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## List of Acronyms

<b>AHSPR</b>	Annual Health Sector Performance Report
<b>ART</b>	Antiretroviral Therapy
<b>CCM</b>	Country Coordination Mechanism
<b>CCS</b>	Country Cooperation Strategy
<b>DRM</b>	Disaster Risk Management
<b>GFATM</b>	Global Fund to Fight HIV/AIDS, TB and Malaria
<b>GPW</b>	General Programme of Work
<b>HMIS</b>	Health Management Information System
<b>HSDP</b>	Health Sector Development Plan
<b>IDSR</b>	Integrated Disease Surveillance and Response
<b>IHP+</b>	International Health Partnerships
<b>IHR</b>	International Health Regulations
<b>LLINs</b>	Long-Lasting Insecticide Treated Nets
<b>MDG</b>	Millennium Development Goal
<b>MIS</b>	Malaria Indicator Survey
<b>MoH</b>	Ministry of Health
<b>MTR</b>	Mid-Term Review
<b>mTRAC</b>	Mobile Tracking
<b>NCDs</b>	Non-Communicable Diseases
<b>NDA</b>	National Drug Authority
<b>NDP</b>	National Development Plan
<b>NGO</b>	Nongovernment Organization
<b>NTDs</b>	Neglected Tropical Diseases
<b>RMNCAH</b>	Reproductive, Maternal, Neonatal, Child and Adolescent Health
<b>SDGs</b>	Sustainable Development Goals
<b>SWAp</b>	Sector-Wide Approach
<b>TB</b>	Tuberculosis
<b>UDHS</b>	Uganda Demographic and Health Survey
<b>UNDAF</b>	United Nations Development Assistance Framework
<b>UNHS</b>	Uganda National Household Survey
<b>WCO</b>	Who Country Office
<b>WHO</b>	World Health Organization

## Foreword

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthening WHO capacity and making its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, it aims at achieving greater relevance of WHO's technical cooperation with Member States; It also focuses on identification of priorities and efficiency measures in the implementation of WHO reform and of the Transformation Agenda in the African region which aims, to foster "pro-results" values of excellence, team work, accountability, integrity, equity, innovation and openness.. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.



**Dr Matshidiso R. Moeti**

The Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy (policies, plans, strategies and priorities), and the United Nations Development Assistance Framework (UNDAF). The CCS also takes into account the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on Aid Effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of Governments to improve the quality of public health programmes and interventions.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country; formulate the WHO country workplan; advocate, mobilise resources and coordinate with partners; and shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff, particularly WHO Country Representative to double their efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to health and development in Africa.

A handwritten signature in black ink, appearing to read "M. Moeti".

**Dr Matshidiso Moeti**  
**WHO Regional Director for Africa**

## Preface

WHO concluded implementation of the second generation Country Cooperation Strategy (CCS) from 2009 to 2015. During this period, the country made some significant health achievements including increasing the life expectancy of Ugandans at birth from 45.7 years to 62.2 years for male and 50.5 years to 64.2 years for females from 1991 to 2014 respectively. Infant mortality rate dropped from 111 to 38 deaths per 1,000 live births from 1990 to 2015 and under 5 mortality rates dropped from 187 to 55 deaths per 1,000 live births in the same period.

This third generation CCS builds on these successes and aims to further contribute to improved health outcomes for the people of Uganda. The CCS III followed a participatory approach with participation of WHO country office staff members and wide consultations with senior level decision makers from government, UN agencies, development partners, NGOs and Civil Society Organizations.

The CCS is aligned to the National Development Plan II and the Health Sector Development Plan 2015/16-2019/20 which were anchored on Uganda Vision 2040. WHO's 12th General Programme of Work (2014-2019), the WHO Regional Priorities, the Transformation Agenda and the United Nations Development Assistance Framework (UNDAF) 2016-2020, provided further guidance on the selection of strategic priorities for the CCS.

With close collaboration and support from all partners and stakeholders, we hope the CCS will enable us to contribute yet again to the government's public health commitments and to strengthened health systems for Universal Health Coverage.

We thank all the people and organizations that contributed to the development of this CCS. We look forward to synergistic collaboration during the implementation, monitoring and evaluation of the CCS as we strive to contribute to the achievement of national health priorities and the Sustainable Development Goals.

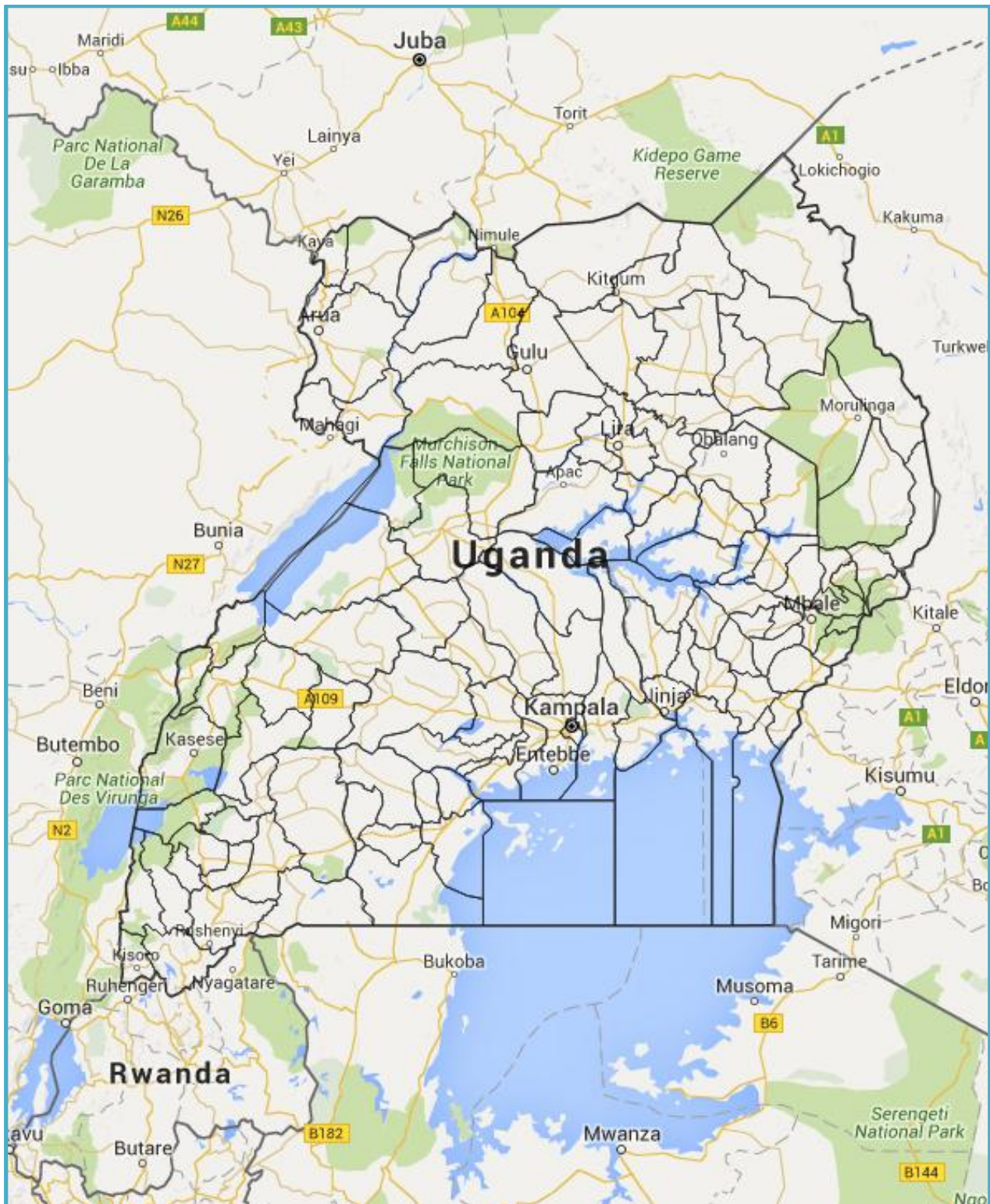


Dr Jane Ruth Aceng  
Minister of Health



Dr Wondimagegnehu Alemu  
WHO Country Representative

# Map of Uganda



## Executive Summary

A country cooperation strategy (CCS) is a medium-term strategic document defining the work of the World Health Organization (WHO) in a country. The WHO Uganda office has previously implemented two such strategies, and this CCS for 2016–2020 (CCS III) builds on the strong foundation laid by those two.

The core principles underlying CCS III are country ownership of the development process, alignment of the strategy with national priorities, harmonization of the functioning of the WHO country office with that of the other United Nations Development Assistance Framework (UNDAF) agencies, and partnership and collaboration of stakeholders in health. The health-related human rights, gender equality, universal health coverage, accountability, transparency and sustainability are values that this CCS upholds. The goal is to maximize WHO contribution to the improvement of health outcomes for the people of Uganda.

### **The objectives of CCS III are:**

- To provide strategic direction for WHO in Uganda in advancing the national health development agenda for the five year period;
- To guide the development of the biennial work plans and budgets for WHO Uganda;
- To provide an institutional framework within which WHO in Uganda will function and collaborate with the other levels of the organization, the UN and other development partners in Uganda.

Uganda's main health priorities for CCS II were (i) promoting health and preventing diseases through behavioural change communication and tackling the social determinants of health; (ii) focusing on programmes of national priority such as those for HIV, TB, malaria, non-communicable diseases, and reproductive, maternal, neonatal, child and adolescent health; (iii) strengthening health systems and service delivery; (iv) strengthening information for health planning and management for improved health outcomes, including for Integrated Disease Surveillance and Response (IDSR) and epidemic preparedness and response; and (v) promoting partnerships through mechanisms like the International Health Partnership (IHP+) and local partnership forums such as the Health Development Partners group and the country coordination mechanism (CCM) of the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM).

During the implementation of the previous strategies, Uganda saw life expectancy at birth rise during 1991–2014, going from 45.7 years to 62.2 years for males and 50.5 years to 64.2 years for females<sup>(1)</sup> Uganda also attained two out of the three child mortality Millennium Development Goal (MDG) targets, seeing infant mortality rates drop from 111 to 38 deaths per 1,000 live births and the under-five mortality rate go from 187 to 55 deaths per 1,000 live births<sup>(1)</sup> Stunting rates dropped from 38.3% in 1995 to 33% in 2011.

CCS III was developed through a participatory and transparent consultative process engaging senior level decision-makers from the government, United Nations agencies, development partners, nongovernmental organizations (NGOs) and WHO staff at large. The process drew on the experience and achievements from the implementation of CCS I and CCS II, and took into account the government political commitment to achieve universal health coverage; national health plans and policies; analyses of government leadership, governance and accountability; functionality of partnerships; coordination mechanisms and programme ownership; and progress made in the development and strengthening of the health system.

## WHO will implement CCS III under five strategic agenda priorities:

- **Strategic priority 1: Strengthen the national capacity to promote health security for all people in Uganda** – WHO will support Uganda to attain the International Health Regulations' (2) minimum core capacities for all-hazard alert and response using the IDSR framework. Under this agenda, WHO will also focus on heightening the capacity for resilience and preparedness to mount rapid, predictable and effective responses to major natural and human-made disasters, as well as on supporting capacity building to maintain the current polio status of zero cases.
- **Strategic priority 2: Strengthen the health system for effective, equitable and quality health service delivery** – WHO, with partners, will support the government to put in place sound and comprehensive policies, adequate and motivated human resources for health and effective financing mechanisms. WHO will also support the strengthening of health information systems, including for civil registration and vital statistics, and improvement of access to and rational use of safe, efficacious and quality medicines and health technologies.
- **Strategic priority 3: Scale up essential health services for communicable diseases** – This will be achieved through increasing access to effective interventions for the prevention and successful treatment of patients with HIV, TB, malaria and viral hepatitis, and through scaling up of interventions aiming for the control and/or elimination of neglected tropical diseases.
- **Strategic priority 4: Strengthen the multisectoral approach for addressing reproductive, maternal, neonatal, child and adolescent health (RMNCAH) and the social and environmental determinants of health** – This will involve scaling up essential and cost-effective maternal, newborn, child, and adolescent health services to significantly reduce preventable morbidity and mortality using a multisectoral approach. The interventions will also cover the strengthening of the national system to address the social, economic and environmental determinants of health and the mitigation of the impact of climate change.
- **Strategic priority 5: Strengthen the multisectoral approach for the prevention and control of non-communicable diseases (NCDs) and nutrition-related conditions** – WHO will support the creation of a multisectoral and multi-stakeholder coordination mechanism, development and implementation of a multisectoral strategic plan, and strengthening of research and surveillance on NCDs. A multisectoral approach will be used also to facilitate the development, implementation and monitoring of a nutrition plan.

Teams with different functions will work together to ensure synergy, cost-effectiveness and complementarity of their programmes in order to achieve results and impact. The human resources at the country office will be reorganized to ensure that the right skills mix and capabilities exist to deliver on the strategic priorities. Where needed, specialized competencies will be outsourced. The WHO headquarters, the Regional Office for Africa and the inter-country support team will provide timely technical and financial support to complement the country office's capacity needs, as well as to boost capacity during disease outbreaks and emergencies.

Monitoring and evaluation of CCS III will occur alongside the biennium work plan review, which will comprise quarterly, semi-annual, annual and end-of-term reviews. External evaluations also will be conducted for objectivity and validity of the performance assessments. The results will be disseminated to the Ministry of Health and other partners and will also be used for more effective engagement among the partners and to inform the next strategic plan.



# 1. Introduction



The WHO country cooperation strategy (CCS) is a medium-term strategic document that defines the broad strategic framework for WHO work with Member States. It articulates clearly the vision on how the effectiveness, efficiency and quality of WHO work in the countries will be improved, with the ultimate aim of ensuring the greatest possible contribution to health and development outcomes.

WHO Uganda has previously implemented two CCS's and this one, for the period 2016–2020 (CSS III), builds on the strong foundation built by the previous two. The core principles of CCS III are:

- country ownership of the development process
- alignment of the strategy with national priorities
- strengthening of the national health system
- harmonization of the functioning of the WHO country office with that of the other United Nations Development Assistance Framework (UNDAF) agencies

The health-related human rights, gender equality, universal health coverage, accountability, transparency and sustainability are core values that this CCS upholds. The goal is to maximize WHO contribution to the improvement of the health outcomes for the people of Uganda.

### **CCS III specifically aims to:**

- Provide the strategic direction for WHO in Uganda in advancing the national health development agenda for the five-year period 2016–2020 within the context of the Sustainable Development Goals (SDGs);
- Provide a framework for the WHO biennial work plans and budgets;
- Provide an institutional framework within which WHO in Uganda will function and collaborate with the three levels of the organization, the United Nations and other development partners in Uganda.

CCS III takes into consideration the evolution of the country's political, economic and institutional contexts as well as the regional and sub-regional environments. It examines the health situation in the country using a holistic approach covering the existing health policies and strategies and other socioeconomic determinants of health. It also reviews the current epidemiological and demographic trends and their impact on people's health and the country's health system.

The CCS is aligned with the requirements of the National Development Plan II and the Health Sector Development Plan, 2015/16–2019/20, both of which are based on the Uganda Vision 2040. The national strategies it articulates are consistent with the resolutions and commitments made by Uganda as a member of the East African Community and African Union, and with the SDGs. Further, the focus and priorities of this CCS are guided by the WHO 12th General Programme of Work (GPW) for 2014–2019 and the WHO regional priorities. Since Uganda is a Delivering as One country, CCS III is fully aligned with Uganda's UNDAF for 2016–2020. The CCS's priorities will guide the preparation of the biannual budgets and plans (Figure 1).

The development of CCS III was led by the WHO country representative and involved a participatory and transparent consultative process. The WHO CCS guideline (3) was used in collating inputs from WHO staff, senior government decision-makers and managers, United Nations agencies, development partners, NGOs, and research and academic institutions in the country.

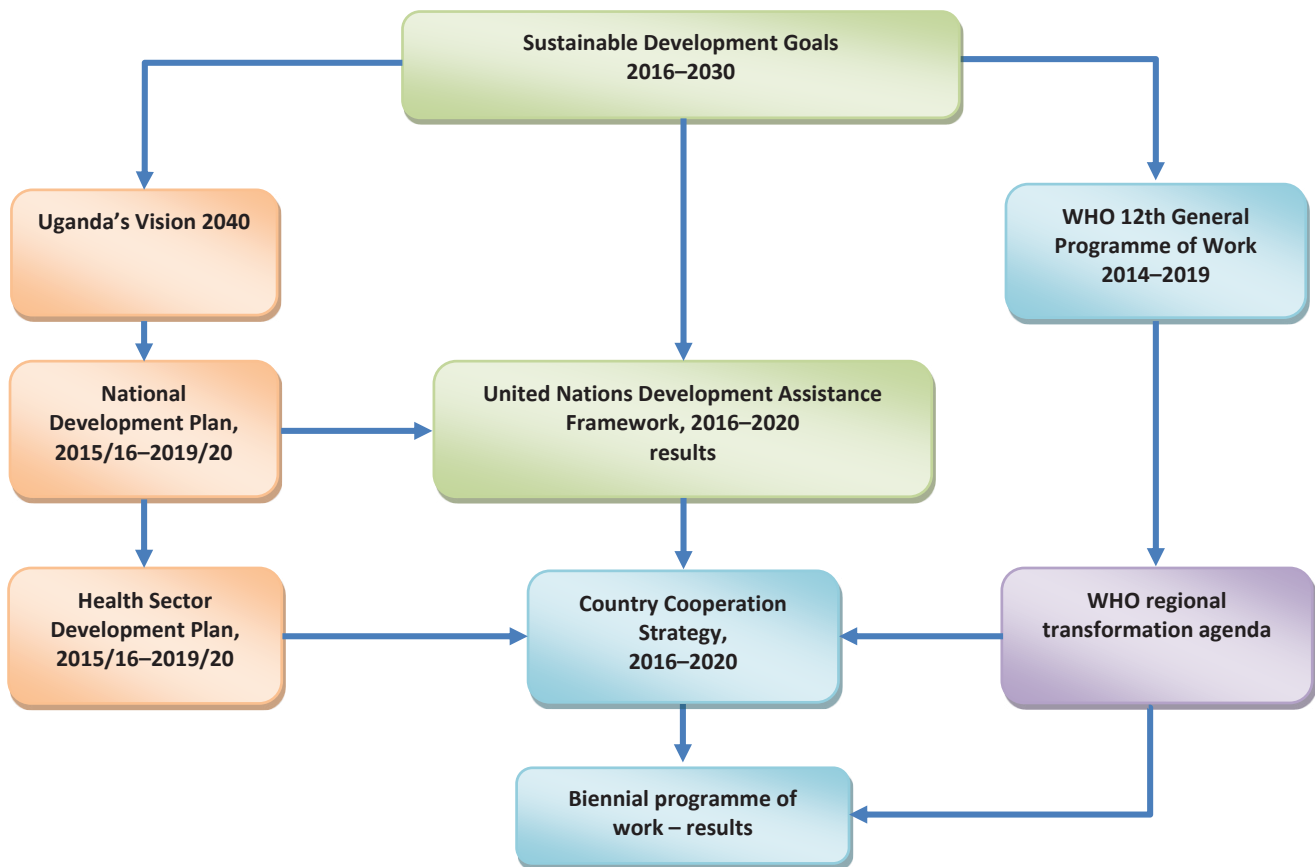


Figure 1: WHO Uganda planning framework.

## 2. Health and development situation



Uganda has made momentous progress in both its economic and social sectors over the last two decades, with the averages for the annual gross domestic product growth rate for 2005–2014 at 6.9% and for the annual human development index growth rate for 1990–2014 at 1.89%. In 2010, the Government of Uganda launched Vision 2040 with the aspiration of transforming from a predominantly peasant and low income economy to a competitive upper middle income nation. Vision 2040 is operationalized through three 10-year plans, six 5-year development plans and other sub-national frameworks to enhance collaboration with the private sector, improve infrastructure and develop human capital and the services sector.

### 2.1 Political, social and macroeconomic contexts

Uganda is an active member of the United Nations, the African Union and the East Africa Community. Its constitution recognizes health as a human right, and health sector development is a priority. Uganda's commitment to the attainment of the SDGs is demonstrated by the alignment of the national development plans with the SDGs, development of governance structures for SDG coordination and advocacy, and regular monitoring of SDG implementation.

Uganda has a population of 34.6 million with an annual growth rate of 3.03%. The estimated total fertility rate is 6.7 children per woman(4) The youth constitute 48% of the population, meaning that the country has one of the youngest and most rapidly growing populations in the world. The high population growth and fertility rates and youth population present several development opportunities and challenges for the country in the short and medium terms. Wise investment in family planning, education and health could turn the population dynamic into an opportunity. Uganda has put in place a population policy that will allow the use of the population dividend to transform and develop the country.

Uganda has a liberalized economy that is undergoing reform with the active participation of the private sector and civil society organizations. The country recorded an impressive economic growth rate averaging 5.5% per annum between 2010 and 2014, with per capita income rising from US\$ 490 in 2009 to US\$ 680 in 2014 (5). In addition, the poverty level declined from 31% in 2006 to 19.7% in 2012/13 (6,7). However, economic and social inequalities exist across regions, social groups and rural and urban communities, with only a minimum reduction in the GINI coefficient, from 0.426 in 2009/10 to 0.395 in 2012/13.

Uganda has social and legal frameworks for promoting human rights, good governance, peace and security. The 2015 Gender gap report(8) which quantifies the magnitude of gender-based disparities and tracks their progress over time, placed Uganda 58th in 2014 worldwide compared with 88th in 2013 which is a 34% improvement. However, gender inequality is sliding, and Uganda fell from 110th place in 2012 to 122nd place in 2014 in Human development report rankings(9) .

Political conflict in the neighbouring countries of the South Sudan, the Democratic Republic of the Congo and Burundi has led to social instability, population displacement and influx of refugees, currently estimated at 480,000(10, 11) Uganda is also prone to natural hazards including disease epidemics, drought, flooding and persistent landslides that have led to resettlement of affected populations. Displacement of people by the various hazards has stretched the health and social services in the host communities.

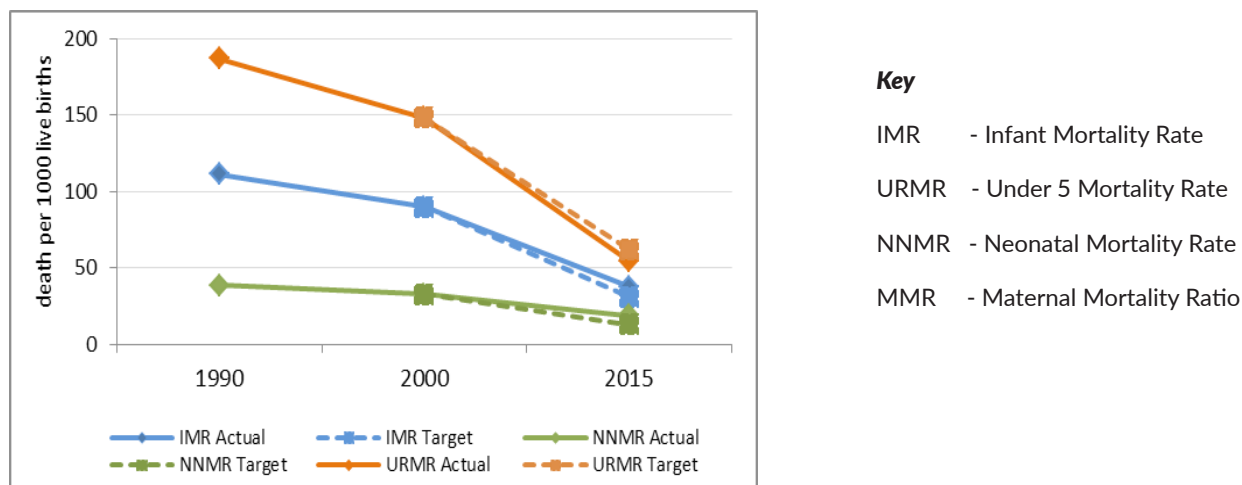
## **2.2 Health situation analysis**

Within the context of the National Development Plan II, Uganda aspires to achieve universal health coverage using the primary health care approach. The country has also developed several policy guidelines and strategic plans on the prevention and control of communicable and non-communicable diseases and conditions, human resources for health, health financing, and multisectoral disaster risk management. However, translating these strategic commitments into desired health outcomes remains a major challenge for the health sector.

### **2.2.1 Health status of the population**

Life expectancy at birth in Uganda rose from 45.7 years to 62.2 years for males and 50.5 years to 64.2 years for females over the period 1991 to 2014 (1) Uganda also attained one out of the three global MDG targets on child health as shown in Figure 2. Between 1990 and 2015, under-five mortality rate dropped from 187 to 55 deaths per 1,000 live births, bettering the MDG target of 63. Stunting rates also dropped from 38.3% in 1995 to 33% in 2011 (12).

## Health status of the population



**Figure 2: Trends in Child mortality Indicators (1990-2015)**

The maternal mortality ratio dropped over the period 1995 to 2015 from 684 to 343 deaths per 100,000 live births (1) but was short of the MDG target. The failure to reach this goal was attributed to the health system's bottlenecks, mainly the lack of skilled health care workers at the health facilities, delayed arrival of mothers at the delivery facilities and poor functioning of referral systems.

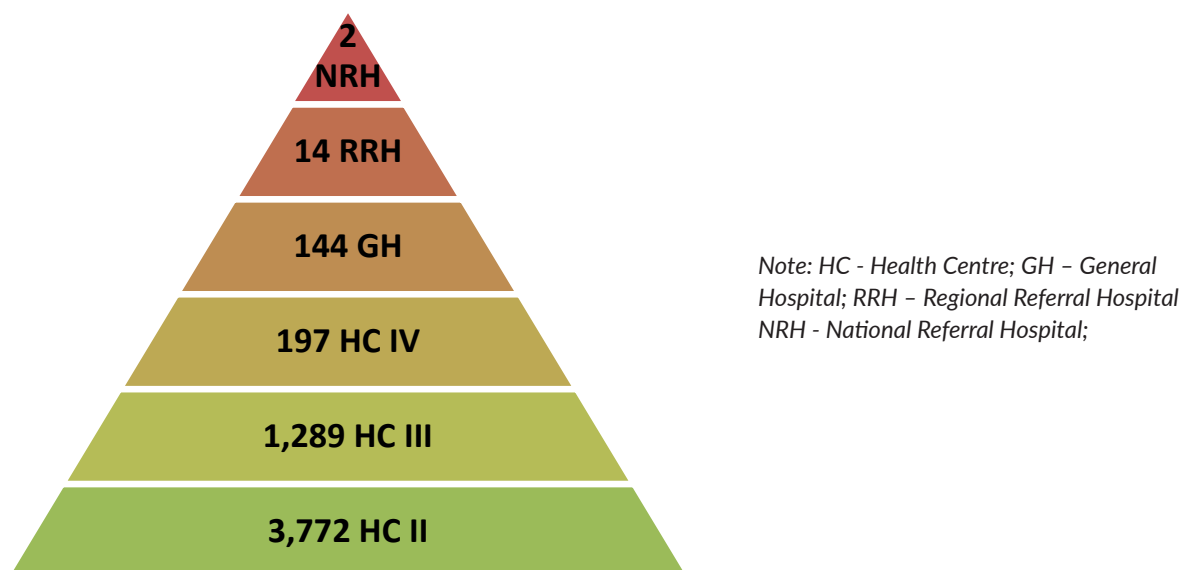
### 2.2.2 Uganda's health system

The structure of Uganda's national health system and health services delivery framework is elaborated in the Health Sector Development Plan (HSDP) and incorporates the public and private sectors, with the public sector accounting for 44% of the services. The private sector is composed of the private not-for-profit health care providers, private health practitioners, and traditional and complementary medical practitioners (13). Health services are delivered through decentralized entities including facilities managed by 112 local government institutions, 22 municipalities, 181 counties, 1,382 sub-counties and 7,241 parishes.

The Ministry of Health (MoH) is responsible for the overall leadership and governance of the sector, with responsibility for policy formulation, strategic direction, definition of standards, disease surveillance, quality assurance and resource mobilization. The local governments are responsible for district level planning, budgeting and resource appropriation, passing of health-related by-laws, recruitment and management of personnel, and service delivery. The health sub-district level strengthens the management of health services, improves equity of access to essential health services and provides promotive, preventive and curative services.

All the health facilities are organized in a tier system (Figure 4) within a health sub-district, with the referral of patients starting at the health centre II (HC II) level and ending at the national referral hospitals (NRH).

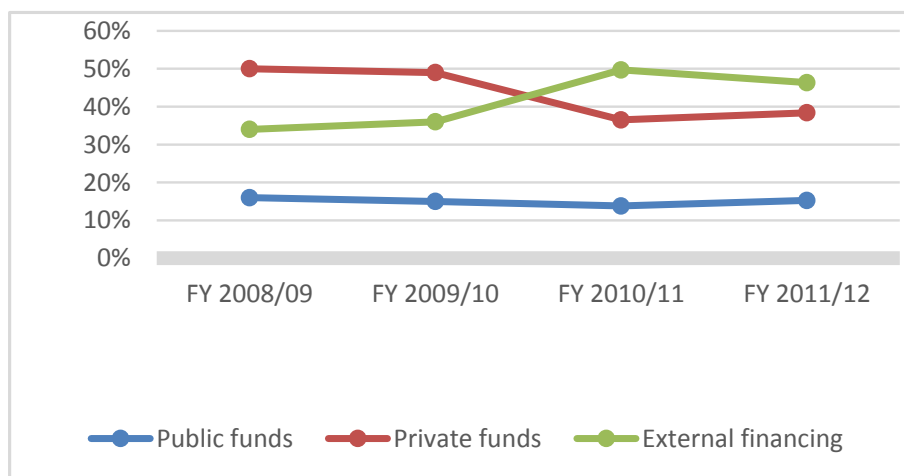
The referral system is hindered by inadequate logistics processes and supplies and lack of ambulances and fuel, which affect timely transfer of patients for emergency care, particularly obstetric cases.



**Figure 3: Organization of Health Services in Uganda(DHIS 2)**

As far as physical access to health facilities is concerned, 75% of the population lives within 5 km of a health facility. The community health system comprises village health teams that promote primary health care. The comprehensive assessment of the village health teams' strategy undertaken in 2014 was the basis for the community health extension strategy developed to strengthen service delivery at the community level (14).

The government provides financial support to the health sector, but this is amidst competing priorities. The total budget allocated by the government to the health sector declined from 9.6% of the national budget in 2009/2010 (15) to 8.7% in 2014/15 (16), which falls short of the target of 15% set by the Abuja Declaration. The general government expenditure on health of US\$ 9 per capita (17) was short of the Health Sector Strategic and Investment Plan target of US\$ 17 per capita and the WHO recommendation of US\$ 34. Generally the Government of Uganda's share of the total health expenditure over the years has stagnated at around 15% (Figure 4). This means that the country is still dependent on external support, which accounts for about 45% of the health expenditure, and raises concerns about sustainability. Out-of-pocket spending stands at 37% and is far above the recommended maximum of 20% for catastrophic expenditure, meaning that financial risk protection is poor and there are concerns for equity.



**Figure 4: Trends in the mix of health financing sources in Uganda.**

The public sector employs 52% of the 81,982 registered health workers, 12% are in the private not-for-profit sector and 36% are in private practice, are unemployed or have emigrated (18) . The proportion of the approved posts filled by health workers in public facilities is 70% (19) .

Uganda has policies and plans for essential medicines and health technologies (20,21,22,23). The proportion of health facilities with no stock-out of tracer drugs improved from 41% in 2009/10 to 64% in 2014/15 (19) The quality of medicines imported into the country also has improved, with products failing quality tests dropping from 11% in 2010/11 to 4% in 2013/14 (24).

Improvement has been seen in data management and use, including the adoption of the district health information system (DHIS) and the application of mTRAC, a mobile phone-based platform, to accelerate weekly transmission of key health management information system's data. These developments have contributed to improved transparency, accountability and disease surveillance and made it easy to compile annual health sector performance reports.

The major challenges affecting the health system are the lack of resources to recruit, deploy and retain human resources for health, particularly in remote localities; ensuring quality of the health care services delivered; ensuring reliability of health information in terms of the quality, timeliness and completeness of data; and reducing stock-out of essential/tracer medicines and medical supplies. The emergence of antimicrobial resistance due to the rampant inappropriate use of medicines and irrational prescription practices(20) and the inadequate control of substandard, spurious, falsely labelled, falsified or counterfeit medicines are also key problems in the sector.

### 2.2.3 Burden of disease

Uganda's burden of disease is dominated by communicable diseases, which account for over 50% of morbidity and mortality. Malaria, HIV/AIDS, TB, and respiratory, diarrhoeal, epidemic-prone and vaccine-preventable diseases are the leading causes of illness and death.



## **HIV/AIDS**

HIV/AIDS prevalence increased from 6.4% (25) in 2005 to 7.3% in 2011 (26) but there was a decline in new HIV infections from 160,000 in 2010 to 99,000 in 2014. This still was a significant public health burden(27) There were improvements also in the access to services related to the HIV continuum of care, from HIV counselling and testing to antiretroviral therapy (ART), including for prevention of mother to child transmission. The use of HIV counselling and testing services by the general population increased over 2006 to 2011, from 25% to 66% for women and 23% to 45% for men (26). The people eligible for ART treatment for whom it was initiated increased from 48% in 2013/14 to 56% by 2014. However, the level for children was 38% compared with 58% for adults (19).

The proportion of pregnant women living with HIV receiving ART rose from 33% in 2007 to 87% in 2014. The number of babies born to HIV positive mothers found positive at first testing also went down, from 6.3% in 2013/14 to 5.9% in 2014/15 (19). The number of ART facilities increased from 475 in 2011 to 1,603 by June 2014 (28) The safe male circumcision initiative is progressing steadily, reaching 51% coverage of the targeted 4,245,184 cumulative procedures by end of 2015.

The challenges to providing quality service coverage for HIV/AIDS include the limited attention given to behavioural interventions and the evolving drivers of the epidemic; inadequate capacity for the generation, management and use of quality national HIV data; and shortage of human capacity for rapid scaling up of proven, high-impact interventions.

## **Tuberculosis**

TB remains a disease of public health importance in Uganda, with a prevalence of 253 cases per 100,000 population and an incidence of 234 cases per 100,000 (29) . About 89,100 cases are expected to be notified annually, but in 2014 these were only 46,171 cases, of which 44,187 were new and 1,984 were relapses. Children under 15 years formed about 8% of the cases notified, with a 1:8 male to female ratio. In 2014 about 45% of the TB patients were are co-infected with HIV, and only 81% of those have started ART. Mortality among these patients is 17 per 100,000 population(30). The burden of drug-resistant TB was 1.4% in new patients and 12% in retreatment cases. New diagnostic tools for TB like the Gene Xpert have been introduced. Since 2009, a cumulative total of about 600 patients with drug-resistant TB have been started on second-line treatment.

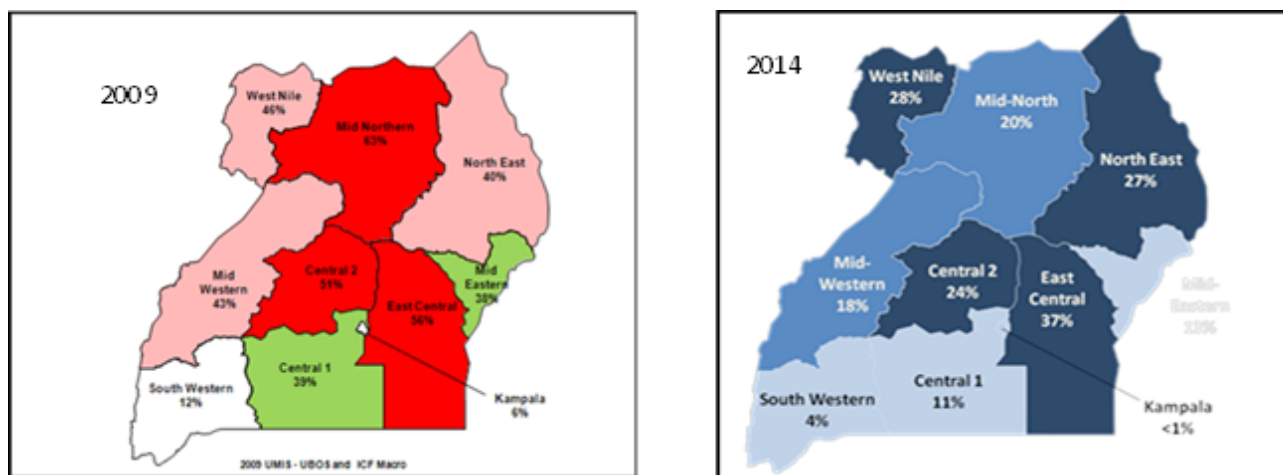
The key drivers of multi-drug resistant TB include poor management of susceptible TB cases, transmission of the disease by patients with infectious drug-resistant TB, inadequate collaboration on TB and HIV activities, and repeated stock-out of TB medicine.

The main challenges to the success of TB interventions are increasing the community's awareness on TB for improved case detection, increasing the skills of workers to diagnose TB and scaling up of the use of Gene Xpert.

## Malaria

Malaria continues to pose a big threat to the health and well-being of the population, drawing interest from partners and increased political commitment to reduce its burden. With support from WHO and other partners, Uganda developed a Malaria Reduction Strategic Plan for 2014–2020, with the vision of a malaria-free Uganda and the goals of reducing malaria morbidity and prevalence by over 85%. This is in tandem with the global malaria technical strategy and SDGs. There have been increased investments from the government, local and international partners and global health initiatives to scale up interventions at the facility and community levels, especially the use of long-lasting insecticide treated nets (LLINs) and malaria case management and diagnostics. The country has demonstrable progress in utilization of LLINs among children and pregnant women, which increased from 33% and 44% to 74% and 75%, respectively. In 2014 69% of the population were reported to be using LLINs (31). Increased utilization of LLINs, behavioural change and access to malaria medicines and diagnostics resulted in a 55% reduction in the malaria prevalence rate from 42% in 2009 to 19% in 2014 (see Figure 5).

The gains recorded are fragile and call for strong sustainability measures. In addition, malaria parasite prevalence is increasing in areas that are prone to upsurges and epidemics of the disease. This means that a strong surveillance system is required that should include epidemic preparedness and response plans. Progress in accelerating the current malaria control gains is constrained by weak programme management and inadequate funding to implement all the actions in the malaria reduction strategic plan.



**Figure 5 : Parasite prevalence by region during 2009 and 2014.**

Source: Malaria Indicator Surveys, 2009 and 2014

## Viral hepatitis

Various forms of viral hepatitis, including A, B, C, D and E varieties, are endemic to Uganda. It is estimated that more than 50% of the population has been exposed to hepatitis B and that nearly 10% of the exposed population are living with chronic hepatitis B. The disease is widely spread in the country, but more so in the north, which has a prevalence ranging between 20% and 24% of chronic hepatitis B infection (32).

A national hepatitis B strategy exists to mitigate the effects of the disease and work towards its elimination. It provides a framework to guide the implementation of programmes for the prevention and treatment of hepatitis B and re-integration of hepatitis B patients, as well as for mobilization of the necessary human, material and financial resources. The successful implementation of the recommendations and establishment of affordable screening, treatment and care programmes in the public and private sectors will depend on good planning and development of a process for that and its integration into relevant national strategies and guidelines such as those for HIV. There are several key considerations that national stakeholders and decision-makers will need to address, which will provide the WHO country office a unique opportunity to organize critical dialogue meetings to tackle all the forms of viral hepatitis over the CCS III period.

### Vaccine-preventable diseases

Uganda has achieved three out of the six specific targets of the Global Vaccine Action Plan (2012–2020), those for reaching zero cases of wild poliovirus, maternal and neonatal tetanus elimination, and introduction of the new vaccines pneumococcal conjugate vaccine (PCV10) and human papillomavirus vaccine. There is steady progress towards achieving the other three targets of measles elimination, rubella elimination, and introduction of the underutilized yellow fever and meningitis vaccines. Figure 6 depicts the routine immunization coverage during 2010–2014 and shows that all childhood antigens had a coverage well above 80%. However there were variations among the districts which could explain the sporadic measles outbreaks in a number of districts.

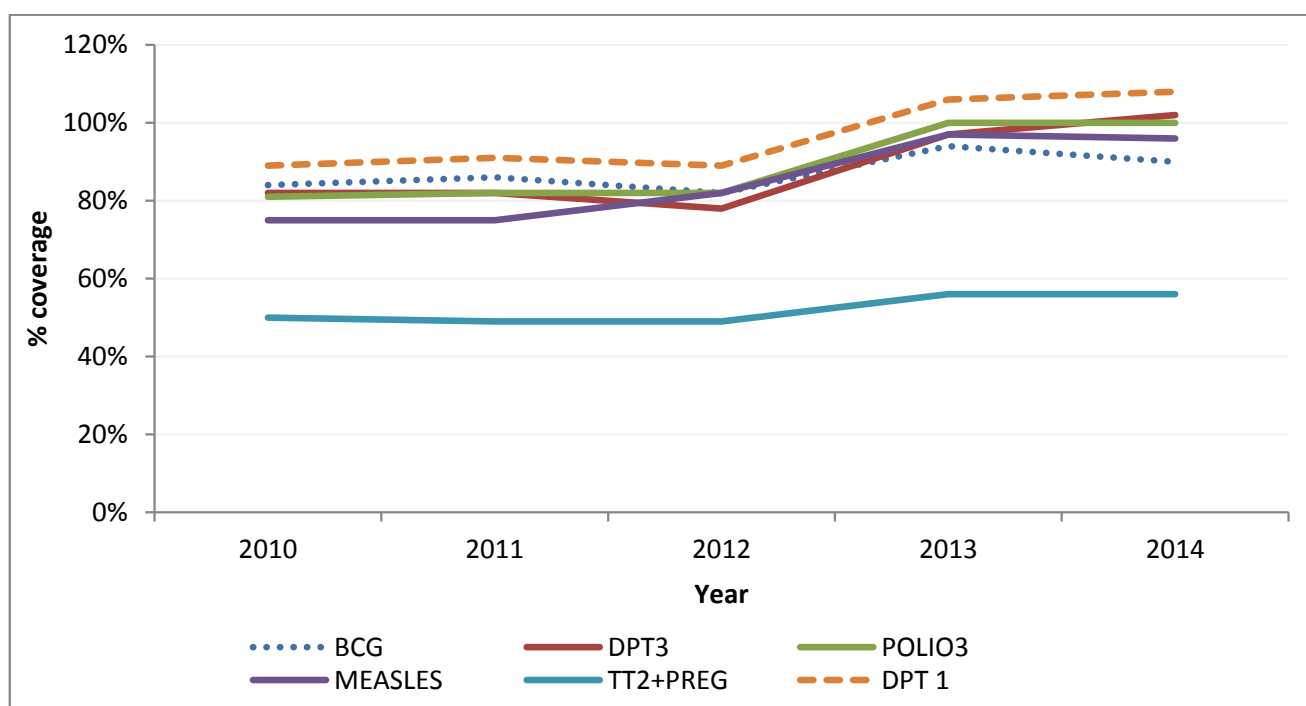


Figure 6: Routine immunization coverage 2010-2014

Challenges still remain in ensuring availability of adequate funding, a skilled workforce, quality data and adequate resources for programme management at all levels.

### Neglected tropical diseases

Uganda eradicated guinea-worm in 2010 and has been free of the parasite since then. There is co-endemicity of NTDs in different districts ( Figure 7). Onchocerciasis, trachoma and lymphatic filariasis have been eliminated in 14, 19 and 16 districts, respectively ( Figure 7). The government is implementing the Neglected Tropical Diseases Master Plan, 2015–2020, with the support of partners and communities to accelerate elimination of these three diseases and to intensify the control of schistosomiasis and soil transmitted helminths.

Over the next five years, the country will focus on environmental management, case management and public awareness to maintain the zero-case status for guinea-worm and to mitigate the impact of the key drivers of NTDs. The challenges include obtaining adequate funding for scaling up activities, heavy reliance on external partners, lack of quality data and cross-border NTD transmission.

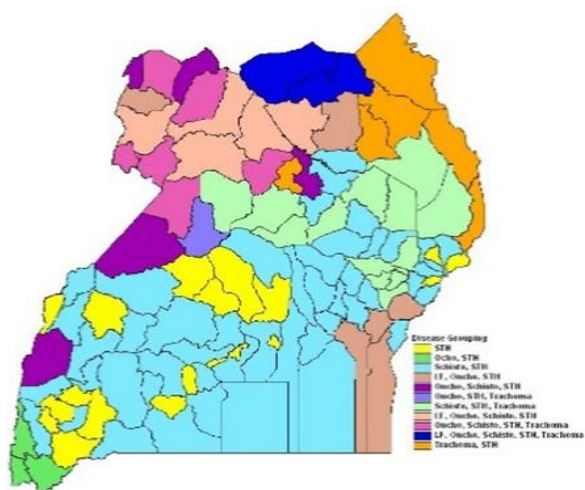


Figure 7: NTD co-endemicity in districts, MoH 2015

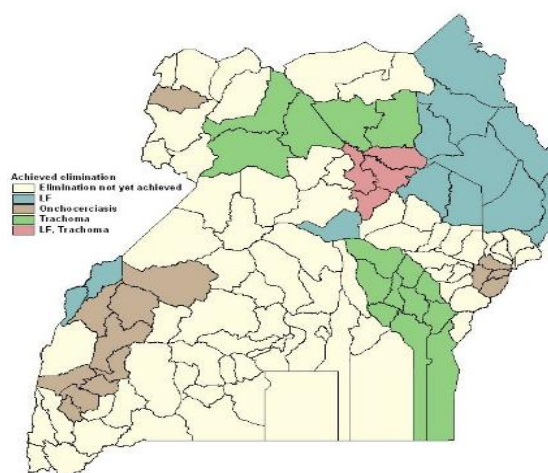


Figure 8 : Districts that have eliminated onchocerciasis, lymphatic filariasis and trachoma, MoH 2015.

### Non-communicable diseases

In 2006 the Government of Uganda established a programme in the MoH to coordinate national interventions for the prevention and control of non-communicable diseases (NCDs). In 2014 the MoH conducted a nationwide NCD risk factor survey to guide policy formulation and multisectoral planning for NCD prevention. That survey highlighted the high prevalence of hypertension at 24%, tobacco use at 11%, overweightness and obesity at 19% for men and 27% for women, and cardiovascular disease at 9% (32). The government continues to work through multi-stakeholder actions to address the common behavioural risk factors for these diseases, which are tobacco use, harmful use of alcohol, physical inactivity and an unhealthy diet.

Uganda has an enabling policy, legal and institutional framework to address the major NCD risk factors, including the Tobacco Control Act, 2015. Access to specialized quality care for NCDs has been improved through the establishment of the heart and cancer institutes and the upgrading of the renal dialysis unit at the national referral hospital.

The level of preventable deaths is high at 217 fatalities per 100,000 population, and it emanates from the violence and injuries, including motorized accidents, associated with increased substance abuse. The road traffic fatality rate estimated at 27.4 deaths per 100,000 population is higher than the global average of 18 deaths per 100,000 population (34)

Mental illness and neurological and substance abuse disorders are on the rise owing to the problems brought about by urbanization, civil strife, violence and alcohol and substance abuse. Following the successful implementation of the Mental Health Gap Action Project at the primary health care level in Jinja, Kamuli and Kitgum districts, where trained general practitioners manage common mental illnesses and neurological and substance abuse disorders, the country is now ready to roll out the project to the other districts. WHO will collaborate with the MoH and other partners in this process.

### ***Reproductive, maternal, neonatal, child and adolescent health***

Uganda made good progress in the delivery of RMNCAH services between 2006 and 2014. During that period the proportion of deliveries attended by a skilled health worker went up from 42% to 58%, post-natal care from 27% to 33% and prevalence of contraceptive use from 15% to 30%, while teenage pregnancies dropped from 45% to 24% (12) Maternal deaths due to unsafe abortions were reduced from 13% in 2013/14 to 3% in 2014/15 (19).

Maternal and perinatal deaths surveillance are reported through the district health information system, and all maternal and perinatal deaths are reviewed in selected referral hospitals within 7 days (35). Provision of basic emergency obstetric care is steadily increasing, but huge disparities exist among the regions and population groups. Access to comprehensive obstetric care remains low with 51% of the health centre IV's providing caesarean section services (36).

The country has made some progress in increasing awareness on and planning for adolescent health services, mainly for sexual and reproductive health and HIV/AIDS. WHO supported the creation of an enabling policy environment for implementation of adolescent health services, capacity building for health workers and increased service coverage of adolescent youth friendly services. However, more remains to be done to understand the main determinants of adolescent health, including on sexual and reproductive rights, alcohol and substance abuse, mental health, injuries, nutrition, tobacco use and violence in its different forms. There is need to refocus attention to developing the right policy environment and instruments to ensure that adolescents are no longer neglected but rather enjoy the highest attainable standard of health and well-being, maximize their potential and have a foundation for positive transition to adulthood. This will have a positive impact on the demographic dividend that Uganda is expecting to harness.

## **Nutrition**

Uganda's food and nutrition policy was developed in 2003 and the national nutrition action plan in 2010. The action plan provides the strategic direction for scaling up of multisectoral interventions with the ultimate goal of reducing malnutrition among women and children and ensuring that all Ugandans are properly nourished. The country is implementing the World Health Assembly 2012 global targets for 2025, the ICN2 2014 Framework for Action, the global NCD targets for 2025, and the goals of the Decade of Action on Nutrition, 2016–2026.

The food insecure population increased from 22.3% in 2010 to 24.8% in 2012, with 48% of the population considered energy deficient. One-third of the children under five years old suffer from chronic malnutrition, 14% are underweight and 5% have acute malnutrition. Micronutrient deficiencies are highly prevalent in women and children. Vitamin A deficiency worsened in children, rising from 20% in 2010 to 36% in 2012, while anaemia prevalence was at 49% and 23% among children and women, respectively. Under-nutrition underlies most child deaths. Obesity and overweightness among women have increased from 16.5% in 2006 to 18.8% in 2011 (12).

At the national and district levels, multisectoral coordination mechanisms require strengthening. There is a need to increase the human resources capacity for nutrition services in order to improve their coverage and for nutrition monitoring and surveillance.

## **Environment, climate and health**

The threats to the environment that Uganda faces have negative consequences on health. These threats include unplanned urbanization, expansion of informal settlements, deforestation, draining of swamps, and industrialization, all which contribute to climate change and increased incidence of disease outbreak.

Uganda achieved the MDG target of providing safe water coverage for 75% of the population but only 41% of the protected sources in rural areas meet the national standards for water quality. The national average for latrine coverage is 77%, but 35% of the coverage is with low quality latrines (12). This, together with the poor hand-washing habits rated at 33.2%, is a factor in disease outbreaks. The use of biomass fuels in poorly ventilated cooking facilities causes indoor air pollution, the result of which is respiratory infections especially among children and women. Indoor air pollution from the use of biomass fuel is reported to cause 9,263 deaths annually, or 2.84% of total deaths (37).

## **Disaster preparedness, crisis management and IHR (2005) implementation**

Over the last five years, Uganda has had to deal with outbreaks of Ebola virus fever (2011 and 2012), Marburg virus disease (2012 and 2014), yellow fever (2010), cholera (annually) and hepatitis E (2011–2014), along with floods and landslides (2010–2014) and drought (2011–2015). Civil wars and unrest in the neighbouring countries have seen the number of refugees grow from 146,000 in 2008 to over 480,000 in 2015, affecting over 500,000 local people annually(38).

The country has capacity for disaster risk management and a disaster preparedness and management policy.

It is also implementing IHR (2005) to build core capacities to manage public health events of international concern and so far has developed 50–74% of the IHR core capacities.

Uganda has strengthened its emergency preparedness capacity, including for Integrated Diseases Surveillance and Response (IDSR). The country has established an emergency operations centre to facilitate and coordinate public health emergency and outbreak response. Furthermore, improvements have been made in the laboratory infrastructure, referral of samples for specialized testing and confirmation, documentation, and supply chain management.

Uganda has a lot of work still to do to implement the disaster risk management strategy, develop all the IHR (2005) core capacities, increase the capacity for forensic medicine, establish a viable external quality assessment programme, intensify surveillance at the points of entry, and improve coordination of and response to potential radio-nuclear, chemical, and food safety hazards and zoonotic diseases.

## **2.3 Development cooperation, partnership and contribution of the country to the global health agenda**

### **2.3.1 Partnership and development cooperation**

Since 2000, Uganda has been applying the Sector-Wide Approach (SWAp) to facilitate its health sector coordination and harmonize support for health system strengthening. In 2010, the country, with its partners, signed the global five-year International Health Partnerships (IHP+) Compact intended to maximize the effectiveness of development aid in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

From the national health accounts for 2010/11 and 2011/12, public funds accounted for 15.3% of the total health expenditure, private funds for 38.4%, and international partners, NGOs and donors for 46.3% (19). Uganda is a beneficiary of funding from global initiatives such as GFATM and the GAVI Alliance, the Central Emergency Response Fund for humanitarian assistance, and other mechanisms. Several funding arrangements are in place including budget support, programme support, projects and global financing mechanisms.

### **2.3.2 Collaboration with the United Nations system at the country level**

The implementation of the second CCS strengthened coordination and collaboration of Uganda with the United Nations system. The factors contributing to that included the participatory approach for the development of UNDAF 2016–2020, presence of coordination structures, and development and implementation of joint programmes under the leadership of the United Nations country team. UNDAF 2016–2020 focuses on upstream work and is aligned to both the medium and long term National Development Plans (NDP II and Vision 2040). The UNDAF focuses on three priority areas of Governance, Human Capital Development (HCD) and Sustainable and Inclusive Economic Development (SIED). The adoption of the Delivery as One principles has enhanced the interaction and collaboration of the WHO country office technical staff and

the heads of the United Nations agencies. This has resulted in greater harmonization of implementation and less duplication of efforts especially in the support for HIV/AIDS & TB, RMNCAH and gender. In the area of RMNCAH the UN has developed One-UN-Health, led by WHO Country Representative, to facilitate high level engagement with government for RMNCAH. This platform has enhanced coordination and harmonization of UN efforts to support RMNCAH in Uganda.

### **2.3.3 Contribution of the country to the global health agenda**

Uganda has played a leading role in and contributed to important global health initiatives including through:

- Generating evidence on the benefits of male medical circumcision as an HIV prevention technology (Rakai Health Sciences Programme). This intervention has been rolled out to the 15 priority countries for HIV prevention;
- Provision of technical support for epidemic and emergency response, including for the Ebola response in West Africa;
- Provision of technical support to several countries for identified thematic areas.



### 3. Review of WHO cooperation over the CCS III cycle



#### 3.1 Strategic priorities and main focus areas for CCS II

CCS II, which ran from 2009 to 2014, addressed the following priorities (see Table 1 also):

- Promoting health and preventing disease through behavioural change communication and tackling the social determinants of health;
- Focusing on programmes of national interest such as HIV, TB, malaria, non-communicable diseases and reproductive, maternal, neonatal, child and adolescent health;
- Strengthening health systems and service delivery;
- Strengthening information generation and sharing for health planning and management for improved health outcomes, including for integrated disease surveillance and response and epidemic preparedness and response;

- Promoting partnerships through mechanisms like IHP+, local partnership forums such as the Health Development Partners group, and the GFATM CCM.

CCS II was well aligned with the National Development Plan II and National Health Sector Strategic Investment Plan 2010/11–2014/15, and harmonized with UNDAF. It also addressed priorities articulated in the Strategic directions: WHO action in the African Region, 2010–2015 and the WHO Medium-term Strategic Plan 2008–2013.

The biennial plans and budget allocations reflected by and large the priorities of CCS II, although funding shortage affected implementation of activities in some of the priority programmatic areas. The change in the plan and budget structure from 13 strategic objectives in 2008/9–2012/13 to 6 categories in 2014/15 shifted the polio contribution from CCS strategic objective 1 to 2.

**Table 1: Biennium Funding of strategic objectives 2008 - 2015**

	CCS II strategic objectives	Biennium				Total	% contribution
		2008/09	2010/11	2012/13	2014/15		
1	Focus on programmes of national interest such as HIV, TB, malaria, non-communicable diseases and reproductive, maternal, neonatal, child and adolescent health	9,463,000	8,968,000	18,837,583	10,759,376	48,027,959	61%
2	Strengthen information for health planning and management for improved health outcomes, including integrated disease surveillance and response and epidemic preparedness and response	1,132,000	126,000	1,541,666	10,090,091	12,889,757	17%
3	Promote health and prevent disease through behavioural change communication and tackling the social determinants of health	78,000	48,000	1,098,518	31,000	1,255,518	2%
4	Strengthen health systems and service delivery	2,564,000	2,000,000	3,196,674	1,734,082	9,494,756	12%
5	Promote partnerships through mechanisms like IHP+, local partnership forums such as the Health Development Partners group and the GFATM CCM	2,654,000	642,000	1,183,895	1,404,000	5,883,895	8%
	<b>Total</b>	<b>15,891,000</b>	<b>11,784,000</b>	<b>25,858,336</b>	<b>24,018,549</b>	<b>77,551,885</b>	<b>100%</b>

The WHO country office implemented CCS II from 2009 to 2015. During that period the staff capacity was enhanced through retreats and other training activities relevant for the competences required by the office.

The important lessons learnt and best practices were documented, including those relating to the necessity for the interventions to be integrated and focused, and development partners to be actively engaged in planning, implementation, and monitoring and evaluation under the leadership of the government.

### **3.2 WHO contribution to the enhancement of the national ownership of the health development process**

Stakeholder interviews were conducted to obtain their perspectives on the WHO contribution to Uganda's national health development. The partners acknowledged WHO leadership in fostering national ownership of the health development process and made suggestions for improvement. In the areas of coordination and leadership, the partners affirmed that WHO provided the necessary leadership to promote creation of partnerships such as the Health Policy Advisory Committee, the Health Development Partners Group, the AIDS Development Partners Group, CCM, and the Roll Back Malaria initiative. WHO's role as the secretariat for IHP+ and Harmonization for Health in Africa and in monitoring progress on the Compact was recognized. Furthermore, the stakeholders noted that WHO was actively engaged in the United Nations country team's activities under the Delivering as One UN initiative in Uganda. The partners pointed out that WHO could focus on policy dialogue on major strategic issues, exploiting the comparative advantage associated with its role in convening and coordination of health interventions in Uganda.

The MoH and other stakeholders noted that the WHO country office's technical and financial support overall was aligned with Uganda's national priorities and that it enabled the country to attain the MDG targets for nutrition, HIV, malaria, TB, and reproductive, maternal, neonatal and child health. The technical support for areas like health financing, human resources for health, partnerships, and access to medicines was appreciated.

### **3.3 Conclusions and recommendations**

CCS II was an important guide in the development of the WHO plans, prioritization of interventions and resource allocation. WHO provided technical and financial support to the government and contributed to the achievement of national health goals and some of the health MDG targets. WHO was acknowledged for its crucial role in fostering national ownership of health development and strengthening of partnerships for health through existing coordination mechanisms. WHO was expected to further take advantage of its convening role for health actors to enhance its leadership for high level engagement with partners.

#### **Recommendations**

The following recommendations guided the development of the WHO agenda for CCS III:

- Prioritize upstream and strategic technical issues such as advocacy for the health sector budget, resource mobilization and policy dialogue on public health topics such as universal health coverage, health insurance, NCDs, and social determinants of health among others;

- Generate evidence and advocate for the development of policies and strategies and scaling up of high impact interventions for improved health outcomes for all Ugandans;
- Support the strengthening of the health system in line with the universal health coverage goal by leveraging WHO leadership in health coordination for policy dialogue on partnerships, accountability and engagement of the parliament and partners, including the private sector and non-state actors;
- Consolidate and take advantage of WHO's comparative advantage in areas such as health security, emergency and disaster risk management, and health information;
- Strengthen WHO's internal capacity for negotiation, policy dialogue, analysis of data, programme navigation, and effective communication with strategic audiences, including in defining clear positions on emerging issues of public health concern.

## 4. Strategic agenda for WHO cooperation



In 2015, countries adopted the newly introduced SDGs, which build on the eight MDGs. Attainment of Goal 3 – ensure healthy lives and promote well-being for all at all ages – is essential for sustainable development. However, all SDGs 1 to 17 are linked and incorporate the social, economic and environmental determinants of health.

Uganda has adopted the principle of universal health coverage as a means of ensuring that all Ugandans obtain the health services they need, of good quality and without suffering financial hardship when paying for them. This commitment is rooted in the human right to health, which governments are obliged to guarantee, and is essential in closing the gap in inequities in health outcomes. The universal health coverage principle was unanimously adopted at the United Nations General Assembly (2012) and the East, Central and Southern Africa 60th Health Ministers' Conference. CCS III will support the advancement of universal health coverage with a focus on delivering a strong, efficient and well-run health system.

### 4.1 Strategic agenda

The strategic agenda for CCS III has five priorities:

**Strategic priority 1:** Strengthen the national capacity to promote health security for all people in Uganda;

**Strategic priority 2:** Strengthen the health system for effective, equitable and quality health service delivery;

**Strategic priority 3:** Scale up essential health services for communicable diseases;

**Strategic priority 4:** Strengthen the multisectoral approach for addressing RMNCAH and the social and environmental determinants of health;

**Strategic priority 5:** Strengthen the multisectoral approach to address the prevention and control of non-communicable diseases and nutrition-related conditions.

#### **4.1.1 Strategic priority 1: Strengthen the national capacity to promote health security for all people in Uganda**

The impact on health of emergencies and crises can be substantially reduced if both national authorities and communities in high risk areas are well prepared and are able to reduce the level of their vulnerability and increase their resilience. The government has made a strategic decision to shift from reacting to emergencies to managing risks. WHO will collaborate with partners to support the implementation of programmes to support this strategic shift and contribute to the building of a resilient health system capable of responding to all types of hazards. While WHO will continue supporting the government in responding to health emergencies as and when they happen, particular emphasis will be given to the building of the core capacities to prevent, detect, report, assess and respond to public health emergencies and public health risks in order to ensure the country's compliance with IHR (2005). Therefore, WHO will streamline its assets to focus in the following three areas.

##### **Focus area 1.1: By 2020, the IHR (2005) minimum core capacities for all-hazard alert and response using IDSR framework attained**

- Support building of core capacities to prevent, detect and respond to public health emergencies of international concern as part of the country's obligation under IHR (2005);
- Support scaling up of IDSR implementation, including community-based surveillance, with a focus on coordination of activities, development and retention of the human resources for health, information management, and surveillance at points of entry;
- Using the One Health approach, consolidate the initiatives and foster multisectoral collaboration and partnerships for radio nuclear and chemical risks and other events of public health concern;
- Support the development and implementation of a food safety programme.

## **Focus area 1.2: By 2020, heightened capacity to manage public health risks associated with emergencies and disasters and resilience built, including strengthening preparedness to mount a rapid, predictable and effective response to major natural and human-made disasters**

- Support the incorporation of health disaster risk management into public health legislation, policies and strategies;
- Support risk profiling and vulnerability and capacity assessments to generate evidence for the development of an all-hazard disaster risk management strategic plan;
- Update tools, guidelines and standards for disaster risk management;
- Support the building of community resilience to manage major health risks and hazards.

## **Focus area 1.3: By 2020 capacity to maintain the current polio status of zero cases supported**

- Strengthen the national capacity to attain and maintain quality acute flaccid paralysis surveillance within the IDSR framework;
- Support the polio containment and certification processes;
- Support the MoH to attain and maintain adequate population immunity with a special focus on high risk areas;
- Support the development and implementation of a polio legacy plan.

### **4.1.2 Strategic priority 2: Strengthen the health system for effective, equitable and quality health service delivery**

WHO will support the national effort to build a resilient health system with the ability to protect human life and produce good health outcomes for all at all times through the delivery to the Ugandan population of essential, quality and affordable health services. To realize this goal, WHO will focus on providing leadership in health coordination, advocating for and fostering continuous policy dialogue involving key stakeholders including politicians, non-state actors, community members, and leaders from different sociocultural structures, within the principles of PHC and universal health coverage. WHO will consolidate and further build on the gains realized so far.

## **Focus area 2.1: By 2020, sound and comprehensive policies, adequate and motivated human resources for health and effective financing mechanisms in place for increased access to people-centred and integrated health services**

### **Leadership and governance**

- Support evidence-based policy formulation and decision-making and monitoring and evaluation of policy implementation;

- Support strengthening of partnerships and their coordination for health following the principles of guidelines of IHP+, SWAp, the health Compact and the Health Policy Advisory Committee;
- Support advocacy and high level policy dialogue on critical health issues.

### Health financing

- Support operationalization of the health financing strategy through advocacy and high level policy dialogue for sustainable and innovative financing for health;
- Support evidence generation for increased awareness and decision-making for universal health coverage.

### Human resources for health

- Support advocacy policy dialogue on the implementation of the national Human Resources for Health Plan, 2010–2020;
- Monitor the trends in the production, distribution and retention of human resources for health and implementation of the WHO Code of Practice on International Recruitment of Health Personnel.

### Health services delivery

- Strengthen the sub-national health management systems with a particular focus on the district level;
- Support the operationalization of the community health strategy;
- Strengthen quality improvements for overall service delivery with a focus on patient care and safety.

## Focus area 2.2: By 2020, strengthened health information systems including for civil registration and vital statistics

- Strengthen the generation and use of data for monitoring of health trends, evidence-based decision-making and policy formulation;
- Improve health information sharing, including of resolutions and decisions of the World Health Assembly and the Regional Committee;
- Support the development and implementation of norms, standards and guidelines to improve the civil registration and vital statistics systems.

## Focus area 2.3: By 2020, improved access to and rational use of safe, efficacious and quality-assured medicines and health technologies

### Access to medicines and other health products

- Strengthen the national supply chain management system, including fostering the rational use of medicines;
- Advocate for the production of quality-assured essential medicines locally;



- Strengthen the regulatory framework for quality assurance for medical products and other health technologies and food products.

#### **Laboratory**

- Strengthen the national laboratory diagnostic capacity, including the forensic medicine capacity;
- Support the coordination of the national laboratory network and the quality management system using established standards, working towards the certification and accreditation of laboratories;
- Strengthen laboratory-based surveillance to confirm outbreaks and diseases of public health importance and antimicrobial resistance.

### **4.1.3 Strategic priority 3: Scale up essential health services for communicable diseases**

#### **Focus area 3.1: By 2020, increased access to effective interventions for prevention and successful treatment of patients with HIV, TB, malaria and viral hepatitis**

- Strengthen the capacity for adaptation and implementation of the guidelines and tools for TB, malaria, HIV and viral hepatitis;
- Scale up proven, innovative and cost-effective interventions for the prevention, care and treatment of TB, malaria, HIV and viral hepatitis within the universal health coverage concept;
- Strengthen the capacity for operational research and monitoring of disease trends, service utilization and drug resistance;
- Strengthen advocacy and coordination for community engagement and partner participation in the delivery of quality TB, malaria, HIV and viral hepatitis services.

#### **Focus area 3.2: By 2020, support provided for scaling up of interventions towards the control and/or elimination of neglected tropical diseases**

- Support the scaling up of high impact interventions including mass drug administration for the control and elimination of NTDS;
- Strengthen operational research, monitoring and evaluation, and post-treatment and post-elimination surveillance for NTDS;
- Promote morbidity management strategies for NTDs to alleviate suffering and associated disabilities;
- Contribute to the strengthening of the coordination mechanisms and partnerships for harmonized support for the implementation and monitoring and evaluation of the NTD master plan.

#### 4.1.4 Strategic priority 4: Strengthen the multisectoral approach for addressing RMNCAH and the social and environmental determinants of health

##### Focus 4.1: By 2020, essential and cost-effective maternal, newborn, child and adolescent health services scaled up to significantly reduce preventable morbidity and mortality

- Strengthen the capacity for the development and implementation of evidence-based policies, plans, standards and guidelines for sexual, reproductive, maternal, newborn, child and adolescent health;
- Support the generation and use of evidence, including maternal and perinatal death surveillance data, to scale up high impact interventions for SRMNCAH through a multisectoral approach;
- Support multisectoral action to design and implement programmes for the prevention of all forms of violence and for providing care for survivors;
- Support capacity building for gender mainstreaming and human rights-based approaches for improved health outcomes, and monitor the related actions;
- Support the achievement and sustenance of elimination, eradication and control of vaccine-preventable diseases through implementation of the Global vaccine Action Plan

##### Focus area 4.2: By 2020, national systems strengthened to address the social, economic and environmental determinants of health

- Support the generation of evidence on social, economic and environmental determinants of health and the designing of mechanisms for multisectoral action such as the health-in-all-policies approach, to address the key determinants of health by competent agencies and stakeholders;
- Advocate for monitoring of impact and improvement in health inclusiveness and equity;
- Advocate for increased coverage for the key determinants of health such as education, livelihoods, workplace, housing.

##### Focus area 4.3: By 2020, national systems strengthened to mitigate and adapt to the impact of climate change and other environmental risk factors

- Promote multisectoral collaboration in activities to mitigate and adapt to the impact of climate change and other environmental risk factors, including through fostering the development and implementation of emergency and disaster risk management and other strategies;
- Support the development of regulations, guidelines and innovative approaches that will help stakeholders promote environmental sanitation;
- Support efforts to improve the quality of drinking water and reduce indoor air pollution through strengthening surveillance activities.

#### 4.1.5 Strategic priority 5: Strengthen the multisectoral approach to address the prevention and control of non-communicable diseases and nutrition-related conditions

##### Focus area 5.1: By 2020, multisectoral actions strengthened for increased access to effective interventions for prevention and management of non-communicable diseases and their risk factors

- Support the creation and operation of a multisectoral and multi-stakeholder coordination mechanism to accelerate and scale up the national response to the NCD epidemic;
- Support the development and implementation of a multisectoral strategic plan based on the 2013–2020 Global Action Plan for the prevention and control of NCDs and management guidelines based on WHO Package of Essential NCD Interventions - 2014 (WHO PEN);
- Support the development and implementation of technical guidelines and legal instruments for enforcing the measures to prevent and control exposure to NCD risk factors;
- Support the strengthening of research, surveillance and monitoring of the trends of NCDs and their risk factors, in line with the Global Monitoring Framework.

##### Focus area 5.2: By 2020, essential, evidence-based and cost-effective interventions scaled up to reduce nutrition risk factors

- Facilitate the development, implementation and monitoring of a national action plan for nutrition;
- Advocate for multisectoral actions for strengthened managerial capacity for effective leadership to accelerate and scale up the national response to the double burden of malnutrition;
- Strengthen the multisectoral approach for the implementing a comprehensive plan for maternal, infant and young child feeding, including integrated management of acute malnutrition, and advocate for legislation on a code for marketing of breast-milk substitutes;
- Strengthen the national capacity for designing and implementation of effective nutrition programming, including for research and nutritional surveillance, based on the global targets for nutrition.

**4.2 Table 2: Linking CCS focus areas with 12th WHO General Programme of Work (GPW) outcomes**

	<b>CCS strategic priority</b>	<b>CCS focus area</b>	<b>12th GPW outcome</b>	<b>HSDP (2015–2020)</b>
1	Strengthen national capacity to promote health security for (the population of) Uganda	1.1 By 2018, attainment of IHR (2005) minimum core capacities for all-hazard alert and response using IDSR framework supported	Category 5, outcome 1: All countries have the minimum core capacities required by IHR (2005) for all-hazard alert and response	Specific objective 1: To contribute to the production of a healthy human capital for wealth creation
		1.2 By 2020, heightened capacity to manage public health risks associated with emergencies and disasters and resilience built, including strengthening preparedness to mount a rapid, predictable and effective response to major natural and human-made disasters.	Category 5, outcome 3: Countries have the capacity to manage public health risks associated with emergencies  Category 5, outcome 2: Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics	Specific objective 1: To contribute to the production of a healthy human capital for wealth creation
2	Strengthen the health system for effective, equitable and quality health service delivery	1.3 By 2020, capacity to maintain the current polio status of zero cases supported	Category 5, outcome 5: No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally	Specific objective 1: To contribute to the production of a healthy human capital for wealth creation
		2.1 By 2020, sound and comprehensive policies, adequate and motivated human resources for health and effective financing mechanisms in place for increased access to people-centred integrated health services	Category 4, outcome 2: Policies, financing and human resources are in place to increase access to people-centred, integrated health services	Strategic objective 3: To increase financial risk protection of households  Strategic objective 4: To enhance health sector competitiveness in the Region and globally
		2.2 By 2020, strengthened health information systems, including for civil registration and vital statistics	Category 4, outcome 4: All countries have properly functioning civil registration and vital statistics systems	Strategic objective 4: To enhance health sector competitiveness in the Region and globally
		2.3 By 2020, improved access to and rational use of safe, efficacious and quality medicines and health technologies	Category 4, outcome 3: Improved access to and rational use of safe, efficacious and quality medicines and health technologies	Strategic objective 4: To enhance health sector competitiveness in the Region and globally

	<b>CCS strategic priority</b>	<b>CCS focus area</b>	<b>12th GPW outcome</b>	<b>HSDP (2015–2020)</b>
3	Essential health services for communicable diseases scaled up	3.1 By 2020, increased access to effective interventions for prevention and successful treatment of patients with HIV, TB, malaria and viral hepatitis.	Category 1, outcome 1: Increased access to key interventions for people living with HIV Category 1, outcome 2: Increased number of successfully treated tuberculosis patients	Strategic objective 1: To contribute to the production of a healthy human capital for wealth creation Strategic objective 1: To contribute to the production of a healthy human capital for wealth creation
		3.2 By 2020, support provided for scaling up interventions towards the control and/or elimination of neglected tropical diseases	Category 1, outcome 3: Increased access to first-line antimalarial treatment for confirmed malaria cases Category 1, outcome 4: Increased and sustained access to essential medicines for neglected tropical diseases	Specific objective 1: To contribute to the production of a healthy human capital for wealth creation Specific objective 2: To address the key determinants of health
4	Strengthened multisectoral approach for addressing RM-NCAH and social and environmental determinants of health	4.1 By 2020, essential and cost-effective maternal, newborn, child and adolescent health services scaled up to significantly reduce preventable morbidity and mortality	Category 3, outcome 1: Increased access to interventions for improving health of women, newborns, children and adolescents	Specific objective 2: To address the key determinants of health
		4.2 By 2020, national systems strengthened to address social, economic and environmental determinants of health	Category 3, outcome 4: Increased intersectoral policy coordination to address the social determinants of health	Strategic objective 1: To contribute to the production of a healthy human capital for wealth creation
5	Strengthened multisectoral approach to address the prevention and control of non-communicable diseases and nutrition-related conditions	4.3 By 2020, national systems strengthened to mitigate impact of climate change and other environmental risk factors	Category 3, outcome 5: Reduced environmental risk factors	Strategic objective 1: To contribute to the production of a healthy human capital for wealth creation
		5.1 By 2020, multisectoral actions strengthened for increased access to effective interventions for prevention and management of non-communicable diseases and their risk factors	Category 2, outcome 1: Increased access to interventions to prevent and manage non-communicable diseases and their risk factors	
		5.2 By 2020, essential, evidence-based and cost-effective interventions scaled up to reduce nutrition risk factors	Category 2, outcome 5: Reduced nutritional risk factors	

## 5. Implementing the strategic agenda: implications for the WHO Secretariat



CCS III will guide the implementation of identified priorities in the country. It will be implemented within the context of a transitional development environment that will encompass the domestication of the SDGs, universal health coverage, Vision 2040, UNDAF for 2016–2020, the Sendai Framework for Disaster Risk Reduction for 2015–2030, etc. There will be concerted action towards mitigating emerging health challenges including NCDs, climate change, urbanization, and the risks of emergencies and disasters. CCS III's strategic priorities are consistent with 12th GPW and the WHO Regional Transformation Agenda, 2016–2020 and take into account the recommendations of the ongoing WHO organizational reforms.

The WHO country team will adopt innovative approaches and working principles including the use of functional teams to generate the desired results and impact while ensuring synergies, cost-effectiveness and complementarity in the teams. Communication across the teams will be pursued to ensure coordination, accountability and transparency. The successful implementation of CCS III will require functional adjustments to the WHO work at the country level with streamlined support from the regional and headquarters levels. Technical support from the three levels of the organization will be provided in a coordinated and integrated manner through the country office.

## At the country level

The country office will reorganize its human resource capacity to ensure the right staff skills mix and capabilities exist in areas such as policy dialogue, negotiation skills and resource mobilization in order to deliver CCS III's strategic priorities. This will be achieved through various options including matching skills, building capacity of existing staff, and drawing on technical support from other levels of the organization. Specialized competencies will be outsourced, while office operations will be enhanced to improve efficiency. In this regard, operational support in the country office will be reorganized to achieve a good balance between technical and support staff (see Annex 1).

To successfully implement CCS III, additional resources will be mobilized in the country through deliberate and intensive efforts, including through United Nations joint programmes. WHO will strengthen existing partnerships including the Health Policy Advisory Committee, Health Development Partners, HIV/AIDS Development Partners, Country Coordination Mechanism and Roll Back Malaria, and facilitate forums of state and non-state actors to foster policy dialogue and debate on important public health issues. In addition, WHO will remain an active member of United Nations country team, harmonizing its work with that of other United Nations agencies under the Delivering as One framework, observing the existing division of labour and comparative advantage of each agency.

## Roles and responsibilities

The country office will have the primary responsibility for the implementation of CCS III. Technical support will be sought from the other levels of the organization in order to adequately respond to the country's support needs that exceed available WHO country office capacity. Efforts will be made to ensure that the requests to the Regional Office are timely in order to ensure availability of the support.

## Regional office including inter-country support team

The regional level is expected to provide timely technical support to the country office so that it can adequately respond to requests by the country. The Regional Office will also facilitate South–South and triangular cooperation for knowledge exchange based on best practices, and will foster ongoing capacity building for country office staff. The Regional Office will also make available the required resources, including surge capacity during disease outbreaks or other emergencies.

## Headquarters

WHO headquarters will provide global guidance and support the country office's networking with emerging initiatives such as the SDGs and the Global Financing Facility for Every Woman, Every Child and Every Adolescent, and those for the social determinants of health, climate change, and emergency risk management. The headquarters will complement the country office and the Regional Office's technical and financial capacities in the implementation of CCS III priorities.

## 6. Monitoring and evaluation of CCS III



CCS III has no direct indicators or a performance assessment matrix. Emphasis will be on operationalization of the CCS through biennial and annual plans. The progress of the CCS' implementation will be monitored and evaluated through internal mechanisms involving quarterly and semi-annual monitoring, a mid-term review and a biennial report.

The mid-term review will be conducted half-way into the strategic plan's period using a formative evaluation method. Opportunity will be taken to assess adherence to the strategic agenda and to consider any situation or circumstance that might warrant changing the priorities. The annual and end of biennium reports, amongst others, will be used to provide information for the mid-term review. The mid-term review will coincide with those of NDP II, SDP II 2015/16–2019/20, and UNDAF 2016–2020. This will provide the opportunity to align and/or harmonize recommendations while incorporating them into the CCS.

An end-of-term review using a summative evaluation approach will be carried out towards the end of the CCS's strategic period to capture achievements and lessons. The review will be informed by reviews of NDP II, HSDP 2015/16–2019/20 and UNDAF 2016–2020. In addition, biennial reports and other internal office documents will be used. Both internal and external evaluations will be undertaken to ensure objectivity and validity of the performance assessments. The results will be disseminated to the MoH and other partners and will be used for more effective engagement and to inform the next strategic period.





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## Annex 3: Country Office Organogram

### WHO Uganda Country Office: Organization Structure

