest contributors, according to the mapping report, are Government of Uganda, USAID, World Bank, and Global Fund with shares of 29%, 19%, 15%, and 15%, respectively, for a combined contribution of about 80% of total commitments (see Table 12). When the commitment is disaggregated by government and development partners, 71% is from external resources. The government share is estimated to be about $613.1 million (29%) for the whole Sharpened Plan period (see Table 13). The significant share of government expenditure is its estimated contribution to the payment of the wage bill (with the assumption that 60% of the total wage bill will be allocated to RMNCAH services) which accounts for 86%.

Table 12. Commitment by Different Partners (Million US$)

Name of organization	Commitment						
	2021	2022	2023	2024	2025	Total	Share
Government MOH	128	121	121	121	121	613	29%
Donors	267	285	331	303	298	1,484	71%
ENABEL	2.22	4.43	3.66	3.69	3.69	17.69	1%
The Global Fund	41.26	38.31	95.39	76.60	71.43	322.99	15%
Save the Children	4.41	4.35	4.25	4.18	4.19	21.38	1%
UNAIDS	1.29	1.27	1.25	1.26	1.26	6.33	0%
World Bank	62.24	61.43	60.46	60.84	60.93	305.90	15%
UgIFT	9.0	9.0	9.0			27.0	1%
GAVI	13.55	34.49	33.95	34.16	34.21	150.38	7%
UNFPA	7.86	7.62	6.95	6.76	6.76	35.95	2%
WHO	3.39	3.00	2.93	2.77	2.78	14.87	1%
SIDA	0.99	0.63	0.62	0.63	0.63	3.51	0%
UNICEF	12.73	12.29	10.65	10.68	10.69	57.04	3%
Duetsche Stilfung Wettbeokerng	0.50	0.54	0.47	0.43	0.43	2.36	0.1%
Koica	1.81	3.11	3.06	3.10	2.91	14.00	1%
USAID	86.44	81.21	79.94	80.44	80.56	408.58	19%
Royal Netherland Embassy	8.32	8.38	7.65	6.81	6.82	37.97	2%
Other Donors	11.15	14.59	10.47	10.65	10.67	57.54	3%
Total	**395.38**	**406.02**	**451.82**	**424.19**	**419.18**	**2,096.59**	**100%**

The resource mapping exercise indicated that RMNCAH current expenditure and estimated commitment for the coming five years are almost similar for most of the programs with a slight increase for adolescent health, child health, and immunization. The majority (35%) and (34%) goes to

maternal/newborn and reproductive health and other maternal/newborn and reproductive health programs, respectively. The least share is indicated for family planning (0.8%) and school health (0.05%).

Table 13. RMNCAH Expenditure 2020 and Commitment (2021–2025) by Focus Area (000 US$)

Major Focus Areas	Expenditure	Commitment						
	2020	2021	2022	2023	2024	2025	Ave/yr.	Total
Adolescent Health	13,333	13,799	13,724	37,715	36,683	34,623	27,309	136,544
Child Health	13,624	15,584	13,798	28,951	28,325	26,821	22,696	113,478
Immunization	18,078	17,950	37,048	37,046	37,046	37,046	33,227	166,137
Maternal/ Newborn and RH	130,253	135,960	125,181	141,966	126,166	124,909	130,836	654,182
Family Planning	440	437	902	902	902	902	809	4,044
Other MNR Health	129,813	135,523	124,279	141,064	125,265	124,007	130,028	650,138
Nutrition	6,017	4,532	4,246	4,260	4,260	4,260	4,312	21,559
School Health	202	177	177	177	177	177	177	886
Others	51,482	27,607	27,715	28,101	28,119	28,119	27,932	139,661
Total	**363,241**	**351,569**	**347,069**	**420,183**	**386,943**	**380,864**	**377,326**	**1,886,628**

07.3 Funding Gap Management

The analysis of estimated cost and commitments shows a financing gap of US$616 million during the plan period. This implies that about 23% of the estimated costs will not be financed if the additional resources are not mobilized (see Table 14). The financing gap increases from about 13% in 2021 to 33% in 2025. Overall, the financing gap is not that significant.

Table 14. Costs Financing and Gaps (Million US$)

	2021	2022	2023	2024	2025	Total
Required Resources	455	493	540	595	630	2,713
Available Resources	395.3	406	451.8	424.2	419.2	2,097
Gap in US$	59.6	87	88	171	211	616
Gap in %	13%	18%	16%	29%	33%	23%

The financing gap, though not that significant, may negatively affect the implementation of the plan. Managing and matching the costs in relation to available funding during the annual planning and budgeting process will be used as a strategy to match the set targets with available resources. In this regard, three major strategies will be used to manage the resource gap.

- The first strategy is that the implementing units will review annual targets and revise them as part of the annual planning and budgeting process.
- The second strategy is for the sector to work toward enhancing value for money by focusing on efficacy gains in supply chain and human resources. In this regard, the required amount of commodities for the interventions associated with (1) treatment of pelvic inflammatory disease (PID), (2) malaria treatment for children aged 0–4, (3) zinc supplementation,

(4) pneumococcal vaccine, and (5) management of moderate acute malnutrition in children will be annually reviewed and adjusted. To enhance efficiency in the procurement and distribution of commodities, enforcement of the use of the essential medicines list will be followed up. The government will work toward enhancing value for money in the procurement and distribution of all commodities to bridge the costing gap.

- The third strategy is to build the capacity of evidence generation and advocacy for increased funding for the RMNCAH Sharpened Plan from both domestic and external resources. The RMNCAH delivery units will work with the overall health sector to engage and influence for increased government resource allocation for health in general and receive their fair share from this increased investment. They will also work toward mobilizing additional funds from external resources by engaging and showcasing the investment case of this plan to partners that have a potential to increase funding.

ANNEXES

Annex 1: A Call to Action—We All Have a Role to Play

The commitments by stakeholders to help deliver the new Sharpened Plan 2020/21–2025/26 over the next five years are outlined here.

Civil Society Organizations (CSOs)

These commitments are also aligned with the Uganda CSO Global Financing Facility engagement strategy.

CSOs' complementary role and renewed commitments are tailored toward working closely with government to (1) identify high-burden districts using agreed on criteria and also support community engagement in the process and how to address existing RMNCAH issues; (2) advocate and support uptake of the social accountability tools including the RMNCAH scorecard at national and subnational levels; (3) support scale-up and implement prioritized RMNCAH services; (4) leverage resources and expertise in integrating health with other sectors, including strengthening public-private partnerships, and work more effectively toward a shared goal of ending preventable deaths; (5) mobilise citizens to call on government to increase investment/budget allocations for high-impact maternal, newborn, and child interventions for improved RMNCAH outcomes; and (6) track clearly defined district indicators to strengthen and guide the country in planning as well as in allocating resources and ownership of the problem.

Cultural Institutions

Cultural institutions commit to (1) address cultural/gender norms, taboos, and practices that are detrimental to RMNCAH; (2) contribute to mobilization of citizens to create awareness, access, use of and adherence to high-impact service intervention packages; and (3) address sexual and gender-based violence and support all efforts to uplift the status of women and girls in society.

Religious Leaders

Religious leaders commit to (1) contribute to mobilization of citizens to create awareness, access, use of, and adherence to high-impact service intervention packages including highly burdened and under-served populations to ensure women and children everywhere survive and thrive; (2) promote behavior that protects the health of the most vulnerable and marginalized members (including adolescents) of society; and (3) engage in robust community education against discrimination/stigmatization, practices that harm or suppress women and girls, prejudices, other attitudes that restrict members of the community from accessing the full range of RMNCAH services, commodities, and information they need in line with religious beliefs and values.

Annex 2: Workplan

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
A. HEALTH SYSTEM INPUTS							
1.1 RMNCAH Governance and Leadership							
1.1.1 Harmonise, align, and consolidate RMNCAH policies and programming; develop a comprehensive RMNCAH manual/SOPs in partnership with individuals, families, communities, and frontline service providers	Consolidated RMNCAH manual/SOPs	Proportion of facilities where RMNCAH policy manual/SOPs available and in use				Support supervision reports Evaluation survey reports	All components of RMNCAH agree to consolidate
1.1.2 Regionalise technical oversight and performance improvement across public and private sector around regional referral hospitals	17 regional referral hospitals	# regions with fully institutionalised and fully functional oversight and performance teams				Quarterly regional supervision reports	adequate availability of regional leadership support, technical staff, and logistics to functionalise
1.1.3 Develop training, job aids, and tools for improving district and facility RMNCAH leadership in management, partnership with local communities, and achieving people-centred and integrated care	Mid-level health managers and facility governance committees	# districts/health facilities where relevant bodies are consistently engaged and contributing to RMNCAH operations and services in line with refined tools				Periodic administrative reports	Linkage between facilities and community, interaction among various facility management bodies in the district
1.1.4 Develop tools for subnational health governance committees for implementing alterations in service delivery design to people-centred RMNCAH care, population RMNCAH management, inclusive of services and accountability	17 regionals	# regionals where the guidelines and tools are available and in use at all levels				Periodic administrative reports	Governance bodies are fully constituted and fully functional

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.1.5 Reanalysis of legal, policy, and regulatory framework to identify gaps and barriers to RMNCAH extended nurturing care framework and develop a redress strategy	Refined legal, policy, and regulatory framework	% health facilities implementing RMNCAH extended nurturing care based on refined legal, policy, and regulatory framework				Quarterly supervision reports	Support systems are in place to enable review of legal, policy, and regulatory framework
1.1.6 Together with professional bodies and associations develop guidelines, implementing tools, and mechanisms for effective engagement of private sector especially midwifery/nurse in RMNCAH delivery for adolescents and hard-to-reach subpopulations	17 regionals operationalizing this engagement to at least 25%	% midwives/nurses in the private sector engaged in RMNCAH service delivery especially for adolescents and hard-to-reach subpopulation per region.				Quarterly supervision reports (private sector health facilities)	All-inclusive growth plan (public, PNF, PFP) for periodic analysis and growth projection- opportunities and promotion to enable private and PFP complementing public commitment to PPP
1.1.7 Annual meetings of professional councils, associations, and regional teams to review in-service training/CMEs based on RMNCAH performance data and supervision/mentoring reports	18 meetings per year (17 regional, 1 national)	# regions holding meetings per year				Filed meeting minutes	Professional bodies operational in all regions
1.2 RMNCAH Financing							
1.2.1 Improving efficiencies through integration of RMNCAH program implementation, management, training, and supervision activities and increasing domestic resource mobilization for RMNCAH	17 regionals integrated workplans	# regions with integrated plans				Integrated workplans	Willingness of other departments and interventions to integrate
1.2.2 Developing multidepartment activities with HIV, malaria, and TB to implement health system strengthening within the Global Fund and especially community health systems	Integrated workplans all levels planning	% districts/health facilities implementing integrated workplan				Periodic activity reports	Willingness of other departments and interventions to integrate

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.2.3 Continuing tracking national and district level expenditure, reduce off-budget financing of RMNCAH services currently at 79% (UGX 129 billion)	100% of regions and districts	# regions/districts where tracking is routinized (quarterly, semester, and annual)				Resource tracking/finance reports	Open access to finance data
1.2.4 Aligning RMNCAH/N partner funding toward service delivery at community, HC III and IV levels, and establishing measurement and tracking mechanisms in light of high (65%) household total expenditure on health used in seeking services through hospitals	Identify and profile RMNCAH funding partners	% partner funding aligned toward service delivery at community, HC III and IV levels; established measurement and tracking				Budget framework papers	Flexibility in budgeting and management of partner funding
1.3 Health Workforce							
1.3.1 Absorbing the pool of trained health workers (formal recruitment) into health system	17 regions	# health workers (midwives) recruited per region/district annually				HRH reports	Recruitment of HWs is aligned to targets in the Uganda human resource for health strategic plan
1.3.2 Developing a comprehensive training needs assessment and training plan hinged on the comprehensive RMNCAH manual/SOPs	17 regions	# regions/districts where training needs assessment is done and used as basis for annual training plans				Periodic workplans and reports Evaluation reports	Staffing is full and allows for training
1.3.3 Configuring and building capacity for continuously tracking RMNCAH training information to determine district- and facility-level progress and deficits based on electronic Integrated Human Resource Information System (IHRIS).	Comprehensive leadership training, job aids, and tools targeting all mid-level health managers and	# ADHOs-MCH and nursing officers trained in implementation of RMNCAH nursing and midwifery performance improvement management				Periodic administrative reports	

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
	facility governance committees						
1.3.4 Training mid-level managers (especially ADHO-MCH and nursing officers) in implementation of RMNCAH nursing and midwifery performance improvement management	All RMNCAH training materials and tools uploaded on digital platform	Proportion of digitised RMNCAH training materials and tools including adolescent peer providers, school health, and self-care				Digitalised RMNCAH training materials and tools	Support systems are in place to enable digitalisation of RMNCAH training materials and tools
1.3.5 Digitalisation of RMNCAH training materials and tools including for adolescent peer providers, school health, and self-care	17 regions	# regions with trained and functional teams of trainers/supervisors/mentors				Administrative reports	Staffing is full and allows for training
1.3.6 Training 17 regional teams of trainers/supervisors/mentors with integrated biannual short on-site courses and peer support for frontline workers organised within districts; developing ICT enabled distance-learning schemes	At least 20% of target health facilities per district are covered per year	% frontline health workers have had short on-site courses and peer support				Quarterly support supervision reports	Staffing is full to allow for training of health workers with minimum interruption to service delivery
1.3.7 Update midwifery and nursing pre-service and in-service national training curriculum and cover new RMNCAH competence requirements and on rural health issues to improve competences and interest in rural practice.	Updated midwifery and nursing pre-service and in-service national training curriculum	% midwives and nurses trained based on the updated midwifery and nursing pre-service national training curriculum				Midwifery and nursing pre-service and in-service national training curriculum	Effective collaboration of readiness between health training institutions and professional bodies

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.3.8 For VHTs: (1) develop and roll out rationalised training module on expanded RMNCAH package (including use of digitised technologies), (2) incentivize VHTs to meet RMNCAH performance standards within the expanded community package (ICCM-plus, commodity distribution, pregnancy mapping, etc.)	A rationalised training module on expanded RMNCAH package	% VHTs trained based on the out rationalised training module on expanded RMNCAH package				Rationalised training module on expanded RMNCAH package	Harmonised time of development of key documents
1.4 RMNCAH Infrastructure and Equipment							
1.4.1 Procurement of targeted equipment: a) low-cost portable obstetric ultrasound machines for all HC IIIs and IVs and training package for midwives, b) newborn intensive care units for GHs, c) special care units for 100 high-volume HC IVs, general hospitals, d) SCUs for HC IVs, e) KMC beds for all HC IIIs and IVs	A four-level RMNCAH delivery and referral system full equipment	# HC IVs and HC IIs that have procured low-cost portable obstetric ultrasound machines per district # GHs per region equipped with newborn intensive care units # HC IVs and GHs per region equipped with special care units for 100 high-volume HCs				Medical equipment and asset inventory	An integrated planning and procurement system (region) for a functional four- level RMNCAH delivery and referral system
1.4.2 Establishment of blood storage facilities at all HC IVs to ensure timely availability of supply and other products like fresh frozen plasma and platelets	All HC IVs	# HC IVs per region with established and functional blood storage facility				Blood storage facilities	A prioritized procurement and installation process
1.4.3 Procurement of smartphones for VHTs to contact health facilities for referrals, use mobile phone-based alerts and audit services, rapid SMS reporting	All VHTs	% VHTs per district equipped with and utilising smartphones for referrals and reporting				VHT reports and referrals made using smartphone-	VHT dropout rates are managed

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
						based platforms	
1.4.4 Establish facility digital asset inventory system to track equipment availability, functionality, and servicing requirements	All health facilities	% facilities region/district using digital asset inventory system to track equipment availability, functionality, and servicing requirements				Routine health facility asset inventory records/ reports	Simplicity and reliability of the digital asset inventory system
1.4.5 Equip 16 regional hospitals with training aids/simulators to perform as pre- and in-service competence training hubs	16 regional hospitals	# regional hospitals with training aids/simulators to perform as pre- and in-service competence training hubs				Administrative reports	Supportive environment for the functionality of training aids/simulators to perform as pre- and in-service competence training hubs
1.4.6 Renovation of a few grossly dilapidated health facilities in selected districts	TBD	# and proportion of HFs renovated per district annually				Planning and needs assessment reports for construction and renovation	Renovations prioritized in infrastructure plans
1.4.7 Equipping and strengthening of Regional Equipment Maintenance Workshops to maintain all equipment being procured and distributed to districts	17 Regional Equipment Maintenance Workshops	# regions with functional Equipment Maintenance Workshops				Supervision reports	Internal capacity is built within the regions for maintenance of medical equipment available in the region

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.5 RMNCAH Commodity Security and Technologies							
1.5.1 To increase access points to commodities	An integrated distribution system	% FP and self-care commodities integrated in the private sector distribution strategy.				Facility assessment reports for reproductive health commodities and services	Enabling environment of PPP
1.5.2 Developing comprehensive RMNCAH self-care commodity security and safety strategy for the five years	Five-year RMNCAH commodity security strategy document	Five-year RMNCAH commodity security strategy document disseminated and in use				Five-year RMNCAH commodity security strategy document	Availability and harmonisation of key RMNCAH documents
1.5.3 Establish and support an effective government-led regulatory and stewardship subcommittee to steer and monitor the digital health development partnership among government health services, private IT platforms, and public and private sectors to harness ICT potential	A regulatory and stewardship subcommittee to steer and monitor digital health development	A functional regulatory and stewardship subcommittee to steer monitoring of digital health development partnership				Report by the regulatory and stewardship subcommittee	Supportive system for multisectoral engagement
1.5.4 Research on use of new technology under m-health and e-health in supporting service delivery improvements and community engagement; focus less on answering “what” and more on “how” questions through operations and implementation research	TBD	# new technologies under m-health and e-health developed, piloted, and adopted for use				New technologies in m-health and e-health	Supportive environment for research and innovation in m-health and e-health

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.6 Health Management Information							
1.6.1 Developing and tailoring reporting tools and configuration of RMNCAH reporting in existing Uganda EMR platform	Tailored RMNCAH tools configured for reporting in Uganda EMR	3 level indicators (region, district, facility)				HMIS	Tools are compatible with the existing Uganda EMR platform
1.6.2 Roll out RMNCAH dashboard embedded in DHIS2 to the remaining 10 regions	17 regions	# regions where RMNCAH dashboard has been rolled out and in use				HMIS	Effective training of the relevant cadres in use of RMNCAH dashboard Strengthened RMNCAH's data demand and use infrastructure
1.6.3 Digitalize and operationalize the Community Health Information Systems with simplified mobile application dashboard	A functioning and simplified mobile application dashboard for Community Health Information Systems	A functioning and simplified mobile application dashboard for Community Health Information Systems				HMIS	VHTs are well trained, equipped, and incentivised to collect and submit community data
1.6.4 Implement a home-based record of history of health services received by an individual in the family initially kept in the household (paper or electronic), but gradually integrated into the health information system and complement records maintained by health facilities	TBD	# and proportion of health facilities implementing a home-based record of history of health services received by an individual in the family.				CAPA	Capacities of VHTs strengthened to support the implementation of home-based record of history of health services received by an individual in the family

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.6.5 Together with Division of Health Information and NITA-U, develop a platform for national and district health managers to access interlink data from RMNCAH sensitive sectoral information systems	TBD	% national and district health managers accessing and utilising interlink data from RMNCAH sensitive sectoral information systems				HMIS	Capacities and core competences of national and district health managers in data use built A strengthened RMNCAH's data demand and use infrastructure
1.6.6 Deploying the RMNCAH Equity Assessment building on existing sentinel sites and efforts	TBD	# regions/districts conducting RMNCAH equity assessment per year				Annual assessment reports	Functionality of existing sentinel sites and more will be set up
1.7 Community Engagement for RMNCAH							
1.7.1 Developing, digitisation, and dissemination of RMNCAH CAPA manual that prioritizes community and family-oriented models of care as a mainstay of practice with a focus on prevention and health promotion	RMNCAH CAPA implementation manual	% health facilities implementing CAPA in their catchment areas				Action plans	Health facility staff trained and appreciate CAPA
1.7.2 Training in implementation of CAPA	At least 20% health facility- in-charges trained per district per year	% health facility-in-charges trained and disseminating RMNCAH data for comprehensive RMNCAH social and behaviour change among target communities.				Training manual and training reports	Availability of RMNCAH CAPA implementation manual
1.7.3 Harmonise and disseminate a comprehensive RMNCAH social and behaviour change (RMNCAH&N SBCC) strategy that incorporates IT and practices on health determinants	RMNCAH SBCC strategy	# districts/health facilities using RMNCAH SBCC strategy				Quarterly reports, annual performance reports	A comprehensive RMNCAH social and behaviour change (RMNCAH&N SBCC) strategy is developed and disseminated at all levels

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
1.7.4 Extensive awareness campaigns on RMNCAH self-care commodities and technologies	TBD	% targeted population having knowledge of RMNCAH self-care commodities and technologies				Survey reports	Population groups are profiled and targeted for RMNCAH self-care commodities and technologies Appropriate modes of awareness campaigns for targeted populations are used
1.7.5 Reaching and engaging underserved, disadvantaged, and marginalized populations (see Shift 2)							
1.8 RMNCAH service delivery emphasising evidence-based, high-impact interventions							
1.8.1 Develop guidelines, pilot, and scale up system for remodelling facility and community RMNCAH service delivery organisation toward integrated people-centred RMNCAH services across the continuum of care and differentiated care	Guidelines developed	# and proportion of health facilities delivering integrated people-centred RMNCAH services across the continuum of care and differentiated care				Supervision reports	Appropriate guidelines are developed, piloted, and adopted
1.8.2 Support development of a centrally coordinated system of regionalized RMNCAH care services integrated with coordinating RMNCAH care, HRH training, regional service delivery-ambulance network, multilevel quality improvement and simplified effective RMNCAH referral pathways. Develop guidelines and scoping study; procure	17 centrally coordinated systems of regionalized integrated RMNCAH care services developed	# regions with a functional centrally coordinated system of regionalized integrated RMNCAH care				Regional support supervision reports	Regional teams are fully constituted and resources to support development of a centrally coordinated system of regionalized RMNCAH care services integrated with coordinating RMNCAH care

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
mentoring and training aids, support supervision to establish 17 regional referral hospital skills hubs in line with national regional support policy guidelines							
1.8.3 Training regional mentoring teams and supporting quarterly mentoring visits (5) for training, support supervision, and management for VHTs to: a) rationalise VHTs initial and continued training including adolescent /young people VHTs, b) retool and procure critical equipment, c) mobilize, train, integrate, and provide tools for adolescent and young people (AYP) peer educators, and providers through the AYP Constituency in the RMNCAH CSO coalition	5 cadres per region trained to conduct support supervision and quarterly mentoring visits	# regions with trained teams in conducting support supervision and quarterly mentoring visits				Training reports	Regional teams are fully constituted to allow training support supervision and mentoring
1.8.4 Differentiated service delivery (DSD) for increasing diversity of needs of demographic groups/locations; develop guidelines, provide training and mentoring, adjust existing RMNCAH data systems for variety of delivery approaches.	All health facilities adopt DSD	# and proportion of health facilities providing DSD per district and region annually				Supervision reports Surveys	Population groups are profiled and targeted for DSD
1.8.5 School health promotion services including stronger linkages of health services within the schools or partnerships between schools and nearby HCs	75% of schools reached	# and proportion of schools reached with school health promotion per district/region annually				Quarterly activity reports	Sufficient multisectoral collaboration with MOES
1.8.6 Develop guidelines, pilot, and scale up system for remodelling facility and community RMNCAH service delivery organisation toward	Developed guidelines	% health facilities per region/district implementing integrated people centred RMNCAH				Quarterly reports	Support systems to accommodate and facilitate the adjustment process

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
delivery of integrated people-centred across the continuum of care and differentiated care		services across the continuum of care and differentiated care based on the new guidelines					
1.8.7 Develop guidelines, scoping study, procurement of mentoring and training aids, support supervision to establish 17 regional referral hospital skills hubs in line with the national regional support policy guidelines	Consolidated guidelines	# regional referral hospitals with established and functional skills hubs in line with the established policy guidelines				Quarterly support supervision reports	Timely development and dissemination of guidelines at all levels
2.1 Focusing First on Districts with Highest Maternal and Child Mortality							
2.1.1 Establish functioning bEmONC in all HC IIIs and cEmONC in HC IVs within a coordinated referral system of regionalized RMNCAH service and hold biannual joint reviews	50%	% functional HC IVs offering C/S and blood transfusion per region				Administrative reports	Established and functional blood storage facilities at all HC IVs
2.1.2 Quality initiatives that elevate and standardise RMNCAH&N care delivery at all HFs and effective use of scaled MPDSR and community verbal autopsy	90%	% HFs holding MPDSR				HMIS quarterly reports	Facilities have adequate number of staff to conduct MPDSR
2.1.3 Comprehensive community delivery (VHT) system and community engagement to address access barriers and data-driven community-led actions	100%	% HFs using VHT data for community-led action				Quarterly health facility plans and report Periodic surveys	Adequate training of health facility staff in CAPA

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
2.1.4 Continuously measuring disparities through strengthening BDR through NIRA and DHIS2, community HMIS, and use of composite indices to identify overburdened districts/regions; track progress in reduction of disparities	All districts (100%)	% of national and district health managers analysing and using BDR data for RMNCAH programming % health facilities notifying all births in the birth registration system				Quarterly RMHCAH performance review reports	CRVS fully rolled out A linked and fully functional database (NIRA and DHIS2)
2.2 Increasing access for high-burden populations							
2.2.1 Shifting to targeted delivery channels through task-shifting to community-led (peers) or -based (VHTs, outreach, and satellites) service delivery to ensure services reach marginalised and disadvantaged	All health facilities (100%)	% health facilities per region/district implementing community-led service delivery				Quarterly reports Survey reports	Increased community awareness and demand for RMNCAH services
2.2.2 Engaging and contracting private health care midwives (CSOs, PNFP, and PHP) especially through district-level RBF to expand access	All districts engaging private care midwives	% private sector actors enrolled on RBF				Annual performance reports	Private sector facilities are profiled
2.3 Addressing the broader multisectoral context							
2.3.1 Establish a nurturing care lead office to drive implementation of strategies needed to incorporate Nurturing Care into daily routines, policy development, program coverage, monitoring and continuous quality improvement.	Nurturing care lead office	A functional nurturing care lead office				Administrative reports	Clearly defined structure, instruments, and terms of reference for the nurturing care lead office
2.3.2 Strengthen formalised engagement and partnership with other sectors and private sector (CSOs, TCMPs, PHP, school, workplace,	TBD	# MOUs signed with private sector facilities				Administrative records	Good multisectoral collaboration

Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
businesses, etc.) at district level in implementation of the NCF							
2.3.3 Inclusion of NCF indicators within the community HMIS	TBD	# NCF indicators included in the community HMIS				HMIS reports	Valid measurements of national nurturing care environment for all age groups are based on reliable indicators
2.3.4 Strengthening clinical response to child, gender- and sexual-based violence through cascaded training of health care providers (facility and community levels) on management of sexual- and gender-based violence, update GBV referral pathways, data protection protocols, and service quality improvement	TBD	% health care providers per region/district trained and providing clinical response to child, gender- and sexual-based violence.				Training reports	Effective cascade training of health care providers on clinical response to child, gender- and sexual-based violence
2.4 Strengthening Mutual Accountability							
2.4.1 Roll out implementation of Maternal and Perinatal Death Surveillance and Response Guidelines 2017	100% rollout in the relevant health facilities	% health facilities per region/district with access and implementing Maternal and Perinatal Death Surveillance and Response Guidelines 2017				Guidelines 2017 available at health facilities and readily accessible to health care providers	Timely rollout of Maternal and Perinatal Death Surveillance and Response Guidelines 2017 at all levels
2.4.2 Support 17 annual regional RMNCAH reviews and one national review with results from community scorecards and patient satisfaction surveys	17 regional and 1 national	# performance reviews successfully held per year				Annual performance review reports	Interventions to improve data use are fully implemented

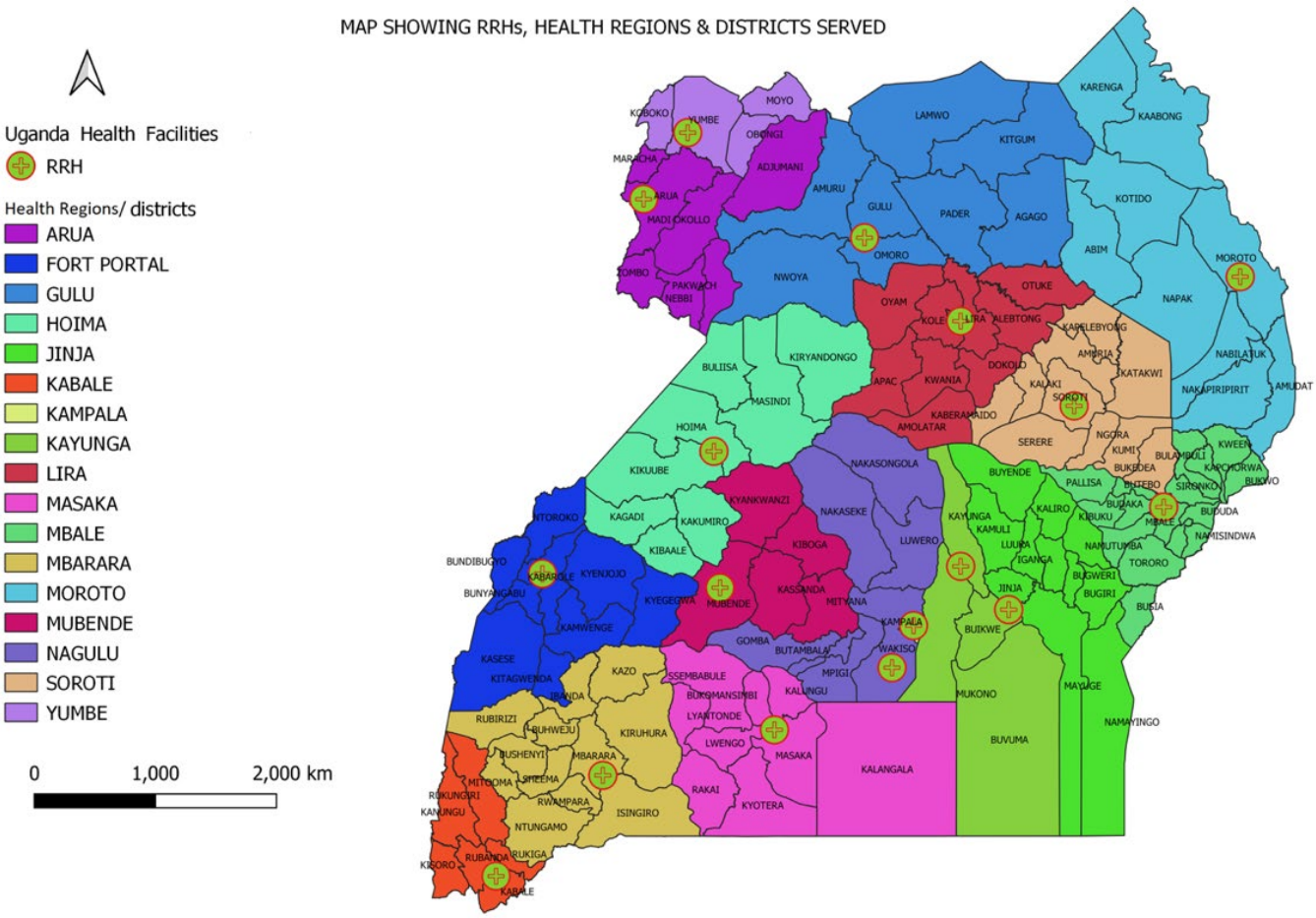
Key Intervention Activities	Target	Indicators	Years			Means of Verification	Risks/Assumptions
			1-2	3-4	5		
2.4.3 Develop facility management committee guidelines and tools for inclusiveness; community feedback, reporting, action, follow-up; IT-based RMNCAH community scorecard and its use in social accountability	100% of HUMC and HBs	# facility management committees per region/district using the new facility management committee guidelines				Facility management committee reports	Fully constituted and functional facility management committees fully oriented on the new guidelines
2.4.4 Establish and support a technical working group for performance accountability tracking and action on indicators for RMNCAH: (1) eliminating preventable maternal and child deaths, (2) eliminating inequities within populations, (3) improving care using available resources, (4) reaching adolescents and young people, (5) extending nurturing care framework.	1 TWG at national level	# RMNCAH analytical reports produced per year				Analytical reports	Improved capacity and core competences of technical teams in data use Availability of quality RMNCAH data

Annex 3: National Performance Targets in the NDPIII

Indicator	Baseline					
	Baseline	'20/21	'21/22	'22/23	'23/24	'24/25
Impact Indicators						
Reduced Maternal Mortality ratio (per 100,000)	336	311	286	261	236	211
Reduced Under-5 Mortality Rate (per 1,000)	64	59	55	50	46	42
Total Fertility Rate	5.4	5.0	4.9	4.8	4.6	4.5
Reduced teenage pregnancy	25	22	20	18	16	15
Reduced unmet need for family planning	28	26	22	18	14	10
Thematic Indicators						
Total users for modern contraceptive methods (excluding condoms and fertility awareness methods) in '000,000	2.93	3.12	3.32	3.53	3.75	4.00
Reduced prevalence of under-5 stunting	29%	27%	25%	23%	21%	19%
Under-5 Vitamin A second-dose supplementation	30%	35%	38%	42%	46%	50%
DPT3 Coverage	95%	98%	99%	100%	100%	100%
Human Papilloma Virus vaccination coverage for 10-year-old girls	40%	50%	65%	60%	65%	70%
% pregnant women receiving iron/folate supplement	50%	55%	60%	65%	68%	70%
Basic sanitation coverage (improved latrine coverage)	19%	50%	55%	61%	68%	75%
Improved hand-washing facility (household)	34%	50%	38%	42%	46%	75%
% work places with breastfeeding corners	0%	5%	10%	15%	20%	25%
Improved average % availability of a basket of 41 tracer commodities at all reporting facilities	79%	82%	85%	88%	90%	93%
% health facilities with 95% availability of 41 basket of EMHS, including lab, vaccines, and blood transfusion supplies	46%	55%	60%	70%	75%	80%
% health facilities in the country utilizing the e-LMIS and (ERP) and reporting into the PIP	30%	35%	40%	45%	60%	70%
Number of functional National and Regional Call Centres with EmONC referral streamlined	0	2	5	10	14	14
% functional HC IVs (offering C/S and blood transfusion)	50%	60%	70%	80%	85%	90%
% subcounties with HC IIIs	50%	55%	60%	65%	70%	75%

Indicator	Baseline					
	Baseline	'20/21	'21/22	'22/23	'23/24	'24/25
% functional imaging and radiotherapy equipment in hospitals	65%	68%	70%	72%	74%	75%
% RRHs with functional ICUs/HDUs	20%	100%	100%	100%	100%	100%
% approved staffing levels filled by qualified health workers	73%	80%	82%	84%	85%	86%
% staff with signed performance agreement and appraisals for performance management in health service delivery	80%	80%	85%	90%	95%	100%
% public and private hospitals, HC Ivs and high-volume HC IIIs utilizing the Electronic Medical Record System	0%	10%	20%	30%	40%	50%
Timeliness of weekly surveillance reports	60%	75%	78%	80%	85%	85%
% private health providers (private for profit) facilities reporting into the DHIS2	20%	25%	30%	35%	40%	45%
% quarterly RMNCAH performance reports analysed and actioned	0%	75%	100%	100%	100%	100%
Increased children under 5 years registered and issued Birth Certificates	40%	70%	75%	80%	85%	90%
Percentage of deaths in a given year continuously reported, registered, and certified with key characteristics	2%	10%	40%	50%	60%	70%
% hospitals using the ICD 11 Classification of diseases and Medical Certification of Cause of Death	0%	10%	20%	30%	40%	50%
Adolescent birth rate (aged 15–19 years)	132					125
Adolescent pregnancy rate	25%					15%
Increase in couple years of protection ('millions)	3.2	4.5	5.7	7	8.2	9.5

Annex 4: Health Regions



RRH	Population	Districts Served and Catchment Population Including Refugee Population
1) Arua	2,185,390	Arua (411,578) Madi Okollo (164,200) Nebbi (282,600) Maracha (208,300) Pakwach (196,800) Terego (339422) Zombo (283,100) Koboko (5,739 Refugees) Madi Okollo (124,453 Refugees) Terego (69,198 Refugees)
2) Fort Portal	3,347,271	Bundibugyo (263,800) Bunyangabu (195,100) Kabarole (337800) Kamwenge (335,200) Kasese (793,200) Kitagwenda (178,300) Kyegegwa (442,000) Kyenjojo (525,400) Ntoroko (76,000) Kamwenge (76,510 Refugees) Kyegegwa (124,961 Refugees)
3) Gulu	1,846,720	Agago (251,200) Amuru (216,800) Gulu (325,600) Kitgum (223,600) Lamwo (143,800) Nwoya (236,000) Omoro (196,400) Pader (197,300) Lamwo (56,020 Refugees)
4) Hoima	2,855,757	Buliisa (149,300) Hoima (374,500) Kagadi (430,200) Kakumiro (473,400) Kibaale (198,200) Kikuube (358,700) Kiryandongo (313,800) Masindi (340500) Kikuube (127,291 Refugees) Kiryandongo (71,866 Refugees)

RRH	Population	Districts Served and Catchment Population Including Refugee Population
5) Jinja	4,263,000	Bugiri (480,400) Bugweri (191,600) Buyende (414,600) Jinja (515,100) Iganga (402,600) Kaliro (288,500) Kamuli (558,500) Luuka (267,100) Mayuge (565,100) Namutumba (306,500) Namayingo (237,000)
6) Kabale	1,489,100	Kabale (248,700) Kanungu (277,300) Kisoro (315,400) Rubanda (208,500) Rukiga (105,400) Rukungiri (333,800)
7) Kayunga	2,450,900	Buikwe (474,100) Buvuma (128,900) Kayunga (407,700) Mukono (701,400) Nakasongola (523,600) Luwero (215,200)
8) Lira	2,444,900	Amolatar (170,100) Alebtong (266,100) Apac (226,600) Dokolo (215,500) Kole (284,300) Lira (478,500) Kwania (216,600) Oyam (453,700) Otuke (133,500)
9) Masaka	2,029,400	Bukomansimbi (156,600) Masaka (335,700) Kalangala (67,200) Kalungu (194,100) Kyotera (261,000) Lwengo (290,500) Lyantonde (110,500) Rakai (317,700) Sembabule (296,100)
10) Mbale	4,381,600	Budaka (253,100) Bududa (271,100) Bukwo (119,100) Bulambuli (230,600) Busia (384,000) Butaleja (300,500) Butebo (121,200) Kapchorwa (123,800) Chibuku (250,600) Kween (109,500) Manafwa (175,200) Mbale (586,300) Namisindwa (231,500) Pallisa (353,400) Sironko, Tororo (597,500)
11) Mbarara	3,451,999	Buhweju (144,100) Bushenyi (248,300) Ibanda (277,300) Isingiro (596,400) Kazo (217,600) Kiruhura (185,700) Mbarara (390,700) Mitooma (194,300) Ntungamo (540,800) Rubirizi (144,100) Rwampara (144,600) Sheema (220,500) Isingiro (147,599 Refugees)
12) Moroto	1,168,600	Abim (153,500) Amudat (134,900) Kaabong (125,400) Karenga (68,500) Kotido (206,500) Moroto (118,500) Nabilatuk (89,700) Nakapiripirit (113,300) Napak (158,300)
13) Mubende	1,684,000	Kasanda (312,700) Kiboga (171,200) Kyankwanzi (282,800) Mityana (362,500) Mubende (554,800)
14) Entebbe	3,717,900	Butambala (107,800) Gomba (173,800) Mpigi (286,600) Nakaseke (234,600) Wakiso (2,915,200)
15) Soroti	2,227,800	Amuria (225,000) Bukedea (259,300) Kaberamaido (132,700) Kalaki (138,700) Kapelebyong (103,8000) Katakwi (194,600) Kumi (284,800) Ngora (165,8000) Serere (359,500) Soroti (363,600)
16) Yumbe	1,903,372	Adjumani (235,900) Koboko (258,000) Moyo (109,500) Obongi (49,100) Yumbe (663,600) Adjumani (224,044 Refugees) Yumbe (238,279 Refugees) Obongi (124,949 Refugees)

Annex 5: Synergies with Other NDPIII Programs

Programme	Areas to strengthen synergies
Agro-Industrialization	Linking with the recruited and facilitated agricultural extension workers up to parish level; increasing the proportion of households that are food secure from 60% to 80%; operationalizing the parish development model; management of domestic pests, vectors, and diseases, and enforce micronutrient industrial food fortification of the already identified food vehicles. Construct and regularly maintain community access and feeder roads for market access.
Climate Change, Natural Resources, Environment, and Water Management	Maintain and/or restore a clean, healthy, and productive environment; reduce human and economic loss from natural hazards and disasters; assure availability of adequate and reliable quality fresh water resources for all uses; scale up use of renewable energy through off-grid electrification and liquefied petroleum gas.
Private Sector Development	Sustainably lower the costs of doing business especially private sector providers; increase access to long-term finance; support the formation of cooperatives; strengthen the organisational and institutional capacity of the private sector to drive strengthening-system capacities to enable and harness benefits of coordinated private sector activities; improve data availability on the private sector; and improving dialogue between the private sector and Government; create appropriate incentives and regulatory frameworks to attract the private sector to finance green growth.
Transport Infrastructure and Services	Construct and upgrade strategic transport infrastructure; rehabilitate and maintain transport infrastructure; implement cost-efficient technologies for provision of transport infrastructure and services.
Energy Development	Expand and rehabilitate the distribution network (grid expansion and densification, last mile connections, evacuation of small generation plants, quality of supply projects); establish mechanisms to reduce the end-user tariffs; promote use of new renewable energy solutions (solar water heating, solar drying, solar cookers, wind/water pumping solutions, solar water pumping solutions).
Digital Transformation	Digitalise and roll out e-services to all sectors, MDAs, and local governments (LGs); extend ICT infrastructure coverage countrywide and last mile connectivity in health facilities; develop and enhance national common core infrastructure (data centres, high power computing centres, specialized labs); increase ICT penetration (Internet penetration to 70%, countrywide 4G coverage, tele density to 80 percent, digital television signal coverage from 56 to 95%, radio signal coverage from 60 percent to 95%, 70% broadband availability in Government MDAs/LGs); reduce the cost of ICT devices and services (unit cost of Internet from US$237 to US$70, unit cost of low entry smart phones from UGX 100,000 to UGX 60,000, and cost of a computer from UGX 1,600,000 to UGX 800,000).
Sustainable Urbanization and Housing	Decrease the percentage of urban dwellers living in slums and informal settlements from 60% to 40%; improve urban safe water and waste management services and associated infrastructure.

Innovation, Technology Development, and Transfer	Strengthen research and development (R&D) capacities and applications; increase development, transfer, and adoption of appropriate technologies and innovations; support academia and research institutions to acquire R&D infrastructure; develop and maintain a national STI Information Management System (including a database of new and ongoing scientific research, technologies innovations, and indigenous knowledge from public and private sectors); establish a framework where MDAs implement STEI joint initiatives between their R&D departments, academia, and industry.
Community Mobilization and Mindset Change	Review and implement a comprehensive community mobilization (CMM) strategy; conduct awareness campaigns and enforce laws enacted against negative and/or harmful religious, traditional/cultural practices and beliefs; strengthen institutional capacity of central, LG, and nonstate actors for effective mobilization of communities; establish a national incentives framework including rewards and sanctions for best performing workers, leaders, and communities.
Governance And Security Programme	Increase the Democratic Index from 6.5% to 8.6%; increase the percentage of youth engaged in national service from 40% to 65%; strengthen citizen participation and engagement in the democratic processes; strengthen compliance with the Uganda Bill of Rights.
Public Sector Transformation	Reduce corruption as measured by the corruption perception index from 26% to 35%; strengthen accountability for results across government; streamline government structures and institutions for efficient and effective service delivery; strengthen human resource management function of Government for improved service delivery; deepen decentralization and citizen participation in local development; increase transparency and eliminate corruption in the delivery of services.

Annex 6: Costing Assumptions

Share of programs for total HRH cost		
Program	**Estimated personnel time, Minutes**	**Share**
Maternal/newborn and RH	25,841,523,504	55%
Child health	8,880,721,403	19%
Immunization	490,285,587	1%
Nutrition	10,590,037,900	23%
Adolescent health	469,280,555	1%
School Health Programme	459,495,166	1%
Total	46,731,344,114	

Share of different levels of service providers from total outpatient visits per year		
Facilities delivering interventions	**Total baseline # of outpatients per year**	**Share**
Health Centre II	1,813,245,244	9%
Health Centre III	6,507,861,765	33%
Health Centre IV	954,957,976	5%
General Hospital	3,779,305,924	19%
Regional Referral Hospital	2,769,318,996	14%
National Referral Hospital	2,711,132,411	14%
Super Specialized Hospital	1,355,566,206	7%

Unit Costs based on the GOU Procurement and Disposal guideline rates for 2020/21

Exchange rate 3,650 Inflation rate 3% Scale 1,000

Budget Head	Type	Type	Amount UGX	Amount US$
Hall Hire National	Meeting/Training	National	900,000	246.58
Hall Hire Regional	Meeting/Training	Regional	600,000	164.38
Hall Hire District	Meeting/Training	District	300,000	82.19
Hall Hire Community	Meeting/Training	Community	80,000	21.92
Refreshments and meals	Meeting/Training	National	50,000	13.70
Meals and refreshments	Meeting/Training	Regional	35,000	9.59
Tea and Bites	Meeting/Training	Regional	10,000	2.74
Refreshments	Meeting/Training	Community	2,000	0.55
Transport refunds	Local Travel	National	40,000	10.96
Transport	Local Travel	Regional	25,000	6.85
Transport District	Local Travel	District	20,000	5.48
Transport Community	Transport-SCHWs	All	5,000	1.37
Fuel costs	Fuel -Petrol	All	3,800	1.04
Per diem	Facilitator / Technical officers	All	141,000	38.63
Per diem for driver	Driver	All	80,000	21.92
SDA	Driver	All	22,000	6.03

Budget Head	Type	Type	Amount UGX	Amount US$
Engagement meeting	Targeting 40 persons for 2 days		2,800,165	767.17
Capacity building			1,533,000	420.00
Capacity building subregional			803,000	220.00
Honorarium			100,000	27.40
Facilitator Allowance	Facilitator	All	150,000	41.10
Consultant's fee			1,642,500	450.00
Community facilitators	Community level activity		50,000	13.70
Conference package			75,000	20.55
Advocacy meetings			1,725,000	472.60
Technical resource person			150,000	41.10
Stationery for large meetings			100,000	27.40
Workshop materials			400,000	109.59
Community outreaches	Cost per Parish		200,000	54.79
Communication				80.00
Printing costs			8,000	2.19
Research assistants			100,000	27.40
Communications and logistics			250,000	68.49
Review meetings	Cost per person		35,000	9.59
Supervision tools.			50,000	13.70
Desktops			3,000,000	821.92
Laptops			3,800,000	1,041.10
Printing forms			25,000	6.85
Field allowances			100,000	27.40
Media Press			2,000,000	547.95
Community Dialogue			300,000	82.19

Annex 7: Composite Coverage Index (CCI) Calculations

In addition to tracking the performance of the Sharpened Plan II using the above indicators, there shall be overall tracking by use of the composite coverage index (CCI). The CCI is the weighted average of the percentage coverage of 13 interventions along four stages of the continuum of care: reproductive care, maternal care, childhood immunization, and management of childhood illness.

The interventions are:

1. BCG coverage < 1 year (%)
2. DPT-HepB-Hib 3 coverage (%) <1 year
3. Fully immunized coverage < 1 year (%)
4. Proportion of children under 5 years with up-to-date immunization
5. Proportion of <5 with confirmed Malaria RDT received and ACT
6. Proportion of pregnant women attending ANC 1 in first trimester
7. Proportion of ANC 1 mothers who received at least 3 doses of SP for IPTP
8. Facility deliveries
9. Proportion of mothers who delivered in facility and received family planning in postpartum (timing)
10. Percentage of mothers initiating breast feeding within 1st hour after delivery
11. Percentage of perinatal deaths notified
12. Percentage of pregnant women with Hb level >11g/dl or diagnosed with anaemia at ANC 1st visit
13. Proportion of adolescents and young people who received HPV vaccine

CCI is calculated according to the formula:

$$\frac{1}{4}\left(\mathrm{FPS}+\frac{\mathrm{SBA}+\mathrm{ANCS}}{2}+\frac{2\mathrm{DPT3}+\mathrm{MSL}+\mathrm{BCG}}{4}+\frac{\mathrm{ORT}+\mathrm{CPNM}}{2}\right)$$

Each stage receives the same weight, and within each stage the indicators have equal weights, except for DTP3, which receives a weight of two because it requires more than one dose. Substituting into this formula respective indicators and data extracted from DHIS2 for the year 2020 for each district, district level baselines for CCIs were obtained.

Limitations: Incomplete data and low reporting rates in the DHIS2 on some indicators, e.g., indicators on family planning.

Annex 8: Mid-Year Population Projections and Demographics over Five Years

Demographic Variable	%	2020	2021	2022	2023	2024	2025
Total population	100	41,583,600	42,885,900	44,212,800	45,562,000	46,930,900	48,317,300
Children under 1 year	3.6	1,507,600	1,535,300	1,561,600	1,586,100	1,608,300	1,627,800
Children under 5 years	17.1	7,129,300	7,270,400	7,409,400	7,545,300	7,675,400	7,798,600
Older children (6–12)		8,186,500	8,379,000	8,578,500	8,801,300	9,044,100	9,301,700
Adolescents (10–19)	24	14,580,200	14,970,800	15,343,500	15,709,400	16,097,100	16,493,400
Expected pregnancies	5	2,079,180	2,144,295	2,210,640	2,278,100	2,346,545	2,415,865
Women (15–49)	20.2	8,399,887	8,662,952	8,930,986	9,203,524	9,480,042	9,760,095
Older people (60+)	4.1	1,525,700	1,588,000	1,661,100	1,734,200	1,806,200	1,872,800

Annex 9: Forty Priority Districts with RMNCAH Composite Coverage Index Less Than 60

District	Region	Projected Population	RMNCAH Composite Service Index Score
Amudat District	Karamoja	134,900	43%
Pakwach District	West Nile	196,800	46%
Kazo District	Ankole	217,600	47%
Kassanda District	North Central	312,700	47%
Namutumba District	Busoga	306,500	48%
Kampala District	Kampala	1,680,600	49%
Kyankwanzi District	North Central	309,900	49%
Kotido District	Karamoja	218,300	50%
Buvuma District	North Central	122,000	51%
Nakapiripirit District	Karamoja	113,300	51%
Nakasongola District	North Central	215,200	51%
Nakaseke District	North Central	256,000	51%
Mubende District	North Central	519,100	51%
Wakiso District	South Central	2,893,900	52%
Amuru District	Acholi	216,800	52%
Butebo District	Bukedi	171,000	52%
Lwengo District	South Central	371,700	52%
Bukomansimbi District	South Central	156,600	53%
Agago District	Acholi	251,200	53%
Buyende District	Busoga	313,800	53%
Kalangala District	South Central	67,200	54%
Masindi District	Bunyoro	340,500	54%
Kyenjojo District	Tooro	509,800	54%
Pader District	Acholi	197,300	54%
Tororo District	Bukedi	597,500	54%
Kagadi District	Bunyoro	415700	54%
Luuka District	Busoga	267100	55%
Koboko District	West Nile	242,000	55%
Bukwo District	Bugisu	119,100	56%
Kalaki District	Teso	138,700	56%
Arua District	West Nile	517,700	56%

District	Region	Projected Population	RMNCAH Composite Service Index Score
Mayuge District	Busoga	443,200	56%
Nebbi District	West Nile	282,600	57%
Hoima District	Bunyoro	374,500	57%
Luwero District	North Central	523,600	58%
Mukono District	North Central	701,400	58%
Ntoroko District	Tooro	67,000	58%
Lira District	Lango	450,900	59%
Kabarole District	Tooro	284,300	59%
Amolatar District	Lango	170,100	59%

Annex 10: Glossary of Key Terms

Accountability: The obligation to report, or give account of, one's actions – for example, to a governing authority through scrutiny, contract, management, regulation, and/or to an electorate.

Adolescent health: Adolescents are young people between the ages of 10 and 19; they are often thought of as a healthy group. Nevertheless, many adolescents do die prematurely due to accidents, suicide, violence, pregnancy-related complications, and other illnesses that are either preventable or treatable (WHO 2018).

Care coordination: A proactive approach in bringing care professionals and providers together around the needs of service users to ensure they receive integrated and person-focused care across various settings.

Child health: Child health is a state of physical, mental, intellectual, social, and emotional well-being; not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential (WHO 2018).

Continuity of care: The degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time, and consistent with their health needs and preferences.

Continuous care: Care that is provided to people over time across their life course.

Empowerment: The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or the ability to self-manage illnesses.

Engagement: Involving people and communities in the design, planning, and delivery of health services that, for example, enable them to make choices about care and treatment options or to participate in strategic decision-making on how health resources are spent.

Integrated health services: Health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, and rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.

Intersectoral action: The inclusion of several sectors, in addition to health, when designing and implementing public policies that seek to improve health care and quality of life.

Maternal health: Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period (WHO 2018).

Mutual accountability: The process by which two (or multiple) partners agree to be held responsible for the commitments that they have made to each other.

Neonatal health: During first 28 days of life, the child is at highest risk of dying. It is thus crucial that appropriate feeding and care are provided during this period, both to improve the child's chances of survival and to lay the foundations for a healthy life.

People-centred care: An approach to care that consciously adopts individuals', carers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than

patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

Person-centred care: Care approaches and practices that see the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health.

Population health: An approach to health care that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Primary health care: Refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology, and a central role played by the health system.

Reproductive health: Within the framework of WHO's definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions, and systems at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.