SCOPING ASSESSMENT REPORT

UK PARTNERSHIPS FOR HEALTH SYSTEMS | UGANDA

CONTENTS

ADH	Adolescent Health
AOGU	Association of Obstetricians and Gynaecologists of Uganda
CHEW	Community Health Extension Workers
CHW	Community Health Worker
DFID	Department for International Development
DHO	District Health Office
EPRC	Uganda Economic Policy Research Centre
GOU	Government of Uganda
HF	Health Facility
HRH	Human Resources for Health
HS	Health System
HSDP	Health Sector Development Plan
HSS	Health System Strengthening
IMCI	Integrated management of childhood illness
LSTM	Liverpool School of Tropical Medicine
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
NOM	National Oversight Mechanism
QoC	Quality of Care
RBF	Results Based Financing
RHITES	Regional Health Integration to Enhance Services
RISE	Research on Improving Systems of Education
RMNCAH	Reproductive, Maternal, Newborn Child and Adolescent Health
SSH	Sub-Saharan Africa
THET	Tropical Health and Education Trust
TOC	Theory of Change
UHC	Universal Health Coverage
UKPHS	UK Partnerships for Health Systems
UNFPA	United Nations Population Fund
UNICEF	United Nations Children fund
URHVP	Uganda Reproductive Health Voucher Project
URMCHIP	Uganda Reproductive Maternal and Child Health services Improvement Project
UUKHA	Uganda UK Health Alliance
VHT	Village Health Team
WHO	World Health Organization

INTRODUCTION

A scoping assessment was conducted in Uganda by a team from LSTM and THET in preparation for the implementation of the UK Partnerships for Health System Strengthening (UKPHS) programme in Uganda from 27th -31st January 2020.

PURPOSE AND OBJECTIVES OF THE SCOPING ASSESSMENT

The overall purpose of the scoping assessments was to introduce the UKPHS programme and to consult with stakeholders to determine national health systems (HS) priorities and how Health Partnerships (HPs) could contribute to addressing these and to national health system strengthening (HSS) (ToR in Annex 1).

The specific objectives of the scoping assessment were to:

- Introduce and improve understanding of the UKPHS programme among key in-country stakeholders, as well as the approach and expected outcomes of the scoping assessment.
- Receive inputs from key stakeholders to identify, validate and/or get consensus on national HSS issues, gaps and priorities, while considering gender equity and social inclusion (GESI), across the 6 HS building blocks with key stakeholders.
- Explore the feasibility of the Health Partnership (HP) model (using selected criteria) to address the identified HSS priorities.
- Identify interventions that could be implemented through hps and address these HSS priorities, as well as support the country's progress towards Universal Health Coverage (UHC).
- Map interventions on a country specific Theory of Change (ToC).
- Review the UKPHS programme outcome statement and outcome indicators to ensure these are aligned with the identified priorities.
- Identify and understand the work of key actors supporting HSS in the country to ensure hps build complementarity and synergies with these programmes and initiatives.
- Agree the way forward and to discuss and agree mechanisms for ongoing programme oversight and monitoring through a national oversight mechanism (NOM).

ACTIVITIES UNDERTAKEN

DESK REVIEW

Prior to the scoping visit, recent reports and publications on Uganda's health status, health systems, policies, plans and strategies were reviewed. The Uganda Ministry of Health has a comprehensive Knowledge Management Portal that integrates health and health-related information resources from the Ministry of Health and beyond, to provide a single point of access to valuable information that facilitates evidence-based decision making. Three key documents were reviewed, namely, the Health Policy and Health Sector Development Plan 2015/16 – 19/20, the Third National Reproductive, Maternal, Newborn, Child and Adolescent Health Assembly Report, August 2019 and the Annual Health Sector Performance Report 2018/19 Financial year.

Summary information, findings and priorities identified through the document review aredocumented below. They were presented to key stakeholders for comments and to frame discussions on HSS issues, gaps and priorities.

STAKEHOLDER ENGAGEMENT

A stakeholder mapping exercise, undertaken prior to the scoping visit, identified a range of key stakeholders that should be consulted by the team. Stakeholders engaged during and after the scoping visit were from across Uganda, and

represented government, professional councils and associations, service delivery units, private for-profit and not-for-profit health institutions, and health care personnel training institutions.

The team conducted a series of briefing meetings, in-depth interviews, and key informant interviews with specific stakeholders/groups, including a briefing with the MoH Permanent Secretary and the senior management team (a list of the participants at meetings during the scoping assessment is in Annex 3. A stakeholder consultation workshop (see Annex 4 for full week programme) was also facilitated to: raise awareness of the UKPHS programme and the THET Health Partnership model; to demonstrate success and lessons learnt from current or recently completed Health Partnership; and to narrow down potential activities and immediate outcomes for Health Partnerships (HP) projects in Uganda. A UKPHS Frequently Asked Questions document was made available to all participants (Annex 2). Three presentations were prepared and presented to frame and guide the identification and prioritisation of potential interventions that could be addressed through HPs.

SUMMARY OF FINDINGS

DESK REVIEW FINDINGS

Three years into the SDGs, Uganda has made progress with many of the SDG 3 good health and well-being indicators, when compared to the sub-Saharan Africa (SSA) average (.

Table 1). However, the met need for family planning and adolescent pregnancy rates are below the SSA average (United Nations, 2019).

Table 1: Uganda SDG 3 progress[1]

No.	Indicator	Uganda	SSA	Data ref. date
3.1.1	Maternal mortality ratio per 100, 000 live births	375 (278-523)	525 (480-625)	2019
3.1.2	The proportion of births attended by skilled health personnel (%)	74.2	59.3	2016
	The lifetime risk of maternal deaths	1 in 49	1 in 39	2019
3.2.1	Under-five mortality rate, by sex (deaths per 1,000 live births)	46.4	78.1	
3.2.1	Infant mortality rate (deaths per 1,000 live births)	33.8	53.1	
3.2.2	Neonatal mortality rate (deaths per 1,000 live births)	19.9	27.7	

[1] **Data extracted from the following sources:** SDG report 2019: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 2019; Trends in maternal mortality: 2000 to 2017, estimates by World Health Organisation (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank Group and the United Nations Population Division.

3.7.1	The proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (% of women aged 15-49 years)	53.5	54.7	
3.7.2	Adolescent birth rate (per 1,000 women aged 15-19 years)	131.5	101.4	2015
3.8.1	Universal health coverage (UHC) service coverage index 2017	45		2017
3.8.2	The proportion of the population with large household expenditures on health (greater than 10%) as a share of total household expenditure or income (%)	15.27		2016
3.c.1	Health worker density, by type of occupation (per 10,000 population)-Dentists	0.069	Target 10/ 1000	2015
3.c.1	Health worker density, by type of occupation (per 10,000 population)-Nurse	6.303	Target 40/10, 000	2015
3.c.1	Health worker density, by type of occupation (per 10,000 population)-Physicians	0.908	Target 10/10, 000	2015
3.c.1	Health worker density, by type of occupation (per 10,000 population)-Pharmacists	0.011	Target 5/10, 000	2015

Category of Health Facility	% accessing healthcare within 5 km radius			
	2002/03	2005/06	2009/10	2012/13
Government hospital	10.7[4]	4.3	5.7	4.9
Government Health Centre	23.1[5]	21.4	23.8	34.9
Private hospital/Clinic	48.7	48.1	46.5	37.5
Pharmacy/Drug shop	17.5	14.8	16.8	7.8

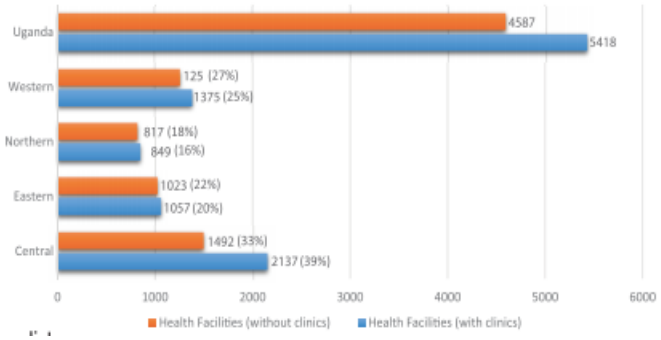
Source: Compiled from UBOS – UNHS (2002/03, 2005/06, 2009/10, 2012/13)

Within the SDGs, UHC is a vehicle for improving equity and quality of health care. UHC is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Equity in the availability of infrastructure (physical, drugs/medicines, equipment and supplies) and adequately trained human resources for health (HRH) and appropriate distribution of skills mix to provide quality services are essential to accelerate reductions in health outcomes.

The distance to health facilities can be a barrier to access. Generally, in Uganda, the proportion of the population accessing health care within 5km has improved significantly since 2002/2003 but is still less than 50% (Odokonyero *et al.*, 2017).

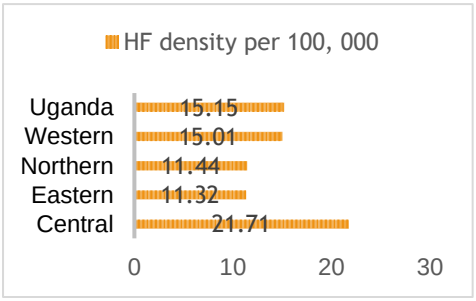
Based on the Uganda Health Facility inventory and the HSDP 2015, the Uganda Economic Policy Research Centre (EPRC) reported that there are significantly more health facilities (HF) in Central and Western regions compared to the Eastern and Northern regions (Odokonyero *et al.*, 2017) ***(Figure 1)***.

Figure 1: Distribution of health facilities in Uganda



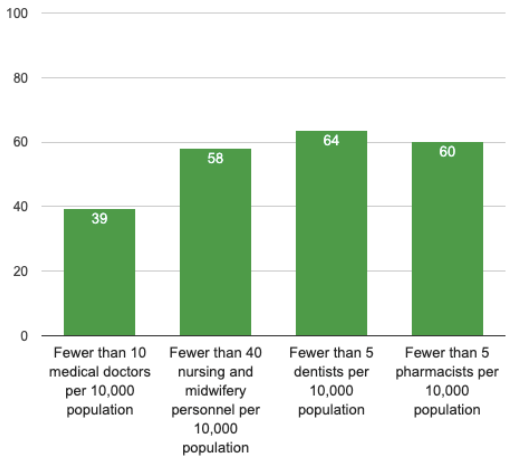
The EPRC also reported that there is marginal private sector investment in HFs in the Eastern and Northern regions, with private for-profit clinics accounting for only 3.2% and 3.7% of all facilities respectively in these regions.

The same pattern of health facility maldistribution is seen for HF density per 100, 000 population.



The WHO reported in 2019 that there are deficits of health personnel in countries where they are needed most. For example, Uganda is amongst about 40% of countries globally with fewer than 10 medical doctors per 10, 000 population. Although the picture is slightly better for other critical cadres, the problem is compounded by a saturation of the national employment norms (the proportion of pre-determined staff positions filled) and the inequitable distribution of the health resources available (Central region is much better staffed than the Western, Eastern and Northern regions). (Odokonyero *et al.*, 2017). The estimated density based on set norms was 0.87% in December 2013, and the largest gap in critical care cadres in the public section were medical doctors (consultants and non-consultants).

Figure 2: The proportion of countries with an insufficient number of health-care professionals, latest available data, 2013–2018 (percentage).



The midterm review of Uganda's Health Sector Strategic Plan II (2005/06-2009/10) highlighted high staff turnover, absenteeism, and low productivity as key determinants of poor health workforce performance.

UGANDA NATIONAL HEALTH PRIORITIES

Two key national documents were reviewed to identify national priorities, to assess progress in achieving these, and to determine the extent to which they align with the objectives and expected outcomes of the UKPHS. (All documents reviewed are provided in Annex 7).

National Health Policy (NDP) and Health Sector Development Plan (HSDP) 2015/16 – 19/20

The second NDP 2015/16 – 2019/20 sets out Uganda's medium-term strategic direction, development priorities and implementation strategies. The goal of the HSDP is to accelerate movement towards UHC, with essential health and related services needed for the promotion of a healthy and productive life.

The key objectives to be attained during the 5-year period set out in the plan included the following:

- Contributing to the production of a healthy human capital for wealth creation through the provision of equitable, safe and sustainable health services.
- Increasing financial risk protection of households against impoverishment due to health expenditures.
- Addressing the key determinants of health through strengthening intersectoral collaboration and partnerships.
- Enhancing health sector competitiveness in the region and globally.

The expected results at the end of the implementation period of this plan are:

- Reduced Infant Mortality Rate per 1,000 live births from 54 to 44;
- Reduced Maternal Mortality Ratio per 100,000 live births from 438 to 320/100,000;
- Reduced total fertility rate to 5.1 children per woman;
- Reduced child stunting as a percentage of under-5s from 33% to 29%;
- Measles vaccination coverage under one year from 87% to 95%;
- Increased TB case detection rate;
- Increased measles vaccination from 80% to 95%;
- Increased ART coverage from 42% to 80%;
- Increased deliveries in health facilities from 44% to 64%;
- Increased number of HC IVs offering CEmOC services from 37% to 50%.

In order to achieve these objectives and results, the plan recommended that the health sector would work towards strengthening the national HS, including governance; disease prevention, mitigation and control; health education and promotion, curative services; rehabilitation services; palliative services; and health infrastructure development.

Areas of investments to achieve the objectives and results under the NDP 2015/16-2019/20

Only 8 of 41 Uganda Health Sector Development Plan indicators were achieved at the end of the 2018/19 financial year. The areas for investments to achieve the expected results categorised by the 6 HS building blocks, and the potential alignment of these focus area with the UKPHS programme and the HP model are presented below.

HS building block	Focus areas	UKPHS potential support
Leadership and Governance	Strengthening the governance and partnership structures Strengthening management and stewardship Strengthening Public-Private Partnerships and coordination Strengthening health legislation and regulation, knowledge translation and improving sector competitiveness.	Yes, potential to reach more vulnerable populations and new districts, recently upgraded HC III facilities and new facilities.
Health Information Systems	Building a harmonized and coordinated national health information system covering routine HMIS data; surveillance, vital statistics, research and surveys, and innovative e-health solutions	Yes, through innovative e-health solutions that improve service delivery and the performance of audits for quality improvement
Financing	Mobilising, and allocating resources to implement planned services in an efficient, effective and equitable manner by introducing reforms in systems for:	Yes, by indirectly supporting other aligned building blocks

	• Revenue generation, • Risk pooling, • And strategic purchasing of services; Improving the public financial management system, procurement system and governance and regulatory system for the National Health Insurance Scheme	
Service Delivery	Delivering the essential health service package Improving referral system/ambulance service Improving community health services and supervision and quality of care Constructing new facilities with priority given to consolidation of existing facilities (well equipped to function optimally) Making HC IIIs in all sub-counties functional and piloting the establishment of Community Hospitals Strengthening service delivery in new districts (infrastructure development, equipping and staffing)	Yes, through training to improve the delivery of the essential health service package and improving community health services, supervision and quality of care. The focus could be new districts, recently upgraded HC III facilities and new facilities.
Human Resources for Health	Enhancing effectiveness and efficiency in health workforce development; Improving equity in the distribution and utilization of health workers; Improving health workforce performance at all levels; Strengthening Public-Private Partnerships in the development and utilization of the health workforce; Establishing a supportive HRH policy environment. Building capacity and mobilizing resources for operation and maintenance of medical equipment and infrastructure.	Yes, through improving the effectiveness and efficiency of the health workforce.
Medicines and technologies	Ensuring availability, accessibility, affordability and appropriate use of essential medicines of appropriate quality, safety and efficacy at all times Regulating and quality assurance of health products; production of health products and supplies; procurement, warehousing & distribution; and rational use of health products.	Yes, through strengthening supply chain management systems Strengthening efficiency and effectiveness of facility pharmacies

It was expected that the NDP 2015/16-2019/20 would be financed by both domestic and external resources, with the Government contributing about 27%, 36% the bilateral partners' contribution, 7% contributed by multilateral partners, and 30% being private contributions. However, there was an anticipated financing gap of about 54% over the implementation period, and there was an expectation that this should be covered through increased revenue efforts and off-budget financing.

It was expected that the HSDP would be implemented under the sector-wide approach and that the MoH would perform the key roles of policymaking, providing guidelines, training and capacity-building, monitoring the health sector, and the coordination of partners. The following reforms were proposed for the monitoring and evaluation framework: an M&E Unit was to be established to facilitate tracking of planned results and facilitate coordination and more efficient reporting of results. It was also planned that sector reviews would be conducted at the national and sub-national levels, focusing on performance reporting on the realization of the HSDP results.

There were no monitoring and evaluation reports of the NDP 2015/16-2019/20 available at the time of this desk review. The 2019 SDG report, however, reports on the progress made, and indicated that some of the HSDP targets are on track, some have been achieved, while others exceed the target (***Table 2***).

Table 2: NDP 2015/16-2019/20 achievements by expected results

NDP 2015/16 – 2019/20: expected results	Status in the SDG 2019 Report
Reduced Infant Mortality Rate per 1,000 live births from 54 to 44	33.8/1,000 live births
Reduced Maternal Mortality Ratio per 100,000 live births from 438 to 320/100,000	375 (278-523)/ 100, 000 live births
Increased deliveries in health facilities from 44% to 64%	74.2% of births attended by skilled health personnel

The 2018 Third National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Assembly Report (MoH Uganda, 2019) indicates that there was no progress on 3 of the 9 2018 national RMNCAH assembly resolutions (**Table 3**).

Table 3*:* Analysis of 2018 RMNCAH assembly resolutions that made no progress

No progress	HS building block
Establish and maintain a streamlined mechanism through district led planning and implementation	Leadership and Governance
Improve access, programming and implementation of equitable and high impact solutions/interventions to reach the most vulnerable populations	Service Delivery
Strengthen RMNCAH indicator tracking system and implement the RMNCAH Scorecard at National, District and community level	Health Information Systems

Eight stakeholder groups made commitments in the second National RMNCAH Assembly. Of these stakeholders, only the interreligious council of Uganda and the young people stakeholder groups made good progress in at least 1 commitment. There was slow or no progress in 61% (27) of the total commitments made in 2018 by key stakeholders.

Table 4: *Progress on key stakeholder commitments to end preventable, maternal, perinatal and child deaths in FY 2018/2019*

Stakeholder and the total number of commitments made	Good progress	Ontrack	Slow/ no progress
District local gov (6)	0	1	5
Development partners (8)	0	4	4
Civil society and implementing partners (6)	0	3	3
Young people (10)	1	2	7
Private sector (5)	0	1	4
Professional bodies (2)	0	2	0
Interreligious Council of Uganda (4)	1	0	3
Media (3)	0	2	1
	2 (5%)	15 (34%)	27 (61%)

Detailed analysis of the commitments by development partners and professional bodies and the potential of UK HPS contributing to accelerated progress is presented in **Table 5**.

Table 5: Detailed analysis of the commitments by development partners and professional bodies

Commitment	Assessment of progress	HS building block	UKPHS potential support
Development partners' commitments			
Strengthen coordination and accountability mechanisms at National, District and community level.	*Slow Progress* Monthly HPAC meetings with MoH and other stakeholders held; Health development partner coordination meetings held monthly and monthly representation on relevant technical working groups. Decisions from these fora translated well to lower levels (regions, district and community level).	Leadership and governance	
Support capacity building approaches at all levels for strengthening the HS blocks to be able to provide quality services for RMNCAH including rolling out of the Maternal and newborn health (MNH), child and adolescent health quality standards	*On track* Investments in ongoing capacity building and mentorships of service providers through implementation funded by development partners (Research on Improving Systems of Education programme (RISE), USAID's Regional Health Integration to Enhance Services (RHITES) projects in 5 regions, WHO, UNFPA, UNICEF). Slow progress on the institutionalization of quality of care (QoC), Continuous support to enhance skills not well supported, Slow progress in improving the working environment & inputs required to perform against WHO RMNCAH Standards.	Human resources Service delivery	Yes
Support multi-sectoral approaches geared towards promoting early childhood care and development, and maternal nutrition	*Slow progress* Coordinating agencies undertake implementation roles Clarification of sectors' roles unclear, leading to duplication of efforts, Multi-sectoral coordination needs to be strengthened under the ministries of Health, Education and Gender. Large number of 22 family care practices need to be thematised and institutionalized.	Leadership and governance Service delivery	
Promote adolescents and young peoples' health and wellbeing.	*On track* Donor support for implementation is increasing. Improved efforts to harmonize implementation approaches e.g. development and update of adolescent health (ADH) policies and standards, National Multisectoral ADH Think Tank launched, national ADH implementation framework developed. Limited resources for implementation of the three-point access model with facility, community and school and engagement of gatekeepers (parents, religious, cultural leaders);	Leadership and governance Service delivery	Yes through health worker training

	Sexuality education framework yet to be institutionalized. Innovations such as community outreaches targeting adolescents need to be widely implemented.		
Strengthen district and national level capacity to respond to RMNCAH needs in humanitarian settings for both host and refugee communities.	*On track* MoH plan for refugees developed and Institutionalized Resource constraints for infrastructure for quality maternal and newborn care, family planning, SGBV safety shelters and multisectoral interventions	Leadership and governance	
Support training and recruitment of key human resource cadres for RMNCAH services.	*Slow Progress* Support to the wage bill is slow Absorbing scholarship beneficiaries, such as anaesthetic officers and midwives slow, In-service training models need to be implemented to scale e.g. eLearning, video conferencing, network support among service providers at higher levels.	Human resources for health	Yes, through support to the training component
Continue to support the government to realize RMNCAH results through evidence-based interventions such as results-based financing (RBF)	*On track* The country almost fully covered by RBF (Uganda Reproductive Health Voucher Project (URHVP), Voucher Plus, RBF under the Uganda Reproductive Maternal and Child Health services Improvement Project (URMCHIP), and Enabel) Need to focus on sustainability and harmonization of packages and systematically measure the quality of care and HS improvements.	Finance	
Call upon government to increase domestic financing for the health sector especially for RMNCAH, including fast-tracking the National Health Insurance Scheme.	*Slow Progress* Budget allocation for health reduced from 8.4% to 7.4% between FY18/18 and 18/19 respectively, Government allocation for RMNCAH - 13%, National health insurance bill to be tracked and passed by Parliament.	Leadership and governance Finance	
Support the development of standards and guidelines for the public and private sector in family planning and Emergency Obstetric and Newborn Care	On track Professional bodies (Association of Obstetricians and Gynaecologists of Uganda (AOGU) & Uganda Paediatric Association) consulted and central to development of training standards and guidelines, and policy and service standards, including roll out in training institutions.	Leadership and governance Service delivery	Yes
Improve the capacity of health workers to provide quality reproductive health and MNCH services through in-service training and mentorship	*On track* Implementing partners have MoUs with professional bodies to train and mentor service providers on RMNCAH, including family planning; Skills labs established in training institutions, Mulago national referral and Teaching Hospital and proposed in regional referral hospitals.	Human resources	Yes

	Non-profitability and reinvestment in the associations and professional bodies leave them dependent on donor support. Sustainability measures through membership fees, ongoing; Self-initiated projects and large-scale consultancies need to be enhanced.	Service delivery	

The 2019 Third National RMNCAH Assembly Report provides further insights into progress made on some aspects of the NDP 2015/16-2019/20 implementation.

Box 1*: Uganda 2019 National RMNCAH Assembly resolutions*

- Strengthen district-led RMNCAH programming, planning, and implementation with partners' support.
- Functionalize all Health Centre (HC) IVs for quality RMNCAH service delivery.
- Strengthen human resource management capacity at the facility level to improve productivity.
- Monitor performance of Results-Based Financing in all the targeted districts in line with the Sharpened Plan.
- Prioritize access to equitable and high impact solutions/interventions to reach the most vulnerable populations.
- Establish Newborn Care Special Units in all HC IIIs and Newborn Intensive Care Units in all HC IVs and general and regional hospitals.
- Strengthen functionality of Maternal and Perinatal Death Surveillance and Response committees at the regional, district, and facility levels.
- Prioritize key family care practices at the community level as a tool to strengthen primary health care and achieving universal health coverage.
- Strengthen implementation of the multi-sectoral approach to address health determinants, including the promotion of safer sex and reduction of teenage pregnancy.
- Engage young people in the design and implementation of adolescent health programmes.
- Prioritize the use of the RMNCAH data and scorecard to make decisions at all levels.

UGANDA HSS AND HPS

Potential priorities for strengthening the HS using the Health Partnership model were identified based on the analysis of these reports. These priorities, which were validated by the MoH senior management team included:

- Strengthening community health systems
- Strengthening health workforce performance
- Strengthening health information and data systems for improved decision making.

HEALTH SYSTEMS STRENGTHENING: WHAT WORKS

The World Health Organization defines Health Systems as "all organizations, people and actions whose primary intent is to promote, restore or maintain health" (WHO, 2000). A good functioning HS increases access to, coverage of, and quality of care. Such health systems are expected to result in improved efficiency, enhancement of social and financial protection and improvement of health outcomes equitably. Health systems need to be strengthened to achieve the SDG 3 targets. The WHO defines health systems strengthening as "an array of activities that improves one or more of

the functions of the health systems and that leads to better health through improvements in access, coverage, quality or efficiency."

Witter (2019) undertook a review of definitions and evidence of HSS, and concluded that HSS interventions should include the following criteria (Witter *et al.*, 2019).

- Scope: The scope of an intervention should cut across HS building blocks in practice and should tackle more than one disease.
- Scale: Should have national reach and cut across more than one level of the system.
- Sustainability: The effects should be sustained over time and addresses systemic blockages.
- Effects: The effects should impact on outcomes, equity (including gender equity), financial risk protection and responsiveness but in practice, these impacts may occur over time.

A review of HSS interventions on health effects such as equity, quality of care and health outcomes are presented below.

- Leadership and governance: collaborative approaches, governance specific interventions that include community engagement, complex leadership programmes that include skills development, mentoring and promotion of teamwork, and inter-sectorial partnerships.
- Health workforce: Typically include health workforce and at least one other HS block focused intervention.
- Financing: Adequate public spending on health, external aid combined with domestic systems and financing plus interventions e.g. performance-based financing.
- Health information: There is limited evidence of effectiveness.
- Medicines and technology: Limited evidence has been generated.
- Service delivery: Most of the evidence have been generated in this HS building block but this is often combined with other HS building block interventions at meso level. Primary health care, integration of maternal and child health services and integrated management of childhood illnesses.

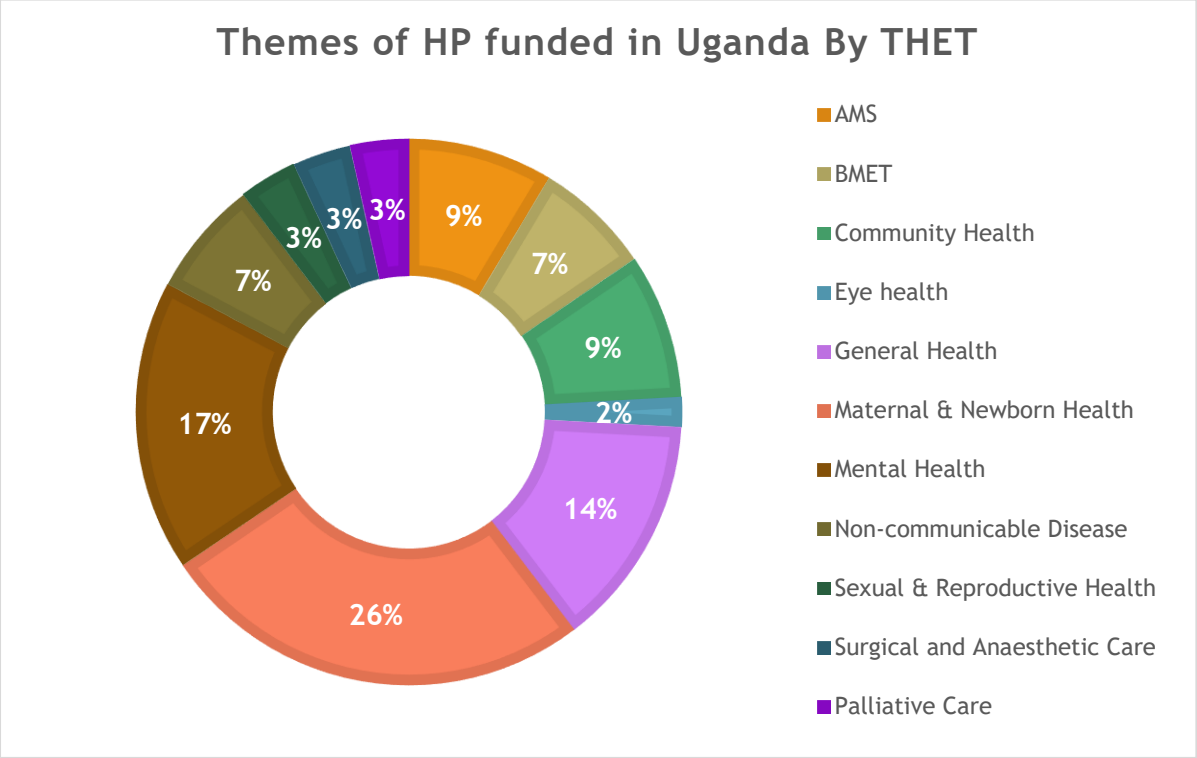
Table 6: Effective HSS interventions (Witter *et al.*, 2019)

HS building block	Examples of effective HSS activities
Leadership and governance **Governance and leadership-centred interventions (with an intended and unintended) strengthening spill over effect on the overall HS and population health outcomes;** **"Governance plus" (interventions paired with ones addressing another HS function;** **Governance policies and reforms embedded within broad programmes aiming at whole-system transformation**	Collaborative working approaches involving different stakeholders working in synergy to achieve long-term strategic reform goals across all levels of the HS from facility to national and within the public sphere. Governance-specific interventions, including civic participation and engaging community members with health service structures and processes, can lead to tangible improvements in health (focusing usually on maternal and child health outcomes) as well as better service uptake and quality of care. Complex leadership programmes blending skills development, mentoring, and promotion of teamwork bring about improvements in service quality, management competence, and motivation. At the mesolevel, some evidence suggests that it may facilitate intersectoral partnerships and promote improvements in health, equity, and efficient use of resources. Success depends on political will and quality of leadership.
Health workforce **Supply, distribution, and performance**	"Workforce plus" interventions (addressing workforce and at least one other building block) is focused on bundled retention packages for health staff in underserved areas, result in reduced staff attrition rates. These have been found to be effective in the short term. Skills mix (task shifting) approaches have been successfully used to address shortages of more highly skilled but scarcer professional groups supporting particular areas of service delivery. These are effective so long as tasks are not complex. Individual performance contracts can reduce absenteeism. Supervision can lead to improvements in quality and productivity. Workforce performance is more likely to improve when a coherent combination of strategies is used.
Financing ***Measures to increase the efficiency with which resources were spent on a significant scale (not pilot projects)*** **Revenue raising/pooling, purchasing** **Benefit package design and service provision,**	Public spending on health is associated with improvements in life expectancy and child and infant mortality across a number of studies, as well as more equitable distributions of health outcomes at population level when compared with private spending. Provision of external aid is associated with improved outcomes (especially infant mortality rates) and health equity— but this effect depends on the aid delivery approach (harmonisation with domestic systems and priorities is key). Mixed health outcome and equity effects a range of other "financing plus" interventions (performance-based financing, purchasing reforms, contracting in/out, reforms to the mix of public and private providers operating in the health sector, and others, most of which combine the financing and governance reform).

Cross-cutting issues such as governance and public financial management.	
Health information	There is limited evidence on the impact of investment in health information systems on long-range health outcomes or intermediate health indicators.
Medicines and technologies	Evidence formally linking investment in supply chains for medicines and supplies to improve access to health care or better outcomes is scarce and mostly grey literature-based.
Service delivery	This is the most broad-based category, incorporating the design and implementation of packages of services, service redesign, organisational strengthening, and other reforms that combine activities across the workforce, financing, governance, and other building blocks at macrolevel and mesolevel. Inclusion of demand generation components tends to increase the effectiveness of the intervention. Limited evidence on the effectiveness of basic or essential packages of health services has been examined primarily in fragile and conflict-affected settings. Strengthening primary care services (including integrated community case management of childhood illness) and the implementation of effective strategies to reach underserved populations have been effective in improving service access and coverage, and health outcomes (focusing principally on infant and child mortality and morbidity, and maternal health). Maternal and child health integration interventions have positive impacts on health outcomes (perinatal mortality and child mortality principally) and intermediate outcomes; evidence for HIV is mixed depending on the service area with which HIV services are integrated. Service quality improves where integrated management of childhold illness (IMCI) has been implemented. There are mixed results of the effects of IMCI on neonatal mortality and nutritional markers.

EXISTING HEALTH PARTNERSHIPS IN UGANDA

The THET Health Partnership approach operates largely at meso and micro levels of the health systems.[2] Fifty-eight (58) of the 89 Health Partnership applications received from partnerships in Uganda have been funded (completed or ongoing). Grants funded covered a number of areas including: maternal health and newborn health (26% or 15 projects), mental health (17% or 10 projects), general health (14% or 8 projects) and community health. Most of the THET funded HP grants addressed HRH and service delivery aspects of health systems, and about 10% included leadership and governance. A significant number of HPs funded to date have been in the Central region of Uganda.



DEBRIEFING SESSION

The team made a presentation to MoH officials as part of their debriefing session. The MoH informed the team that it is planning to establish an HS working group, as this is a crowded area in the country, in order to build synergies and prevent duplication. An Excel tool, which the MoH used to map partners, is currently undergoing internal validation and will be posted to the portal can be made available to the Uganda THET Country Director on request. The MoH also recommended additional stakeholders that the team and the THET Uganda Country Director could engage, such as the Uganda Health Care Federation, a non-state private not for profit actor involved in health and Living Goods, which has developed a social model for marketing approaches that can facilitate behaviour change. (Actions for follow-up by Uganda THET Country Director are in Annex 8).

The role of the MoH and the National Oversight Mechanism (NOM) were also discussed during the debriefing session. It was suggested that the NOM would play a role in the review of applications, regular appraisal of progress, and lessons

[2] At the **macro-level** are legal, regulatory, policy and economic barriers and enablers, such as financing, infrastructure, drug/supplies, employment etc. The **meso-level** concerned local **health** service and community factors, such as attitudes and support from managers and patients: quality of care. The **micro-level** relates to day-to-day practice: quality of care.

learnt. The MoH also suggested that the team consider annual meetings, to bring together all the funded partnerships, the NOM and MoH to discuss progress, share experiences and lessons learnt.

The HPs funded under the UKPHS need to remain engaged with the MoH at national and district level throughout implementation to demonstrate ownership, results and learning. This can be achieved by regular NOM meetings (6 monthly), attendance and active participation of partners at the respective MoH Technical Working Groups meetings, and a specific forum/meeting for peer-peer learning. Online availability of successful HP reports will help create awareness and contribute to building capacity of local institutions interested in Health Partnerships.

The input of MoH at the national and district level is essential for all partnerships and should be a key component of the ToC.

UKPHS UGANDA THEORY OF CHANGE

Following the scoping visit, the team developed an initial country specific Theory of Change for the UKPHS programme in Uganda. A narrative description and graphic of the proposed ToC are presented below.

CONTEXT

The UKPHS will:

- Operate in the context of Uganda Ministry of Health priorities
- Seek opportunities for synergies with other HSS interventions
- Demonstrate accountability through regular engagement with the Ministry of Health, District Health Offices, and technical working groups.

ASSUMPTIONS

- Objectives of the partnership will be based on the Uganda Ministry of Health development plan 20/21-25/26
- The activities will be developed in consultation with MoH and DHO
- The activities will be developed based on existing needs assessments, of MoH or her partners to ensure optimal impact
- Implementation of interventions will be based on MoH guidelines available at: http://library.health.go.ug/publications/performance-management
- MoH will participate actively in NOM
- To significantly reduce inequity in health, UKPHS partnerships will address gender and social inclusion determinants, measure and report progress on these using specific indicators. (See THET gender tool kit)
- MoH will support the development of MoUs, securing of work permits and professional practice licences as required
- Uganda general elections do not disrupt the implementation.

EVIDENCE (WITTER *ET AL.*, 2019)

Interventions that span more than one HS building block have been effective

- Leadership and governance: collaborative approaches, governance specific interventions that include community engagement, complex leadership programmes that include skills development, mentoring and promotion of teamwork, and inter-sectorial partnerships.

- Health workforce: Typically include health workforce and at least one other HS building block focused intervention.
- Financing: Adequate public spending on health, external aid combined with domestic systems and financing plus interventions e.g. performance-based financing.
- Health information: There is limited evidence of effectiveness.
- Medicines and technology: Limited evidence has been generated.
- Service delivery: Most of the evidence have been generated in this HS building block but this is often combined with other HS building block interventions at meso level. PHC, integration of maternal and child health services and integrated management of childhood illnesses.

INTERNAL AND EXTERNAL ENABLERS

- Partners have experience with the Health Partnership model or demonstrate achievement of key milestones in the inception period.
- Partnership agreements, MoUs and contracts are finalized within 3 months of the partnership

The Initial Theory of Change for the programme is presented below .

UGANDA PRIORITIES | INITIAL THEORY OF CHANGE

UKPHS
UK Partnerships for Health Systems

	Service Delivery - Community Health Systems	Human Resources for Health	Health Information Systems
Indicative Activities	· Evidence generation from piloting of CHEWs in 2-4 districts · Training of CHEWs, Training of VHTs · Optimising Mtrack and UNICEF information systems · Interventions to sustain the CALL centre initiative · Support and evaluate the implementation of community supply chain strategy	· Generate evidence to use to advocate for updating NM curriculum · Support regional hospital and N/M schools/oral health training schools around it: Training and placement · Training to improve HW performance · Leadership training, change management, quality improvement training, maternal and perinatal death data management at regional hospitals	· Capacity building to improve the use of data for decision making at regional referral hospitals and district level · Mapping of all existing health data systems and applications · Scaling up of successful pilots i.e. UNICEF HSS district assessment tool · Develop live dashboard for MoH leadership to monitor HS, NDP, health worker performance etc.
Indicative Outputs	· Number of CHEWs and VHTs trained using new curriculum in 2-4 districts · Number of CHEWs and VHTs with improved skills to use MTrack system · Number of referrals between CHW teams and Health facilities · Number of calls received and responded to at MoH CALL centre	· Number of placements in N/M schools · Number of midwifery teachers trained and mentored · Evidence of effectiveness of N/M school interventions generated · Number of participatory events to advocate for improved N/M curriculum with MoH and MoE · Number of N/M, MDs, Hospital administrators given leadership training · Number of HWs trained in MPDSR QI	· Number of mid-level managers at district and regional hospital level trained in data use for decision making · Live dash boards use at referral hospital, DHO and MoH developed and evaluated · Dash boards should have components of health worker performance, patient satisfaction, supply chain, disease surveillance etc. · Mapping of all existing health data systems and applications completed
Indicative Outcomes	·Evidence to guide CH worker policy generated ·Improved health promotion and community service delivery ·Improved CHW performance ·Improved vital registration, district and community level dash boards for decision making ·Improved surveillance and response system	·Improved patient satisfaction ·Improved health worker performance ·Evidence for improved N/M curriculum generated Reduced institutional maternal and perinatal mortality rate	·Improved use of data for decision making and planning at regional hospitals, District and national levels ·District HSS assessment tool scaled up
Potential Impact	**Improved health worker and health service performance, including for the poor and most vulnerable populations.**		

SUMMARY AND CONCLUSIONS

Uganda has made some progress towards the SDG health targets and the expected results of the NDP 2015/16-2019/20, but more can be achieved by implementing HSS interventions that will increase coverage, quality and reduce inequity. Strategies that combine interventions across the various HS building blocks are more likely to be effective. The UKPHS can be most effective when combined with other HSS strategies of the Government of Uganda. For example, MoH Uganda interventions at macro level can address HRH shortages and distribution, the UKPHS can support initiatives at meso and micro levels, including supporting capacity building, leadership, quality of care, interventions to improve staff performance and reduce absenteeism. Key areas from the NDP and national RMNCAH assembly resolutions aligned with the focus of the UKPHS can potentially be supported for improved quality of care and equity in health care.

The team then agreed next steps as follows:

- The THET Uganda Country Director to complete consultations.
- LSTM to complete the development of the country specific ToC.
- THET to develop NOM ToR and circulate to MoH.
- THET to consult MoH on NOM membership.
- THET Uganda Country Director to provide a regular update to MoH UKPHS focal person on progress.

LIST OF ANNEXES

DESIGN AND CONDUCT OF SCOPING ASSESSMENTS FOR THE UK PARTNERSHIPS FOR HEALTH SYSTEMS (UKPHS) PROGRAMME: TERMS OF REFERENCE

BACKGROUND

UK Partnerships for Health Systems (UKPHS) is a DFID-funded grants programme that funds Health Partnerships (HPs) to improve health system performance and to enable progress towards Universal Health Coverage (UHC) in low- and lower-middle income countries (LMICs), especially for poor and vulnerable populations. The UKPHS will support the development of stronger health systems by promoting HPs that are aligned to national health priorities and strategies, focusing on quality, and gender equality and social inclusion (GESI). UKPHS will fund large strategic HPs in ten countries that explicitly focus on supporting LMIC health system priorities, complemented by smaller HP grants that test innovative approaches to specific health system challenges.

PURPOSE OF THE SCOPING ASSESSMENTS

From December 2019 to May 2020, THET and LSTM plan to undertake detailed scoping assessments in each of the 10 countries. The assessments will explore health systems issues, challenges and priorities, and identify and validate health systems priorities that HPs could potentially address and/or contribute to health system strengthening (HSS) or strengthen particular building blocks within the system, whilst ensuring a GESI perspective. These scoping assessments will consider the HP footprint in each country, as well as the potential supply of new and/or adapted HPs, ensuring the best fit between the priorities identified and the likely supply.

During the scoping visit, stakeholders will begin the process of constructing a Theory of Change (ToC) that maps out how HPs can address the identified health system priorities in that country context, contribute to HSS and UHC, and how the poorest and most vulnerable (from a GESI lens) can be supported in particular. All HPs will need to clearly demonstrate their contribution to this ToC. The assessment process will also contribute to stakeholder relationship building and promotion of the programme, and assessment findings will inform grant call design, overall UKPHS programme MEL processes, promote HP alignment with, and support of, national priorities and capacities, and ensure a good fit with the supply of UK expertise.

APPROACH AND METHODOLOGY

1. Desk review

The team will undertake a rapid desk review comprising mainly the review of country specific documents such as: health sector policies, strategies and plans including UHC, Quality Improvement, human resources for health, maternal, newborn, child and adolescent health; available HMIS data; and other relevant key government, donor and/or development partner reports/analyses, in order to construct an overview of health systems issues and priorities, and a stakeholder map for each country.

2. Design of assessment frameworks and tools

The team will draw on a number of frameworks to develop a flexible approach and tools for the scoping assessment that can be adapted to each country context. In addition to the key framework, which will be the WHO Health System Framework and the 6 Building Blocks/core functions,[3] the team will draw on a number of other assessment tools and

[3] World Health Organization (2007) Everybody's Business: Strengthening health systems to improve health outcomes—WHO's Framework for Action. Geneva: WHO, 2007, p.3.

guides, such as the USAID Health Systems Assessment Approach;[4] the Roberts, Hsiao, Berman, and Reich (2003) 'control knobs framework';[5] the DAC OECD Principles for Evaluation of Development Assistance;[6] the WHO five performance criteria for assessing a health system,[7] and the WHO Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence,[8] and the Building Block Benchmarks for Gender[9] to design the methodology, approach and assessment tools to identify health systems issues and priorities, and to assess the relevance of the HP model to address these.

3. Stakeholder engagement

Multidisciplinary and multi-stakeholder involvement to discuss potential HP projects is critical, as is engagement of key stakeholders affected by the implementation of these projects. MOH cooperation, collaboration and participation in the scoping process will be essential for generating high quality findings and outcomes that are acceptable to the government of each country. Country commitment will also be critical to increase the likelihood of HP interventions being implemented, achieving the expected results, and these results being sustained beyond the lifetime of the project.

Prior to the scoping visit, THET Country Directors (CDs) will meet with high level MOH officials, DFID Health Advisors and other development partner representatives to provide information and create awareness and build support for the UKPHS programme, outline the purpose of the scoping visit and level of cooperation expected from the MOH. These discussions will also provide opportunities for the initial exploration and validation of the country's health systems issues, challenges, and priorities, including GESI issues, and how the UKPHS programme can contribute to these, as well as support the government to achieve UHC and the SDGs.

In-depth interviews (IDIs) and key informant interviews (KIIs), meetings and workshops will be facilitated with a range of national and sub-national level stakeholders, identified in advance of the scoping visit through a stakeholder mapping exercise. These will include policymakers, representatives from the MoH and other strategic sectors and line ministries, in-country DFID teams, professional bodies and associations, including nursing, training institutions, NGOs, civil society, women's, disability and faith-based organisations, development/funding partners, UN agencies, and private sector organisations.

The objectives of such stakeholder engagement are to:

- Share information on the UKPHS and the HP model
- Share findings and priorities identified through the desk review
- Seek stakeholders' inputs and views to validate findings and agree priorities
- Collaboratively assess the potential of the HP model to address the identified priorities
- Get consensus on the interventions that could be implemented through HPs

[4] Health Finance & Governance Project. September 2017. Health Systems Assessment Approach A How-To Manual. Version 3.0. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

[5] Roberts MJ, Hsiao WC, Berman P, Reich MR. 2003. Getting Health Reform Right. New York: Oxford University Press.* This conceptualized a health system as "a set of relationships where the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends)".The framework identifies five major "control knobs" of a health system which policymakers can use to achieve health system goals: financing, macro-organization, payment, regulation and education/persuasion.

[6] DAC Principles for Evaluation of Development Assistance, DEVELOPMENT ASSISTANCE COMMITTEE, OECD, PARIS, 1991 https://www.oecd.org/dac/evaluation/2755284.pdf.

[7] WHO (2007) Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. Geneva, Switzerland: WHO.

[8] WHO (2011) Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence https://www.who.int/gender-equity-rights/knowledge/human_rights_tool/en/.

[9] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

Debriefing sessions will be facilitated to provide an overview of the outputs and outcomes of the scoping visits and present priorities identified and validated. These sessions will provide opportunities for the team to build consensus on the draft country specific ToC, which will outline potential HP activities, outputs, outcome and impact. As part of this debriefing, teams will agree the way forward and the functioning of a national oversight mechanism. Beyond the scoping visits, the teams will continue to refine and finalise these country specific ToCs.

Summary country reports

Scoping visit reports, which provide an overview of the process and outcomes from each of the countries, will be produced. A summary of the agreed priorities that could potentially be addressed by HP projects and interventions and a draft Theory of Change will also be developed, which will be made available to guide grant applicants in the development of their applications and proposals. These outputs will be further refined and validated through the pre-commencement workshops and other planned stakeholder consultation fora in each country.

Specific activities

1. Conduct a rapid desk review of policies and country reports and other relevant documentation (national health sector plan and policies, strategies and plans for UHC, Quality Improvement, HRH, and relevant HMIS and surveillance data).
2. Map existing Health Partnerships and key stakeholders.
3. Produce a draft situation analysis, including health system issues, challenges and priorities, including, progress on GESI, and identify priorities that could be potentially addressed through HPs.
4. Develop standard frameworks and tools to be used across all countries to engage stakeholders in the identification and validation of health system issues, challenges and priorities, and in assessing the feasibility of the HP model to address identified HSS priorities.
5. Conduct in-depth and key informant interviews and group discussions and workshops with a range of national and sub-national stakeholders to identify and validate health system issues, challenges and priorities, and elicit views and perceptions on the extent to which the HP model could address these.
6. Facilitate a debriefing session with a representative group of stakeholders/gatekeepers to present and validate findings of the scoping assessment and agree the cope and functioning of national oversight mechanisms and way forward.

Expected Deliverables:

1. Desk review and situation analysis including map of stakeholders and health challenges and priorities
2. Country scoping assessment report, including an overview of the process, key findings, and a summary of agreed priorities to be addressed by HP projects
3. Draft country level TOC focusing on HP interventions, outputs and outcomes and broad indicators for each of the identified short-, medium- or long-term outcomes, including Gender Equality and Social Inclusion (GESI) indicators.

COMPOSITION OF SCOPING TEAM

Each scoping team will comprise up to two international specialists/leaders in HPs, HSS, and/or Gender, and a representative from the THET country offices.

TIMEFRAME AND DURATION OF SCOPING ASSESSMENT

The scoping assessments are expected to be undertaken between January and May 2020 and each country visit is expected to take up to 5 days. Country Reports and ToC will be completed for all countries by June 2020.

ANNEX 2- UKPHS FREQUENTLY ASKED QUESTIONS

WHAT IS THET?

THET is a global health charity operating in 7 countries across the world – the UK, Uganda, Tanzania, Zambia, Somaliland, Ethiopia and Myanmar. THET's primary aim is to address the statistic that one in seven people globally will never visit a qualified health worker. We do this primarily through health workforce development. We train support and educate health workers across Africa and Asia, working in partnership with organisations and volunteers from across the UK, Africa and Asia. We are the only UK charity with this focus. All of the work which THET does works within the Health Partnership model framework.

WHAT IS THE HEALTH PARTNERSHIP MODEL?

A Health Partnership is a partnership formed between a UK health institution, either a hospital, a trust, a professional association, or a health education facility like a university and their counterpart overseas. The aim of these partnerships is to deliver health worker training and peer to peer support, through utilising the skills and experience of each organisation. Partners co-develop programmes that address organisational and national priorities. The partnerships themselves are generally long term and sustainable, while the projects which they deliver are discrete and tailored to specific identified needs. The aim of all projects is sustainable impact and mutual benefit.

HOW DOES THET WORK WITHIN THE HEALTH PARTNERSHIP MODEL?

THET takes a 3-pronged approach to partnership work – we carry out policy, advocacy and research, we implement programmes directly, and we manage grants for donors. Our policy work involves advocating, mainly with the UK government, for support for Health Partnership work. In our country programmes work we work through our six country offices partnering with others (Mohs, hospitals, universities, professional associations and other organisations) both overseas and UK-based to deliver programmes that respond to local needs. Finally, THET acts as a fund manager for a number of donors. Historically we were grants manager for the Health Partnership Scheme – a 7 year, £32 million programmes funded by the Department for International Development. This programme supported 210 projects in over 30 countries and trained over 93,000 health workers. Currently, we are managing a range of programmes including the Johnson & Johnson Africa Grants Programme, which focuses on surgery and anaesthesia and community health, and the Commonwealth Partnerships for Antimicrobial Stewardship Programme, funded through the Department of Health's Fleming Fund. This supports partnerships with the aim of improving the detection and monitoring of resistant infections at the hospital level, taking measures to reduce infection and ensuring antibiotics' effective use.

WHAT IS THE UKPHS?

The UK Partnerships for Health (UKPHS) programme was announced by the UK Department for International Development as the successor to the HPS in 2018. After some delays, management of the programme was awarded to THET with technical input from the Liverpool School of Tropical Medicine, and the programme officially began on 2nd December 2019. The programme has a total budget of £28.5m and will run for 43 months until July 2023.

The programme aims to help LMICs build stronger, and more resilient health system, making progress towards universal health coverage through improved health service performance, particularly targeting poor and vulnerable populations. Some of the key aims are to:

- Support the development of stronger health systems through better governance, information, and management of health institutions
- Provide the health workforce with opportunities to improve skills and knowledge
- Build on the institutional capacity to decrease any reliance on external support.

WHAT KIND OF PROJECTS WILL BE FUNDED UNDER THE UKPHS?

There are two main strands under the UKPHS. The first focuses on 10 strategic countries which were identified by DFID – Bangladesh, Burma, Ethiopia, Ghana, Nepal, Sierra Leone, Somalia/Somaliland, Tanzania, Uganda and Zambia. Grants under this stream must address pre-identified health priorities, as identified by stakeholders within the country. The second strand will fund smaller projects and will have neither a pre-defined country nor a health theme.

All projects under this funding programme must be delivered by Health Partnerships and must address issues with the health workforce through activities such as training**,** leadership development, or protocol and curricula development. Unfortunately, this funding cannot be used for infrastructure work, including equipment procurement or refurbishment.

HOW MUCH FUNDING IS AVAILABLE FOR WORK IN UGANDA THROUGH THE UKPHS?

The programme has a total budget of £24m available for grants. There will be 6-8 large grants of up to £400k each being implemented in each of the strategic countries. There will be around £2m available for each strategic country, including Uganda, with the number of grants being decided on based on the number and quality of applications.

WHAT ARE THE MAIN OBJECTIVES AND PLANNED OUTCOMES OF THE GRANTS PROGRAMME?

The entirety of the programme aims to contribute to SDG 3 – ensuring healthier lives and promotion of well-being for all at all ages, with a focus on Universal Health Coverage. A key outcome will be improved health worker and health service performance including for the poor and most vulnerable populations. This will be measured through monitoring the number of facilities supported by UKPHS projects demonstrating positive outcomes in health service performance, with a focus on health worker performance. Projects funded under this programme should take an approach which enhances gender equality and social inclusion, focusing on targeting poor and vulnerable groups.

HOW WILL NATIONAL OWNERSHIP AND BUY-IN BE ENSURED?

It's crucial to the success of this programme and the sustainability of its outcomes that national stakeholders play a leading role in determining priorities. The key health priorities addressed by projects being implemented in strategic countries will be determined through a scoping visit undertaken specifically to engage with national stakeholders. Over the course of the scoping visit, national stakeholders will be asked to participate in workshops, focus groups and key informant interviews, aiming to draw out key priorities for those working in the health sector.

The priorities raised during these meetings will then be agreed upon and used to develop a country-specific Theory of Change, which will form the basis for all of the project interventions. Relevant stakeholders will then be invited to join a National Oversight Mechanism (NOM), which will play a key role throughout the programme in ensuring that projects remain aligned with national priorities and feed into the relevant national plans. The NOM will be asked to review and assess applications during the selection phase of the programme and then play an ongoing role in providing oversight on projects as they progress and attending annual national review events.

In addition to the NOM, THET's Country Director and associated country office staff will support funded Health Partnerships for the duration of the programme. They will be continuously engaging with national networks, the Ministry of Health and other relevant partners.

ANNEX 3 - STAKEHOLDERS ENGAGED THROUGH SCOPING VISIT

Organisation	Designation
MOH	PS
MOH	CHS PFP
MOH	CHS-CH
MOH	ACHS (PSC)
MOH	DHS/GR
MOH	ODI FELLOW
MOH	AG CH/HPE&C
MOH	DHSCCS
MOH	AGACHS/RCH
MOH	AC/BIF
UNICEF	Health Specialist
UNFPA	Family Planning Specialist
Makerere School of Public Health/Speed Project	Lecturer/Project Manager
Makerere University School of Public Health	Lecturer
Makerere University School of Public Health	Head of Department Health Policy, Planning and Management, PhD Health Systems Research
MOH	National One Health Platform Coordinator
MOH	Focal Person For Oral Health
MOH	Senior Technical Advisor Community Health Systems Strengthening
MOH	Technical Advisor Reproductive Health
MOH	ODI Fellow
MOH	Assist Commissioner Planning
MOH	AG ACHS, RCH
MOH	Director Clinical Services
MOH	P/O
Pharmaceutical Society of Uganda	Secretary
Uganda Dental Association	President
Uganda Nursing and Midwifery Union	President
SEED Global Health	Country Director
UHSS Palladium	Deputy Chief Of Party
Uganda-UK Health Alliance	Country Lead
AMREF HA	Country M &E Manager

ANNEX 4 - SCOPING ASSESSMENT ITINERARY

Day	Activity	Purpose
Day 1 – 27 Jan	Courtesy calls	Briefing on UKPHS and workshop objectives
	Key stakeholder meeting	Briefing on UKPHS
		Initial discussion of health priorities within Uganda
Day 2 – 28 Jan	Stakeholder workshop	Information sharing and clarifications on UKPHS
		Validation of desk review findings
		Framework for group work
Day 3 – 29 Jan	Selected key informant interviews	Identification of health issues, challenges and priorities
		Identify mechanisms of change/pathways to outputs and outcomes through HPs
Day 4 – 30 Jan	Selected key informant interviews	Gather further information to address information gaps identified during previous exercises
	THET/LSTM team meeting	Collation and synthesis of data
Day 5 – 31 Jan	Presentation and debrief with key stakeholders	Presentations and validation of workshop outputs and outcomes
		Review NOM ToR and nominate members
		Discuss and agree on the next steps

ANNEX 5 - TOPIC GUIDE FOR COURTESY CALLS, IN-DEPTH AND KEY INFORMANT INTERVIEWS, AND SMALL GROUP MEETINGS

POTENTIAL RESPONDENTS

Ministry of Health policy makers and leaders; department heads and programme managers, including gender focal persons; official from other relevant ministries (education, gender finance/ treasury, national planning and development, labour, civil/public service commission or management agencies); representatives from regional and/or local government; professional councils and associations; health training and academic/research institutions; development partners and donors/funders; representatives from UN agencies, international and local NGOs, faith based organisations, civil society groups/organizations, private sector; and institutions (governmental or non-governmental) working on gender equity and social inclusion, including any disability organisations.

MATERIALS

KII guide, notepad, pens, Programme Overview, UKPHS FAQs, Rings Guide on adopting a gender lens in health systems policy, figure of WHO HS Framework; and country-specific desk review findings/priorities.

INTRODUCTIONS

1. All participants introduce themselves
2. Establish post title and roles and responsibilities of respondent(s), if unknown
    - For government officials and NGOs, ask them to describe their area of focus and/or programme(s) they are responsible
    - For DPs and UN agencies ask them to describe their area of focus and/or programme(s) they are supporting and/or implementing
3. Scoping Team provide an overview of the scoping visit, its purpose, objectives and expected outcomes
4. Scoping Team outline stakeholder engagement strategies/plans that will be adopted and seeks respondent's feedback and inputs
5. If a workshop has been agreed, Scoping Team share the workshop programme, and discuss and seek respondent's inputs on the approach, objectives and expected outputs

OVERVIEW OF UKPHS & HP MODEL

1. Scoping Team provide an overview of the UKPHS programme, including FAQs, and examples of any previous HPs in the country, including achievements, challenges and lessons learned
2. Scoping Team provide any informational materials e.g. Programme Overview, UKPHS FAQs, Share the Rings Guide on adopting a gender lens in health systems policy. [10]

DISCUSSION AND VALIDATION OF HEALTH SYSTEMS PRIORITIES

1. Scoping Team provide a brief overview of the health system priorities, including for GESI, identified through the desk review, and through previous stakeholder consultations, if appropriate
2. Scoping Team seek inputs and validation on the identified priorities (share list of country-specific desk review findings/priorities) from respondents and probe for any additional priorities.

[10] https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

3. Scoping team explain that the UKPHS programme will seek to strengthen health systems and HPs will aim to support across the 6 building blocks or individual blocks as appropriate to the context and priorities identified. Check respondent's understanding of the WHO Health System Framework (share graphic in Annex if required) and map identified priorities against the building blocks as well as GESI

APPROPRIATENESS AND FEASIBILITY OF HP MODEL TO ADDRESS IDENTIFIED PRIORITIES

1. Scoping Team Summarise the identified HSS priorities, check respondent's understanding of the HP model and invite respondent's views on how the HP model and HP projects or interventions could address the identified HSS priorities. *Probe for how HP projects could improve health service performance in terms of equity, efficiency, access, quality, and sustainability, and ultimately help the country to achieve UHC?*
2. Probe for 3-5 key priority areas that could be addressed by HPs projects, including indicative activities, outputs and outcome, and overall impact

ADDRESSING GESI PRIORITIES THROUGH HPS

1. Discuss the identified GESI issues across the 6 building blocks, drawing on the Building Block Benchmarks for Gender[11] where appropriate (see Rings "Guide on adopting a gender lens in health systems policy").
2. Explore with the respondent how the identified HP projects/interventions could contribute to improving health sector performance in terms of equity (with a focus on gender equity, disability etc) and could help reach unreached and marginalised populations.

NATIONAL OVERSIGHT MECHANISM

1. Provide an overview of the proposed national oversight mechanism and discuss functions and composition

ADDITIONAL INFORMATION:

1. Any other key stakeholders the respondent would recommend the team should consult
2. Any other key documents the respondent would recommend the team should review that were not available for review during the desk review

CLOSURE

- Ask if the respondent would like to add further comments
- Bring the meeting to a close by summarising the main points
- Check respondent's availability and agree a date for a debriefing session, if required
- Thank the participant for his/her time and active participation.

[11] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

ANNEX 6 - GROUP WORK ACTIVITIES

GROUP WORK ACTIVITY 1: HSS PRIORITIES IDENTIFIED, VALIDATED AND RANKED

- Identified HSS priority areas and activities are distributed amongst the Groups, with each group allocated a different HS building block/core function
- Each group will discuss the identified priorities and validate them, adding any that were omitted
- Each group will rank each priority area and activity, with 1 being the highest ranked priority
- Group work outputs, findings and conclusions can be captured and synthesized using Worksheet 1 below.

WORKSHEET 1

Building Block	HS Priority Area	Ranking	Priority Activity	Ranking
Governance	1. 2. 3.			
Health Financing				
Service Delivery				
Human Resources for Health (HRH)				
Medical Products, Vaccines, and Technologies				
Health Information System				

GROUP WORK ACTIVITY 2: POTENTIAL HP INTERVENTIONS AND PROJECTS TO ADDRESS IDENTIFIED PRIORITIES

- Groups will discuss and identify potential HP projects and interventions that could address the identified and ranked priority
- Groups will discuss how HPs could contribute to HSS within and across the 6 building blocks/core functions by addressing these priorities?
- Group work outputs, findings and conclusions can be captured and synthesized using Worksheet 2 below.

WORKSHEET 2

HS Priority Area/activity	Potential HP project/interventions
1. 2. 3.	

GROUP WORK ACTIVITY 3: ASSESSING HPS CONTRIBUTION TO THE HEALTH SYSTEM PERFORMANCE

- Groups will discuss how potential HP interventions/projects will contribute to improving health system performance
- Groups will answer the questions related to the following criteria to assess contribution:
    - Coherence
    - Relevance
    - Effectiveness
    - Efficiency
    - Access
    - Quality
    - Equity, gender equality and social inclusion
    - Impact
    - Sustainability
- Group work outputs and findings can be synthesized using Worksheet 3.

WORKSHEET 3

HP interventions	Coherence	Relevance	Effectiveness	Efficiency	Access	Quality	Equity	Sustainability	Impact
1									
2									
3									

GROUP WORK ACTIVITY 4: SYNTHESIS OF GROUP WORK AND LINKAGES BETWEEN HP INTERVENTIONS AND OUTCOME/IMPACT

- Groups will discuss and describe the most feasible HP interventions to address the key priorities and the expected outcome(s) and impact
- Group work outputs and findings can be synthesized using Worksheet 4.

WORKSHEET 4

Priority area	Description of HP Interventions	Expected output, outcome and impact

1. Odokonyero, T. *et al.* (2017) 'Universal health coverage in Uganda: the critical health infrastructure, healthcare coverage and equity.', *Research Series - Economic Policy Research Centre*, (136), pp. 31-pp. Available at: http://www.eprcug.org/research/research-series?task=document.viewdoc&id=521 (Accessed: 26 January 2020).
2. United Nations (2019) *The sustainable development goals report 2019*, *United Nations publication issued by the Department of Economic and Social Affairs*.
3. Witter, S. *et al.* (2019) 'Health system strengthening—Reflections on its meaning, assessment, and our state of knowledge', *International Journal of Health Planning and Management*. doi: 10.1002/hpm.2882.