CATHOLIC HEALTH NETWORK IN UGANDA
UGANDA CATHOLIC MEDICAL BUREAU

THE STRATEGIC PLAN 2007 – 2011

AND

OPERATIONAL PLAN 2007 – 2009

ENABLING ALL FOR FAITHFULNESS TO THE MISSION

Kampala
June 2007

THIS VERSION OF THE STRATEGIC AND OPERATIONAL PLAN 2007-11 AND 2007-9 COMPLETES AND SUBSTITUTES THE EARLIER VERSION PREPARED FOR THE CONSULTATION CONFERENCE HELD IN NOVEMBER 2006. THE OUTCOME OF THE CONSULTATION CONFERENCE WAS A BROAD CONSENSUS OVER THE ENVISAGED PLANS. FEW ADDITIONS WERE SUGGESTED, THAT HAVE BEEN ACCOMODATED IN THE VERSION PRESENTED HERE.

THE INFORMATION BASE UPON WHICH TARGETS HAVE BEEN DECIDED HAS, IN THE MEANTIME, BEEN BRAODENED TO INCLUDE INFORMATION THAT WAS NOT AVAILABLE AT THE TIME OF THE EARLIER VERSION'S REDACTION.

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LIST OF ABBREVIATIONS

AES	Assistant Executive Secretary
AFMA	Assistant Financial Management Advisor
ARU	Association of Religious in Uganda
AMSRIU	Association of Major Superiors of Religious Institutions in Uganda
AVSI	Associazione Volontari Servizio Internazionale
BOG `	Board of Governors
BOT	Board of Trustees
CCM	Country Coordinating Mechanism of Global Fund
CEI	Italian Episcopal Conference
CHA	Christian Health Association
CHI	Community Health Insurance
CORDAID	Catholic Organisation for Relief and Development Aid, the Netherlands.
COWA	Companionship of Works Association
CPE	Clinical Pastoral Education
CRS	Catholic Relief Services
CUAMM	Collegio Universitario Aspiranti Medici Missionari
DANIDA	Danish International Development Assistance
DCI	Development Cooperation Ireland
DDHS	District Director of Health Services
DHB	Diocesan Health Board
DHC	Diocesan Health Co-ordinator
DHO	Diocesan Health Office
DHMT	District Health Management Team
DKA	Dreikonig-aktion Austria
DP	Development Partner
ECN	Enrolled Comprehensive Nurse
EDP	Essential Drug Programme
EmOC	Emergency Obstetric Care
ES	Executive Secretary
EU	European Union
EU-DHRH	European Union project Development of Human Resources for Health
FBO	Faith Based Organisation
FMA	Financial Management Advisor
FY	Fiscal Year
GI	Global Initiative(s)
GIFMU	Global Initiatives Fund Management Unit
GFATM	Global Fund for HIV/AIDS, TB, and Malaria
GoU	Government of Uganda
HC	Health Commission
HFA	Health for All
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRA	Human Resource Advisor
HRD	Human Resource Development
HSD	Health Sub-district
HSM	Health Service Management
HTI	Health Training Institution
HU	Health Unit
HUMC	Health Unit Management Committee
ICT	Information Communication Technology
ICDM	Information Communication and Data Management
IICD	International Information and Communication Development
IRCU	Inter-religious Council of Uganda
JMS	Joint Medical Stores

LLU	Lower Level Unit
MHCP	Minimal health Care Package
MoH	Ministry of Health
MoES	Ministry of Education and Sports
MoFEDP	Ministry of Finance, Economic Development and Planning
MoLG	Ministry of Local Government
MoU	Memorandum of Understanding
NGO	Non Governmental Organisation
OD	Organisational Development
NSSF	National Social Security Fund
PAF	Poverty Action Fund
PCS	Pastoral Care of the Sick
PEAP	Poverty Eradication Action Plan
PEPFAR	Presidential Emergency Fund for AIDS Relief
PHC	Primary Health Care
PHC-CG	Primary Health Care Conditional Grant
PMI	Presidential Malaria Initiative
PNFP	Private Not For Profit
PPPH	Public – Private Partnership in Health
P-FB	Public – Facility Based Private Not for Profit Partnership
PNFPP	
PSO	Personnel Services for Overseas
RC	Roman Catholic
RCC	Roman Catholic Church
SHI	Social Health Insurance
SC	Standing Committee
SVFOG	Vronestein Foundation
SWAp	Sector Wide Approach
SWOT	Analysis of Strengths, weaknesses, opportunities, and threats
TCS	Terms and Conditions of Service
TOR	Terms of Reference
TOT	Training of Trainers
UCMB	Uganda Catholic Medical Bureau
UCS	Uganda Catholic Secretariat
UEC	Uganda Episcopal Conference
UJAS	Uganda Joint Assistance Strategy
UJCC	Uganda Joint Christian Council
UMHCP	Uganda Minimal Health Care Package
UMMB	Uganda Muslim Medical Bureau
UMU	Uganda Martyr's University
UPMB	Uganda Protestant Medical Bureau
USA	United States of America

SECTION ONE: CONTEXT DESCRIPTION

1. Background

1.1 COUNTRY INFORMATION

Uganda is a landlocked country in East Africa. Its borders are formed by Lake Victoria on the south and south east, Kenya on the east, Sudan in the north, the Democratic Republic of Congo and Rwanda to the west and Tanzania in the south. The estimated population number is 28.2 million with an average annual growth rate of 3.4%[1].
In the decade 1992 – 2002 Uganda has realised significant improvements in the economy with an annual economic growth rate of +/- 6%. Inflation fell from 150% per annum in 1985/86 to an annual average of 4.8%. However, the percentage of the population living below the poverty line, which had been on the decline from 52% in 1992/93 to 44% in 1997/98 and to 35% in 2000, has risen slightly to 38% in 2003[2]. This has been accompanied by a marked increase in inequality, which has been on the rise since 1997. Poverty continues to be higher in the rural areas, with 96% of the poor living in rural areas in 2000[3]. The recent rise in poverty levels revealed, though, a proportionate rise in poverty higher in urban areas than in rural areas[4] (MoFPED, 2003) Regional disparities still exist with the Northern region lagging behind most of the country followed by the Eastern region[5].

The situation in the north is largely determined by the ongoing civil war, waged by the Lord's Resistance Army (LRA). Since serious negotiations between the LRA and the government have started in July 2006, there is now growing hope that peace may become a reality for this region.

The present government under the leadership of president Museveni has been elected into power in the beginning of 2006. After a period of controversy regarding the third term of the President, the election period was marred by irregularities. At present, however, the opposing parties are initiating dialogue again.

One of the major problems the new government will have to solve is the increasing corruption. The most prominent cases that came to light during the last year took place in the health sector[6]. The International Development Partners of the Government are taking these, and other indications, of inadequate and un-transparent governance very seriously and have withheld funds several times already.

1.2 THE UGANDAN DEVELOPMENT PLAN

The government started the development of Poverty Eradication Action Plans, as comprehensive development frameworks, at the end of 1999. These Ugandan Plans are the equivalents of what other countries call Poverty Reduction Strategies. The first full-fledged Poverty Eradication plan was implemented during the years 2001/03.

The UNDP report of 2005 lists as main achievements:

- a rise in life expectancy from 43 in 2000 to 45,7 years in 2003;

[1] Uganda Bureau of Statistics 2002
[2] Poverty Eradication Action Plan 2001-2003 and Uganda National Household Survey 2003.
[3] Poverty Status Report 2000
[4] Poverty Eradication Action Plan 2001-2003
[5] Uganda National Household Surveys 1999/00 and 2002/03.
[6] The Global Fund for HIV/AIDS, TB and Malaria, suspended its transfers between July 2005 and October 2005 due to the discovery of misuse of funds. A public inquiry indicated the involvement up to the highest level in the ministry. In July 2006 it became known that the allocation for Malaria prevention would not be transferred because of mismanagement of the procurement process.

- an increase of the national literacy rate to 67.7% in 2003;
- a rise in the national Human Development index from 0.449 to 4.888.

The Poverty Eradication Action Plan (PEAP) of 2004 presents the national development framework for five years up to 2009. This plan is the continuation of the 2001 /03 PEAP but then revised to address the regional the disparities as well as consolidate and extend the achievements in Human Development. In this revised plan the Government reaffirms its commitment to the Millennium Development Goals (MDG's) as these fully correspond with national priorities. However, in the PEAP document the Government does specify that the "the relative speed at which any particular target (of the MDG's) is approached will reflect the particular constraints and trade-offs that the country faces".

The Poverty Eradication Action Plan for 2004 – 2009 counts five pillars:

I. Economic management;
II. Enhancing production, competitiveness & income;
III. Security, conflict resolution and disaster management;
IV. Good governance;
V. Human development. This pillar includes health and education.

A number of crosscutting objectives complete the plan. The main ones are: mainstreaming the response to AIDS, mainstreaming attention for gender issues, and promoting cost-effectiveness through output-oriented programming.

The implementation of the PEAP is determined by the principles of sector and district responsibility and realistic assessment of what the country can afford. The tools for implementation are the Sector Wide Approach and Medium- and Long-term Expenditure Frameworks.

The Poverty Eradication Action Plan is funded through a board range of sources and mechanisms:

- Internal tax revenues
- The Poverty Action Fund: earmarked savings, resulting from the debt relief initiatives (HIPC), and budget contributions from International Development Partners (DP's;
- General budget support and sector budget support from the DP's;
- Project support from DP's
- NGO funding and out of pocket contributions of the population.

Macro Economic Constraints:
In 2003/04 Government decided that time had come to curtail the high levels of fiscal deficit registered by the Budget, which had hitherto been financed mainly through donors' inputs in Foreign Exchange7. As consequence Government spending has been capped and ceilings to sectoral budgets have rigidly been applied. Hence spending on social sectors has been limited. As most donors' inputs to the Budget target support to the social sectors, for the health sector this means in practice that additional funding, like Global Initiative projects, have to fit under the ceiling, e.g. these funds are not additional. As matter of fact, Global Initiatives and other Project related spending increasingly displace, from the overall health budget, the much more flexible component financed through taxation and donor's inputs. This policy figures among the main reasons why the budget for health is not – despite the many initiatives targeting health outcomes - growing.

[7] This arrangement, according to the Ministry of Finance, affected macro economic stability in two ways, i.e. by promoting over-valuation of the Uganda Shilling on the currency market (hence hampering exports) and by promoting inflation. Both resulting effects have, according to the MoFPED, negative influence on the much desired levels of economic growth.

1.3 THE DECENTRALISATION POLICY

Uganda has been implementing a systematic decentralisation policy since 1993, guided by the Local Government Statute of 1993, the 1995 Constitution, and the 1997 Local Government Act. This policy aims at devolution of budgetary powers to the districts. In 2004/05 full fiscal decentralisation, to district level, was introduced, in line with the Fiscal Decentralisation Strategy (FDS). The district councils now have gradually increasing autonomy in developing budgets and allocating funds between sectors to meet locally determined needs and priorities. Besides some near critical accidents, the allocations of PHC-CG to the Private Not for Profit (PNFP) health sector have not been negatively affected. However, it is highly likely that this is more due to a misunderstanding as to which ministry should set the guidelines for these allocations. The Ministry of Health (MOH) had included, in its guidelines for these allocations, that PNFP allocations were exempted from district re-allocations. At the end of the fiscal year 2005/06, it became apparent that this directive was not valid, as the Ministry of Local Government (MOLG) is the only authority to determine such exemptions.

In the course of 2005/06 and beginning of 2006/07 the number of districts was increased significantly, raising the number from 56 to 76. This is bound to have huge consequences for the budget for Public Administration.
In addition to this strategy the government intends to accelerate decentralisation further to county and sub-county level. In the health sector this will mean that the Local Councils four and three will increasingly be given the responsibility to set the budgets and channel allocations. As this next step has only just been announced, it is hard to predict what the implications for the health institutions, particularly of the PNFP, will be. In all cases they will need to strengthen the relationships with these councils and the corresponding health officials.

At the same time that decentralisation is accelerated there is a rising call for the installation of a regional tier as an intermediate level between the central level and the districts. The coming year will show whether is call will be heeded.

1.4 THE HEALTH STATUS OF THE UGANDAN POPULATION

The overall health status of the Ugandan population has not (yet) benefited from the economic growth, reported above. According to the successive Poverty Assessment reports, the population is strong aware that poor health is one of the main causes of poverty. In response to this concern the revised PEAP, under pillar four, stresses that good health is necessary prerequisite for Human Development. “It is important not just to improve the quality of life of an individual in terms of his/her general well-being, but also as an essential input for raising the ability of people to increase their incomes at a micro level, thereby contributing to poverty alleviation, and to facilitate a productive and growing economy at the macro level”.
With regards to health care services the plan gives priority to preventive health care and commodities for basic curative care.
That there is cause for concern can be concluded from the following basic statistics, reported in the HSSP II:

- Life expectance at birth: 45.7 years
- Fertility rate: 6.9 (among the highest in Africa)
- Child Immunisation (DPT 3) 83% (target 04/05 was 85%)
- Deliveries in Health Units: 24.4% (target 04/05 was 35%)
- Access to safe water: 62.6%

Indicator	1990	2000	Target 2005	MDG target 2015
Infant Mortality Rate (IMR deaths/1,000 live births)	122	88	68	2/3 Reduction: 41
Under 5 MR (deaths/1,000 live births)	180	152	103	2/3 Reduction: 60
Maternal Mortality Rate (MMR deaths/100,000 live births)	527	505	354	3/4 Reduction: 131
Stunting in children under five years of age (Chronic Malnutrition)	38	38.5	28	½ Reduction to 19%

The trends towards the PEAP and MDG targets:

There are significant disparities in health outcomes between the regions and between the poor and the wealthy. Examples of the latter are: the IMR stands at 60.2 deaths per 1,000 live births for the highest socio-economic quintile compared to 105.7 deaths per 1,000 for the lowest socio-economic quintile with an inter-quintile ratio of 1.76. Similarly, the Under 5 mortality rate for the lowest quintile is twice as high as that for the highest quintile.

The results of the 2005 follow-up Uganda Demographic and Health Survey (UDHS) are expected soon and it is hoped that the HSSP I has reversed the above trends. The stagnation of health outcomes in the past decade is seen as a manifestation of the underlying poverty with deprivation not only in nutrition, housing, water and sanitation, but also education.
The high disease burden consists of the communicable diseases and non-communicable diseases. Communicable diseases continue to be the leading causes of morbidity and mortality in Uganda. As no new data are available, the data of the Burden of Disease study done in Uganda in 1998 / 99 are still used. This study indicated that over 75% of the life years lost, due to premature deaths, are due to ten preventable diseases[8]. Peri-natal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), HIV/AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total disease burden. The common non-communicable diseases include hypertension, diabetes and cancer, mental illness, chronic and degenerative disorders and cardiovascular diseases.

HIV/AIDS
In 2004/05 a national Sero-prevalence and Behavioural study was undertaken and the results have recently been published[9]. The main findings are:

Indicator	Finding / outcome
Adult HIV prevalence in age bracket 15 – 49 years	6.4% overall (7.5% in female and 5.0% in male)
Age bracket peak prevalence	30-39 years
Number of new infections per year	100,000
Number of new infections among children 0-14	28,627
Ugandans living with HIV • Adults: • children:	945,000 • 805,000 • 140,000
Number of people living with AIDS	93,000

[8] National Health Policy 1999
[9] Uganda National HIV/AIDS Sero - Behavioral survey 2004/05, MOH March 2006.

Number of AIDS orphans Overall percentage of orphan children	1,000,000 14%[10]
Main contributing factors in transmission	Multiple sexual partners and genital herpes simplex infection

There are significant variations in prevalence by region, gender, wealth, religious faith, and age. For instance:

- The lowest prevalence is found in West Nile (2.3%) while the highest is in Kampala and central region (8.5%)
- The prevalence rises with rising levels of income, especially among women.
- The association between HIV prevalence and education levels appears to be unclear especially for males. In women the prevalence seems to rise with educational level up to "primary complete". From secondary level and above the reports shows some drop for both male and female.

In both urban and rural areas knowledge about abstinence as a method of HIV prevention is higher than the knowledge about condom although knowledge about both is high in general. In the whole country, primary abstinence (abstinence before any previous sexual contact) is common among the youth (54% for males and 58% for female). But what is called "Comprehensive Knowledge" (e.g. complete and correct knowledge about ways of transmission and prevention) was below 45% in all age categories.

Over time, prevention interventions evolved and now the Governmental Policy includes the full range of interventions available: IEC for behaviour change; condom promotion; Voluntary Counselling and testing (VCT); Prevention of Mother to Child Transmission (PMTCT); management of Sexually Transmitted Infections (STI); safe blood transfusions and Anti-retroviral treatment (ART). The study confirmed the need to continue the combined ABC (abstinence, be faithful, and condom use) strategy as best option for Uganda.

ARV treatments started in Uganda about two years ago, and currently 65.000 people are on treatment. Of the RC health service network 25 facilities are actively involved in the programme.
Funding for most HIV/AIDS prevention and care activities come from international DP's and then mainly Global Initiative programmes. Among others, due to the problems around the use of - and accountability for - the funds allocated under the Global Fund for HIV/AIDS, TB and Malaria (GFATM), first delays in the procurement of ART drugs have recently occurred for the first time.

1.5 The National Health Policy and the Health Sector Strategic Plan.

The National Health Policy dates from 1999. The overall development goal in the policy is *"the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life" (NHP).*
Under this policy a first Strategic Plan has been implemented between 2000/01 – 2004/05.

The implementation of the second Health Sector Strategic Plan (2005/06 – 2009/10) started in the fiscal year 2005/06. The HSSP II retains the same programme goal as for HSSP I, i.e. "*Reduced morbidity and mortality from the major causes of ill-health and premature death, and reduced disparities therein*" - to be attained through universal delivery of the Uganda National Minimum Health Care Package.
The overriding priority of HSSP II will be the fulfilment of the health sector's contribution to the PEAP and Millennium Development Goals (MDG) goals of reducing

[10] MoGLSD; Children on the Brink 2004 (http://www.mglsd.go.ug/ovc)

fertility; malnutrition; maternal and child mortality; and to reducing the burden of HIV/AIDS, Tuberculosis and Malaria, and reduce disparities in health outcomes among the lowest and highest income quintiles by at least 10% over the HSSP II period.

The health related targets of the PEAP for 2009, which also represent Uganda's commitment to attain the MDG's, have been set as follows, based on the status in the year 2000:

- Reduce Infant Mortality Rate from 88 to 68 per 1,000 live births
- Reduce Under-5 Child Mortality from 152 to 103 per 1,000 live births
- Reduce Maternal Mortality Ratio from 505 to 354 per 100,000 live births
- Reduce Total Fertility Rate from 6.9 to 5.4
- Increase Contraceptive Prevalence Rate from 23% to 40%
- Reduce HIV prevalence at ANC sentinel sites from 6.2% to 5%
- Reduce stunting in children under 5 years from 38.5% to 28%

To attain these targets the HSSP II out put targets are:

- Percentage of children <1yr receiving 3 doses of DPT/Pentavalent vaccine according to schedule by district from 87% to 93%
- Total (GoU and PNFP) per capita OPD utilization from 0.72 to 1.0
- Percentage of deliveries taking place in a health facility (GoU and NGO) from 24.4% to 50%
- Proportion of approved posts (HSSP I norms) that are filled by trained health personnel from 68% to 90%
- Percentage of health facilities without any stock-outs of first line anti-malarial drugs, Fansidar, measles vaccine, Depo Provera, ORS and cotrimoxazole from 40% to 100%
- Couple Years of Protection from 223,686 to 494,908
- Reduce the Case Fatality Ratio among malaria inpatients aged less than 5 years from 4% to 2%
- Proportion of TB cases that are cured raised from 62% to 85%

Base year 2003/04

HSSP II Framework for the Delivery of the Minimum Health Care Package is presented in annex VIII.

Principles guiding the implementation of the HSSP II are:

i) The Sector Wide Approach remains the key coordination and implementation strategy.
ii) Adopt strategies that would help overcome the key constraints identified in implementing HSSP I, enhance synergies in health interventions and between the various health-related sectors.
iii) Increase the focus on health outcomes in parallel with process and programme outputs.
iv) Establish effective affirmative action for the attainment of health equity by giving special attention to the most vulnerable groups (women, children under-5, the poorest quartile of the population, Internally Displaced Persons {IDP's}, Orphans, People with Disability).
v) Accelerate operationalising the Health Sub-Districts including the Village Health Team component.
vi) Strengthen management capacity at all levels.
vii) Increase spending on essential medicines, vaccines and other health supplies.

viii) Increase efficiency so as to mitigate the effects of the severe resource constraints (financing, human resources, effective physical access, essential medicines, management capacity, etc) that hamper effective performance of the national health system.
ix) Further strengthen the broader health partnerships, especially at the district level, including community participation, inter-sectoral collaboration and collaboration with the private sector.
x) Strengthen attention to gender concerns in the Health Sector Strategic Plan (HSSP) to take account of the socio-economic differences between men and women that influence their accessibility and utilization of health services.

1.6 THE PARTNERSHIP WITH THE PRIVATE NOT FOR PROFIT SECTOR

The Public-Private Partnership in Health is given specific attention in the HSSP II. The scope has been widened aiming at bringing all the main private actors on board. The presentation to – and adoption of the P-PPH policy is planned for, after the addition of the components for the Private Health Practitioners (PHP) and the Traditional and Complementary Medicine Practitioners (TCMP). Implementation of the policy and the guidelines, with respect to the PNFP will then start, with particular attention for promotion of the partnership at Local Government level.

The HSSP II clearly builds on effective PPPH implementation. It particularly recognises the PNFP facilities as integral part of the health system. However, the events of the past two years concerning HR's and PHC-CG allocations and releases have put a heavy stress on the relationship.

1.7 HUMAN RESOURCES FOR HEALTH

The HSSP II indicates that the Public and PNFP sector have a gap of around 4000 health workers compared to the HSSP I staffing norms. New norms are to be developed on the basis of actual workloads. Whether these will also consider the need to scale up services in response to the Global Initiative projects that have been awarded to the country, is not known. Following the High Level Forum on Health MDG's[11] recommendation that the minimum level, of health workforce density, should be 2.5 health workers per 1000 people, Uganda calculated that it would for instance require 18,000 more nurse and midwives.
In all cases it is evident that the gaps will not change in the positive direction. They will also be difficult to fulfil rapidly as the training capacity is limited and the exodus to other countries in the region and to developed countries is increasing.

During the past three years, two major developments concerning the health work force gravely affected the PNFP sector. First a 40 to 60% salary increase was awarded to public servants in the health sector that was not matched with an increase in subsidies to enable the PNFP sector to follow this increase.
Then in 2005/06 the districts and regional hospitals have been given the possibility to recruit more staff. Due to salary difference between the public and the PNFP sector, this has resulted in an exodus from the latter. Data show very alarming figures: compared to the average attrition rates of key hospital staff in 2003/4 and 2004/05, the upward trend is unmistakeable; for LLUs trend data are not available but attrition rates of last year for key staff are at staggering levels. While in Hospitals the average

[11] Report High-level Forum on Health MDG's: Addressing Africa's Health Workforce Crisis: and Avenue for Action, Abuja, December 2004.

attrition rate for Enrolled Nurses and Enrolled Midwives in 2005/6 was 29%, in LLUs this datum reached 46%!. Annex X gives an overview per category of staff.

A national HR policy has been developed and adopted in 2006. It is to serve as the basis for the elaboration of a Strategic Human Resource Development Plan. Though Partnership with the PNFP is mentioned in general and with regards the training of health workers, the policy does not include strategies to prevent present disparities and tensions.

1.8 NATIONAL HEALTH BUDGET

The HSSP II document specifically mentions that projections for health, in the Mid- and Long-Term Budgetary frameworks (MTEF and LTEF), fall far short of what is required to implement the HSSP. The targets presented in the HSSP II are based on what is needed to attain the PEAP and MDG targets, in the hope that these provisions will be adjusted. The document clearly states, though, that, if the budget is not increased, it will not be possible to achieve these.
The overall health budget for 2006/07 has been reduced, from 508.66 B USHS of last year to 375.38 B USHS (i.e. 7.7 $ per capita). If project inputs are excluded, the health budget has stagnated around 240 B USHS (i.e. about 4.9 $ per capita). The draconian containment measures have been justified with the need to cater for the energy crisis. This means that health spending moves further backward from the ideal figure of 28$ per capita necessary to finance the HSSPII[12], and the proportion of the health budget vs. overall budget (9.6%) is well below the target of 15% fixed in the Abuja Declaration.

Around 47% of the national health budget is funded by Development Partners. Contrary to one of the main goals of the Sector Wide Approach, an increasing percentage of the external funds are again provided in the form of projects. This is largely due to the rapid increase in the number of Global Health Initiatives.

The budget allocated to the PNFP sector, remains virtually the same for 2006/07: 17.74 Billion USHS, which represents 4.7%[13], of the total Health Budget of 375.38 Billion USHS[14]. Compared to the government's share of this budget of 240.42 Billion USHS, the PNFP share stands at 7.37%. This means that no compensation for the salary difference with government health workers has been secured yet. In addition is has to be noted that in an environment of ever rising service delivery costs, a stagnating budget allocation actually means a reduction.

The support for the provision of Essential Drugs to the PNFP facilities will also continue at the same level as 2005/06. This credit line programme has been extended last year with supplies for laboratories, which will also continue.

1.9 SECTOR WIDE APPROACH AND GLOBAL HEALTH INITIATIVES

Uganda embarked on a Sector Wide Approach for Health in 1998/99 to implement its National Health Policy and Health Sector Strategic Plan (HSSP I and II). This systematic approach, to develop the national health system as a whole, just started to yield results when new international policies and funding emerged. These Global Initiatives (GI's) followed from the Millennium Development Declaration of 2000 in,

[12] if ART treatment is excluded, otherwise the necessary per capita expenditure would reach close to 40$ per capita
[13] Against a contribution of the PNFP sector to the health outputs that can easily be estimated at around 30% if not more
[14] National Budget Framework Paper 2006/07 – 2008/09, MoFPED, March 2006.

which the international community pledged to half poverty by 2015. Each Global Initiative targets one, or a number of, specific diseases, or health problems, and has its own funding sources and mechanisms. In most cases the coordination mechanisms are separate from the Health Sector coordination mechanisms. In some cases even the government has little control over the use of these funds. The lack of coordination with the Health Sector Fora means that the SWAp is becoming less effective.

The programmes are essentially vertical in nature and use the project mode as funding and implementation strategy. But what is more important, these programmes hardly cater for the health system elements required to implement the projects. This entails that there is a growing competition for the scarce system resources, especially Human Resources, and a crowding-out of basic health services is coming ever nearer. The latter is certainly also aggravated by the budget ceiling imposed on health care in view of protecting macroeconomic stability. This also contributes to weakening the Sector Wide Approach, if not even the entire system.

The main Global Initiatives being implemented in Uganda are: GFATM: Global Fund for HIV/AIDS, TB and Malaria; GAVI: Global Alliance for Vaccine Initiatives; PEPFAR: President's Emergency Plan for AIDS Relief; PMI: Presidential Malaria Initiative. Though the other key diseases are represented, field workers report an increasing concentration on HIV/AIDS, particularly ART's.

1.10 Important National and International Developments

There are a number of developments emerging that, are already, or may have considerable consequences for the health sector.

1.10.1. Energy Crisis

During the past two years the reduction of the water levels in Lake Victoria has entailed a gradual decline in the production of electricity by the two hydro-electric plants, against an ever increasing demand. Since 2004/05 electricity is being rationed. Expectations that the water table will return to normal are dwindling and the national economy is starting to decline due to the lack of electricity. The huge rise in oil prices is a considerable additional obstacle. The country now has to invest in new power supply solutions and this requires high investments. The 2006/07 budget clearly shows that all sectors will be doubly affected: costs for normal operations are increased due to the high energy costs and contributions to the investments for new power sources are demanded from each.

1.10.2. Social Health Insurance Scheme

In July 2006, the Government and Ministry of Health launched the Social Health Insurance Plan. The aim is to gradually introduce health insurance countrywide starting with salaried workers. This system is to be operational within one year. All the principles, rules, regulations, tools, and guidelines still need to be developed.
For the rural self- or un-employed the government plans to promote Community Health Insurance Schemes. Here also details are not yet available.

It is highly likely that these schemes will, in time, drastically change the current financing structure in the health sector.

In all case the Social Health Insurance will add to labour cost, from July 2007 onwards, as it will be compulsory and both employer and employee are each likely to contribute 4% of the monthly gross salary.

1.10.3. New International Development Assistance Approaches

The World Bank and Ugandan Government have agreed to set up a new strategy and new mechanisms to assure that development assistance to the country is well targeted, coordinated, and effectively used. This strategy is called Uganda Joint Assistance Strategy (UJAS). The main characteristic is that International Development Assistance is to be pooled at government overall national budget level. The contributions will be coordinated and managed by the Ministry of Finance Planning and Economic Development (MoFPED). This means that the direct involvement of individual, multi-lateral or bi-lateral, Development Partners with a specific sector, like health, will be reduced. The majority of the current Health Sector DP's are considering joining this new strategy. For the PNFP this may mean that the international advocacy for their participation may disappear while its own advocacy efforts will have to target the MoFPED, government as a whole, and parliament.

At the same time a completely opposing move can also be noted. Some DP's are so disappointed by the recent corruption scandals and stagnating progress in key health programmes, that they are re-considering the project mode of funding.

2. The Roman Catholic Health Service Network

2.1 THE COMPOSITION AND CONTRIBUTION OF THE RC HEALTH NETWORK

The RC health service network continues to be the largest group of PNFP health facilities. It consists of:

Level of care	RC Number	Total FB-PNFP sector [1]	National total [2]
Hospitals	27 (18 HSD leaders)	56	108
Nurse Training Institutions	11	19	27
Total Health Centres (Lower Level Units)	234	663	3342
- Health Centres level IV	5 (3 HSD leaders)	10 (8 HSD leaders)	165
- Health Centre level III	149	255	904
- Health Centre II	80	404	2273

Source 1. MOH List of PHC Allocations 2006/07 / 2. MOH Health Facility Inventory 2004.

The main difference between the present number of RC Health Centres and the number presented in 2004, reflects the increase of HC accredited to UCMB. In 2006 one new Hospital was opened in Lugazi Diocese, it is called Buikwe Hospital and is the fruit of cooperation between Caritas Prague, the district of Mukono, and the Diocese. This hospital is yet to become operational.
In the past years Nyenga Hospital started a Nurse Assistant training programme. As the Ministry of Health has phased out this programme Nyenga is presently rethinking the future of this school.

Some key output data:
To give some indication of the number of population using the RC health services per region, as well as the contribution of the RC HU's to the HSSP targets, the data of 2004/05 show:

Region	OPD 2005/06	IP 2005/06	ANC 2005/06	Deliveries 2005/06	Immuni-sations 2005/06	DPT3 2005/06	Total population
North	624,497	147,773	88,106	20,034	445,642	30,414	5,345,964
East	310,374	68,442	35,267	8,373	245,385	12,362	6,301,677
West	491411	107,976	53,142	14,864	390,390	32,165	6,417,449
Central	747,565	118,866	84,870	25,856	453,781	61,275	6,683,887
Total in 2005/06	**2,173,847**	**443,057**	**261,385**	**69,127**	**1,535,198**	**136,216**	**27,244,426**
Total in 2002/03	2,198,771	288,443	270,565	48,208	1,229,043	261,400	24,748,977
Total in 2003/04	2,191,554	369,864	274,032	48,982	1,250,476	277,507	25,590,442
Total in 2004/05	2,147,286	434,047	298,572	61,622	1,417,204	137,403	26,460,517

Source: annual reports of RC hospitals and Health Centres per year.

For 2004/05 and 2005/06 it was possible to calculate the share of services delivered by RC and PNFP health units compared to the national totals: in 04/05 the PNFP as

sub sector provided OPD visits 17% Deliveries: 35%, DPT3 26%. The RC units share of the national output was respectively: 9%, 17%, and 9%.
In 2005/06 the PNFP sub-sector provided OPD visits: 17%; Deliveries 35%; DPT3: 29%. The RC units share of the national output was respectively 9%; 18%, and 13%.
In both years the PNFP facilities received 7.35% of the Government share of the health budget.

Annex XIA and XIB Present the evolution of the four key indicators over the past five years in health centres and hospitals.

2.2 ORGANISATIONAL STRUCTURE OF THE RC HEALTH SERVICE NETWORK

The Ugandan Catholic Church counts 19 Dioceses. Each of these dioceses has a number of health facilities, though the number and the levels of the institutions vary between the dioceses (from 2 HC's to 24, from 0 hospitals to 4). In line with the organisational structure of the Catholic Church the RC health institutions belong to their respective diocese (a few exceptions excluded). The Board of Trustees (BOT) of the Diocese is the highest authority for all diocesan institutions, as it forms the sole legal entity. The Bishop is the chairperson of the BOT.

2.2.1 Hospitals

A Board of Governors (BOG) is appointed by the local ordinary, the Bishop, and governs the hospitals. Daily management is entrusted to a Management Team consisting of a Medical Director, Nursing Director, and Administrative Director. The hospitals operate fairly independently and relate, in most cases, directly to the UCMB.
In quite a number of cases the congregation, involved in the hospital, has been appointed as managing agency, by the ordinary. This function presupposes that members of the congregation hold the three management positions. However as the congregations also experience Human Resource shortages this is most often not the case. The mismatch between the reality and the formal assignment are cause of concern as well as tensions.

2.2.2 Nurse Training Institutions

These have all been started by the hospital to which they belong. They are nearly all governed by the hospital BOG and daily management is entrusted to the Management Team of which the principal tutor then is a member. The main categories of staff trained are: enrolled nurses and midwives, registered nurse and midwives and laboratory assistants and technicians. Together with the eight training schools affiliated to Protestant and Muslim hospitals, the PNFP sector represent 60% of the nurses / midwives training capacity in the country.

2.2.3 Diocesan Health Departments

The Diocesan Health Department (DHD) consists, mainly of three components:

<u>Health Centres or Lower Level Units</u>
Since 1999/2000 all Health Centres have installed a Health Unit Management Committee (HUMC) composed of representatives of the most directly concerned stakeholders. The function of the HUMC is to ensure overall management of the LLU and ensure that the policies of the diocese are implemented. Daily management is the responsibility of the In Charge Nurse or Clinical officer. Religious staff and / or a congregation run a significant number of LLU's. In most case the congregation has been appointed by the Bishop to manage the institution. As in hospitals, the mismatch between the organisational structure declared in the units' charter and actual practice is an area of concern.

Diocesan Health Board

The Health Board of the Diocese (DHB) is the policy setting and controlling body for the health centres and programmes. It is appointed by the Ordinary and is formed by representatives of the main stakeholders concerned with the Diocesan health services. As the hospitals have their own BOG, this Board does not govern them but they do align their policies with – and provide technical expertise to – the DHB as members.

Diocesan Health Coordinators and Offices

The Health Co-ordinator (DHC) is the secretary of the Diocesan Health Board and the executive of the same. The main functions of the Health Office / DHC are to co-ordinate and support the health centres in their operations as well as in their relations with the Public health services and other health actors at district and central level. A process of revitalising these structures started in earnest in 2001 with technical guidance of UCMB. Since 2003/04 a number of Diocesan offices is assisted financially as well as financial constraints proved in many cases to be the largest obstacle to becoming effective.

An area of concern is the organisational embedding of the DHO. In a number of Dioceses this office is part of the Development / Social Service Department (quite often known as Caritas) of the Diocese. As the approaches, responsibilities and priorities vary considerably, the DHO is then often not well supported. In addition the DHB is then "de-facto" a committee of the Board of the Development / Social Service Department, meaning that lines of communication and authority become confused.

In the past few years some DHO's have been extended to include the function of Focal Person for HIV/AIDS. The main aim of this function is to initiate and coordinate a multi-sectoral diocesan response to HIV/AIDS. More and more the other Global health initiatives (malaria and TB) are being included in this approach.

2.2.5. The Health Commission and the Uganda Catholic Medical Bureau

The Health Commission, with its statutory committees, is the health policy advisory and supervision board of Uganda Episcopal Conference (UEC). It is composed of representatives of the internal stakeholders of the RC health Services. The policies are set in dialogue with all the affiliated health institutions during the Annual General Assembly (AGA – often referred to and better known as Annual General Meeting – AGM).

The Uganda Catholic Medical Bureau (UCMB) is the Technical - Executive Arm of the Health Commission the health office of the Catholic Church in Uganda. In the structure of the Church, UCMB does not have a hierarchical authority towards the health institutions and diocesan coordination bodies. Its core functions are co-ordination – providing services and technical advice –, liaising with the national/international health care actors, and advocacy. For the RC Health Services Strategic Plan 2001 / 06 and both the Operational Plan period, these functions of UCMB have been largely extended to enable the above member institutions to develop their capacities to improve performance and their management.

2.2.6. Religious Congregations

Religious personnel are present in 120 units (about half of the health units - including hospitals). About one third (81) of the units are managed by members of religious congregations. Congregations are the declared[15] owner of 32 Units (13%

[15] This datum has not been verified and may be somewhat over-estimated.

of the units). As for staffing, 366 members of religious Congregations work in health units, about 6.1% of the 5,958 employees of Catholic Health Units.

2.2.6. Internal Alliances

Within the "internal network", the RC Health Services have two key partners:

Joint Medical Stores (JMS)
JMS is jointly owned by the Catholic Church and the Protestant Churches. They set this organisation up in 1979 to ensure the provision of medicines and medical supplies to their health units. JMS is at present the largest drug supplier in the Country next to National Medical Stores. It is structural partner to the Ministry of Health. The co-operation has intensified during the past year as JMS has been assigned the responsibility to implement the Essential Drug Pull system for the PNFP health facilities. Also several Government facilities and districts are utilising JMS for their supplies.

Uganda Martyrs University:
Uganda Martyrs University, Faculty of Health Sciences (UMU – HS) provides Certificate, Diploma and MSc level courses in health service management. These courses are essential to the RCC health services efforts to improve the management of the institutions. The cooperation between UMU-HS and UCMB became less close in the course of the past four years. There is a high need to renew this cooperation in view assuring that the Faculty courses are adjusted to the needs in the institutions.

2.3 The Mission and Policy of the Roman Catholic Health Services 1999 - 2005

The Mission of the RCC Health Services was renewed, by the Uganda Episcopal Conference (UEC), in 1999 and can be summarised as[16]:
Providing dedicated professional curative, preventive, and promotional health care services that can enable the target population, especially the poor, to live their life to the full.

The core values enshrined in this Mission are: person centred approach and respect for the dignity of the human person; subsidiarity, justice, universality and equality; professionalism and the sacredness of life.

An analysis of the situation of the RC health service network in 1998/99, in comparison to the RC Mission and the environment in which they operate, indicated that the Policy for the period 2001 – 2005 should concentrate on:

- Coordination of services within the RC health network to enhance cohesiveness and assist each other in realising the Mission;
- Consolidation of services to safeguard and improve the existing services;
- Professionalism and quality in care as well as training to improve health outcomes for the population;
- Equitable sustainability to maintain access for the poor while ensuring continuity of the institutions as Not For Profit entities;
- Integration and cooperation with others to maximise results and optimise the use of all health resources.

[16] For the full text kindly be referred to the Document "Mission and Policy of the Catholic Health Service in Uganda", text approved by the Bishops Conference in Uganda, June 1999.

Three priorities aimed at focussing the efforts of all internal stakeholders during these five years:

a. The consolidation of the existing services and institutions;
b. Each diocese to set the pace for the implementation of the policy by adapting the policy and developing and implementing plans to this effect;
c. Monitoring the implementation of the plans would be the responsibility of the Hospital and Diocesan Health Boards, with assistance from the Diocesan Health Coordinators and UCMB, and this would be carried out with the use of objective means of verification.

In line with the organizational structure of the RC Church as well as the guiding principle of subsidiarity, the Mission of the Health Commission, of the UEC, and of UCMB, for this period can be summarised as:

Guiding and enabling *the RC Health Services towards the achievement of the RC Mission and Vision.*

3. THE STRATEGIC PLAN 2001-2005 AND THE OPERATIONAL PLAN 2004 - 2006

The assessment made in the late nineties pointed to the fact that the RC health services had lost, and were still loosing, in quality and sustainability. This was due to the erosion of their human and infra-structural capital during the years of civil strive and inappropriate responses to a rapidly changing external environment. The latter changes offered new opportunities to improve their services and sustainability, but also posed new threats if the responses remained inadequate.

In this light, the RC Mission and Policy priorities meant that the aim of the Strategic Plan for the period 2001 – 2005 should be:
To contribute to the improvement of the health status of the Ugandan population by improving access to health care as well as the quality of services.

In correspondence, the Strategic Goals were set as:

I. A recognised place in the national health system for the RCC Health Services;
II. Improved quality and sustainability in faithfulness to the Mission Statement;
III. Increased dynamic and transparent management;
IV. Improved cohesive internal organisation and external organisational arrangements;
V. Improved advocacy.

3.1 PROGRESS ACHIEVED DURING THE OPERATIONAL PLAN 2001-2003

The first Operational Plan, under the Strategic Plan, ran from January 2001 to December 2003. In November 2002, a team of external evaluators assessed the progress of the Operational Plan itself, at mid-term, and in the perspective of the strategic gaols. They concluded that to a large extent the plan was on track. They recommended a number of improvements and adjustments that would enable the UCMB to enhance its support to assure that the entire RC health network could achieve the gaols and objectives. These recommendations were:

- Develop and monitor quantified and measurable indicators to assure that the objectives are achieved.
- Operate the revised Operational Plan as a rolling plan within the 5-year Strategic Plan.
- Strengthen the Human Resource Unit of the Bureau and develop a more comprehensive Human Resource Development plan.
- Maintain and optimise UCMB's involvement in policy development and assure that RCC health service concerns are taken into consideration in national key health policy decisions.
- Develop strategic alliances with all partners as part of the process of ensuring managerial and financial sustainability.
- Give greater prominence to pastoral care in subsequent reviews of the Strategic Plan.
- Clarify the organisational position of the Nurse Training Institutions and ensure optimal use of their training capacity.

At the end of this Operational Plan period UCMB under took an extensive self-assessment in preparation of the development of the next Operational Plan. Two key

conclusions called for high attention in next Operational Plan, if the Strategic Goals were to be met:

A. Internally progress in service delivery, management, and integration, was being hampered by the limited human resource availability, both in quantity and quality.
B. Externally the continuing changes demanded a high level of responsiveness to enable UCMB and the network to meet new challenges. In particular the new Global Fund initiatives called for new actions from all.

3.2 THE STRATEGIC GOALS AND THE SPECIFIC OBJECTIVES OF THE OPERATIONAL PLAN 2004 - 2006

In response to the developments and the findings of the internal assessment, the purpose of the Operational Plan for the years 2004 – 2006 remained the same as for the operational plan 2001 - 2003:
To improve the functioning of the RC health services through improved support from the diocesan health offices and UCMB.

However, as the conclusions urged for a considerable scaling up of efforts to ensure that the strategic goals could be achieved, the overall theme of this operational plan was:
Investing in Faithfulness to the Mission.

This motto was chosen to convey the need for all internal partners to increase their commitment and efforts towards realizing the RC Mission. Most of all it was a call to UCMB and its Development Partners to continue its extended and accelerated technical support to enable each level to develop their capacity to perform and manage better.
Under this purpose and the motto two scenarios were developed. The first an ideal set of specific and measurable objectives, per Strategic Goal, that could accelerate achievements. In the event that the resources could not be found for the ideal scenario, a more modest scenario, leading to part achievement of the goals, was also developed. As it turned out the ideal scenario could be pursued to a large extent.

3.2.1 The RC Health Institutions occupy a place in the National Health System that is befitting to the needs of the population and their Mission

For this goal ten specific objectives were set and nine indicators to monitor progress. The main thrust of these objectives was to ensure that the Policy for the Public – Private Not for Profit would be implemented at each level and that all the RC health institutions would be recognised as operational partners in the health system at national, district and sub-district level. The fair allocation of and effective use of the governmental subsidies formed another important area of attention.

This strategic area also included the installation of a desk, within the structures of the Uganda Catholic Secretariat, which could enable all RC health and other social services to access and use Global Fund Initiative Funds (the Global Initiative Fund Management Unit or GIFMU). In support of implementation of projects funded multi-sectoral cooperation at diocesan level was an added as area of work.

3.2.2 Improved quality and sustainability in faithfulness to the Mission Statement

As this goal represents the core of what needed to be done to realise the RC Mission in Health: improve the performance of the health institutions, it counted the highest number of objectives (14) and progress was to be measured through the four key outcome indicators (access, equity, efficiency, and quality) and an additional set of fourteen output indicators.
The objectives covered the areas of financial management, reducing user fees and making them predictable (flattening), the Minimum Health Care Package (MHCP) and extension of the holistic care services, extending the accreditation system, Health Education and Promotion, and the transition to training a multipurpose nursing cadre, the Enrolled Comprehensive Nurse.

3.2.3 Increased dynamic and transparent management

This goal aimed at enhancing the capacity at each level to use all the available resources (human, material, finances, and information) in the best possible way to improve performance and to be a trustworthy partner in the national and district health care system. The eight objectives concerned planning and reporting by management and governance bodies (management teams and board of governors, health unit in charges and management committees, diocesan health coordinators and diocesan health boards). As all these stewardship functions require valid information the main emphasis was to be on improving the entire system of collection, compilation, analysis and use of data for decision-making.
Twelve output indicators were defined to monitor and redirect implementation.

3.2.4 Improved cohesive internal organisation and external organisational arrangements

In support of the previous goal, the thrust under this goal was to clarify and strengthen the organisational structures and systems that are required for effective governance and management of the RC member institutions, also in cooperation with other internal partners like the congregations. Eight objectives and seven output indicators were set for this area. These included strengthening diocesan coordination, improving charters / constitutions / statues at each level, aligning the terms of reference of the office bearers, as well as clear agreements between the diocesan authorities and the congregations involved in the diocesan health institutions. Two researches were foreseen one regarding the organisational embedding of the nursing schools and one regarding assumption of public duties as RC institutions. Improving human resource development was targeted through a research – tool development approach. The last objective aimed at identifying an adapted legal status for the RC health institutions in view of protecting the dioceses in the context of the integration into the district and the contractual approach.

3.2.5 Improved advocacy

The main aim here was to support the realisation of the RC Mission and the achievement of the policy as well as the strategic goals by motivating external partners to address issues beyond the control of the RC health network.

3.2.6 Overarching Objectives

This section covered a number of specific objectives that followed from the fact that during this operational plan the Mission and Policy Statement needed to be revisited and a new Strategic Plan be developed on that basis. In addition succession of the Executive Secretary was foreseen in this period and all stakeholders wished to ensure that the areas of innovation and emergencies remained on the agenda.

3.3 THE ACTORS AND IMPLEMENTATION STRATEGIES FOR THE OPERATIONAL PLAN 2004 – 2006

In accordance with the levels of autonomy in the RC Church and Health Services, and with the principle of subsidiarity, the key structural roles (core functions) of the Health Commission and UCMB are to guide, coordinate, represent, and technically facilitate the operations of the RC health services. This institutional role was to continue in the first place.

For this Strategic Plan and even more so for this Operational Plan UCMB's roles, under guidance of the HC, were to be extended to being an agent of change and building capacity in all aspects of improvement of services, quality, and management. The main target groups for these roles were the hospital Managers and Boards of Governors, and the Diocesan Health Coordinators and Health Boards. The Lower Level Health Units were targeted indirectly through the DHC and DHB. For this Operational Plan the Nursing (Health) Training Institutions and Congregations were identified as special target groups in view of their importance in addressing the human resource management and development objectives.

The main strategies planned for capacity building included hands-on technical assistance, tailor-made courses, technical workshops, and facilitating access to formal training programmes through the scholarship fund. These activities were to be supported by the development of new policies, tools, and approaches. As improving the functioning of the diocesan health coordination was a key objective, funding of diocesan health offices that did not have access to funding was added as support strategy.
Two other new strategies foreseen were: mainstreaming of multi-sectoral cooperation and stimulating the development of innovations. Monitoring and feedback, using the information collected and analysed at national level, was to continue both as strategy to strengthen improvements internally as for advocacy purposes at national and diocesan level.

3.4 RESOURCES PLANNED FOR THE OPERATIONAL PLAN 2004 – 2006

The budget for ideal scenario, for this Operational Plan amounted to 5.4 Billion USHS (or 2.7 Million Euro). Of this amount 349 Million USHS (174,518 Euros) would come from local income (mainly contributions of the members) and 2.2. Billion from the RC – UCMB Development Partners.
This budget covered:

- The core functions of UCMB
- Accelerated strengthening of Hospitals and Diocesan Health Departments;
- Installing the Global Initiative Fund Desk;
- Organisational set-up
- Training
- Research, studies, and consultancies;
- Information and communication technology;
- Capital development fund;
- Monitoring and evaluation.

As it turned out, the Operational Plan was financed in its entirety.

SECTION TWO:

PROGRESS ACHIEVED TOWARDS THE RC MISSION, POLICY, AND GOALS OF THE STRATEGIC PLAN 2001 – 2005.

4. THE RC MISSION AND POLICY STATEMENT

The Ugandan Episcopal Conference approved the RC Mission and Policy Statement in June 1999. The underlying aim of the Strategic Plan 2001 – 2005, and thus of the two Operational Plans that have been implemented under its guidance, was to enable all RC Health Service actors to serve and act in faithfulness to this Mission.

It is not evident to measure to which extent the Mission has been realised. This is first of all because the main tenets of the Mission are universal and timeless. As they stem from the social teaching of the Church, these do not change essentially through time. What changes is how they are formulated in a given context.
Realising this difficulty, at the end of the first operational plan, and in a bid to focus everyone's attention strongly on the key aspects of the Mission, UCMB proposed four key indicators (access, equity, efficiency and quality[17]).

The fact that all RC Health Institutions and their internal stakeholders are now well informed of the RC Mission and have adopted the core values in their institutional statutes is an important milestone. The progress achieved towards the four key indicators by the hospitals, mainly, indicates that a change of focus has set in (see 5.2.).

Compliance with - and implementation of - the policy goals and priorities can first of all be assessed through the revised governance documents: all institutions have now adopted these in their charters and constitutions. However, it did take five years to reach this stage. This implies that internalisation and enactment of the key concepts may still require time.
The other strategy put in place to monitor the implementation of the RC Policy Statement was the accreditation system. As 100% of the hospital and 86% of the Health centres have been accredited for more than two years now, this indicates that adherence is really strived at.
Reports of the Diocesan Health Boards and Coordinators, indicate that adherence to the policy priority of consolidation is not sufficiently abided by diocesan actors, mainly those indirectly involved (parish priests and councils and congregations). This suggests that more attention is required for the wider RC network to assure that the Mission and the Policy are known and adhered to by all.

[17] Access is measured in terms of number of Standard Units of Output, weighted against outpatients (SUO); equity is measured in terms of median user fee per SUO, efficiency is determined in two ways – cost per SUO and – nr of SUO per Staff (productivity) and quality is expressed as percentage of professional / clinical staff position filled by qualified personnel). The assessment of quality is the most complex of the four indicators, and the proxy used is, by necessity, very coarse. This has been improved in the second part of the Operational Plan and results are soon expected.

5. PROGRESS TOWARDS THE STRATEGIC GOALS

In this chapter the own assessment of UCMB is reflected. It is not aiming at exhaustiveness but mainly at identifying key issues and challenges that are pertinent for the next Strategic Plan. More details will be available in the annual / end of term report 2006.
To avoid duplications kindly be referred to chapter 3.2. fora short description of the directions aimed at per strategic goal.

5.1 THE RC HEALTH INSTITUTIONS OCCUPY A PLACE IN THE NATIONAL HEALTH SYSTEM THAT IS BEFITTING TO THE NEEDS OF THE POPULATION AND THEIR MISSION

At national level a long distance has been travelled to strengthen the Public- Facility Based Private Not for Profit Partnership in Health (P-FBPNFP). UCMB is a structural member of all the main fora of the Health Sector and has been able to attend most of the meetings. The Primary Health Care Conditional grants have been continued, though they have not increased as expected in 2004. In Annex X two graphs are presented showing the evolution of the allocations.
During the past two years, however, the process has stalled due to budgetary constraints, at government level, and the salary increases in public service. New avenues will need to be found to ensure a further constructive development.
With respect to the adoption of tools for the Partnership, the policy and the implementation guidelines were ready in 2003 but still await adoption by cabinet. As the policy was not adopted the contractual approach has not been developed further either.

At peripheral level the integration into the system has been fairly positive for the RC hospitals that are Health Sub-District leader (HSD). However, at the level of the dioceses and the Lower Level Health Units (LLU's) the process of integration has hardly progressed. The reasons for this are mainly related to inadequate diocesan coordination. Though progress was achieved in strengthening the performance of diocesan health offices, building constructive relations with the districts remains an area of great concern. This concern stems from the accelerating implementation of the decentralisation policy of government, which entails that budgetary allocations, for health, will soon pertain to the districts.

Under this goal tapping into the resources from the Global Initiatives (GI's) was given prominence. Here great progress was achieved through the establishment, within the Catholic Secretariat, of the Focal Point for HIV/AIDS, before this period, and the Global Initiatives Fund Management Unit (GIFMU) during this period. Both new colleague departments proved effective in accessing funds for the RC health institutions. Unfortunately this success is not without problems. At peripheral level the non-systemic nature of GI's tend to produce imbalances in service delivery and management (see further 1.9 and 7.3.3.).

The last area under this goal concerns cooperation with other actors. At central level the cooperation, with existing allies, remained good. The new initiative to enhance cooperation between the PNFP Health Training Institutions (HTI) did not materialise, due to reluctance of one of the Protestant Church partners.
At diocesan level the intended multi-sectoral cooperation has improved marginally due to the GI's. But the more important PNFP cooperation has hardly taken off. The reason is the same as for cooperation with District health actors: lack of a pro-activeness of the majority of the coordinators.

5.2 IMPROVED QUALITY AND SUSTAINABILITY IN FAITHFULNESS TO THE RC MISSION

This goal area is the most important in view of realising the RC Mission in Health. Just before the beginning of this operational plan period, UCMB developed indicators to measure the performance in the key elements related directly to the Mission: access to / utilisation of the health Units (HU's), equity, efficiency, and quality of services. In addition, this area also covered the range of services provided, compared to the Uganda Minimum Health Care Package (UMHCP) and to the Mission assignment of Holistic care.
The progress is evident for hospitals (see Annex XIB) with respect to access, equity and part of the efficiency (staff productivity). Costs of services are however going up, mainly due to the need to pay higher salaries. This means that further progress in improving access and equity may not be possible as the PHC-CG will not increase, during the two to three years, and thus the only recourse to increasing income is user fees.
With respect to quality of care and management, in the hospitals, the results of the surveys and other data indicate:

- patient satisfaction: has remained stable as the median value score stands at 16 points (source survey 2004 and survey 2006);
- drug prescription practices: has shown an improvement whereby the median value score has moved from 83 to 84 points (survey 2004 and survey 2006);
- percentage of qualified staff over the total staff: at the beginning of 2004 the baseline was 40% and at the end of the fiscal year in 2005/2006 the percentage of qualified staff stands 68%.

For the Lower level units this progress is much less evident (see annex XIA). Their accessibility has clearly improved, as has staff productivity. But cost of services show a swinging pattern and equity has worsened as user fees have increased. Regarding the quality components the results of the surveys show:

- the degree of complete implementation of the UMHCP: Health Centres II have progressed from 55 to 70% and Health Centres III from 68 to 75%;
- patient satisfaction: has shown an improvement as the median score moved from 13 to 14 points (survey 2004 compared to survey 2006)
- drug prescription practices: has improved as median score moved from 79 to 83 points (survey 2004 compared to survey 2006)
- percentage of qualified staff (including nursing aides) over the total of staff: at the beginning of the operational plan the percentage was 64% and it rose to 64% at the end of 2005. At the end of the fiscal year 2005/06 the percentage reported was 55%. This reduction is the result of the lower salary compared to government workers and two consecutive recruitment drives for government units.

The fact that these aspects can now all be measured is largely thanks to the UCMB efforts and investments in IC technology, development of the performance assessment methodology, training in data management, and the development of guidelines for various managerial processes. The feedback to DHC's and hospital managements, have meant that they and their Boards are increasingly aware of the findings as well as the need to document and review performance regularly. To ensure that these reviews are done and used to account to the governors and owners, the HC, on suggestion of the managers and DHC's, added an accreditation criterion to this effect. Nearly all hospitals sent this "Accountability for Faithfulness to the Mission" report to their Board. But only a minority of the diocesan coordinators did the same.

In view of improving quality of services and management, e.g. to improve corporate governance, the accreditation system was developed further both for hospitals and for

LLU's. Annually the HC added a number of criteria after consultation with the DHC's and hospital managers. In 2005/06 for the fourth consecutive year all 27 hospitals (=100%) were accredited, albeit with some pushing from UCMB. For the LLU's: after a considerable rise to 92% accredited in 2003/04, the percentage dropped in 2004/05 to 86%. However, in 2005/06 they did their utmost and out of 232 eligible for accreditation, 224 (= 99.5%) could be accredited.

Financial management is great importance to sustainability of the HU's. During this operational plan UCMB developed a standard financial management manual to enhance this. By June 2006, 21 out of 27 hospitals had adapted the standard and adopted their new manual. In Diocesan Health Departments progress has been little so UCMB is developing an adjusted standard manual and its adoption will become a statutory requirement in 2007.

Thus we can conclude that faithfulness to the Mission (or corporate governance) has improved in hospitals but at diocesan coordination level and in LLU's this progress is less evident.
For diocesan health departments this raises considerable questions regarding the effectiveness of the diocesan coordination structure. We may even need to raise the question of the diocesan health structure is viable.
For hospitals the progress in these areas is much better, but UCMB has realised that quite often the improvements have been made to "please" UCMB and are not fully integrated / fully embraced by the managements and boards. In addition many tools and process guidelines now have to be implemented consistently and verified regularly. These aspects call for intern process auditing.

One set of objectives, under this goal, did not progress as planned. This pertains to completing the holistic care package with social care and mental health care. No suitable solutions could be found to increase the capacities in the HU's for these aspects, and the demand from the HU's was very low. For pastoral clinical care and palliative care training programmes were identified but the capacity is limited meaning that fewer workers could be trained than planned.
A new area of concern is the effect of the Global Initiatives on the basic services. Evidence is emerging that the high attention given to the priority diseases, the high pressure to achieve the intended results, and the funding of variable costs only, is resulting in crowding out other services.

5.3 INCREASED DYNAMIC AND TRANSPARENT MANAGEMENT

There is a considerable overlap between this goal area and the previous one. Therefore what has been summarised there will not be repeated here. Issues not yet covered concern improving: annual reporting, overall management, use of information for planning purposes, Human Resource management, and the contributions of the Health Training Institutions.

Since four years, all hospitals submit their annual comprehensive and analytical reports. The percentage LLU's reporting has increased from 93% (2003) to 96% (2005) and the diocesan health departments to 94%. The timeliness, completeness, and quality of these and other reports have greatly improved during this past period. All other information sent to UCMB by the members is improving in quality.
This was made possible by the introduction of the Information and Communication Technology and all the related activities like training in HMIS and other data management, and the development of formats for automate reports. The real time communication connections, through email and website, that now exist, between UCMB and the periphery, greatly facilitated all processes of exchange of information.

At central level, the ICT technology, the improved information management processes, and the amount and quality of the information available, also supported the efforts in organisation development, financial management, human resource management and the assessment of performance.

Regarding improving overall management: in the LLU's, of the 230 HUMC's, 85 have three core members trained. The absence of further funding for the HUMC training, from the PPPH desk, formed the main obstacle to increasing this number of trained committees. Another approach needs to be found as the need to improve LLU management is great.
In hospitals: all hospitals now have one trained manager and 19 even have two trained managers. In addition, a range of new tools and practices have been developed and adopted. In general we can conclude that the management has greatly improved (see also efficiency gains). But we also have to conclude that there remain a lot to be done. First of all the complexity of hospital management increases continuously and this means the demands / objectives also keep increasing. Secondly systematic and strategic planning is not yet an ingrained practice in the RC hospitals (only 8 hospitals enlisted for the strategic planning training). Even contingency planning, to prepare for identified threats to continuity of services, proved difficult for most managers. On the one hand all this can be ascribed to the absence of a clear planning culture. On the other hand, development of a planning culture is hindered by the limited capacity to analyse and use information at hospital level. This conclusion is drawn from the fact that, due to efforts and investment in ICDM capacity development, information is now abundantly available (see above and 5.2.) but it is still rare to find that the same information, fed back to the hospitals is used effectively to plan.
The same conclusion can be drawn with respect to diocesan health departments / health offices.

Human Resource management: all hospitals and 17 DHD's now have an Employment Manual. The hospital managements have been enabled to improve their capacity to set staff establishments and plan rosters effectively. In addition the information available at UCMB on staff establishment, staff attrition, and remunerations has greatly improved. The foreseen study on HR development and retention could not be undertaken partly due to the fact that the actual research question could not be well identified. This was also hampered by the fact that so many other actors are undertaking studies in line with increased international attention for this subject. However, the main obstacle was the serious negative effect of the developments in public service. The salary increases here combined with two successive recruitment-drives caused a new exodus of staff (see 1.7.).
Staff development has improved, though, through the use of the scholarship fund: 1.4 % (140) RC staff members have received formal training in this period. This percentage represents twice that of government (0.7% according to the 2004/05 Annual report of the MOH). This percentage does no include other training opportunities through short courses of UCMB and hospital / diocesan scholarships.

The last component addressed under this goal concerned the Health Training Institutions. A Task Force was installed by the HC to investigate the assumed barriers to access to nurse training / under utilisation of the schools. The work of the TF greatly improved the understanding of all issues related to training health workers. It clearly indicated that the actual internal problems were mostly related to management inadequacies and thus relatively easy to solve. More importantly the findings put in evidence, that there are large structural problems to training in the country. The TF developed, and the HC adopted, a clear strategy and plan for the way forward in close cooperation with the other PNFP HTI. Unfortunately the proposed interdenominational organisation proved a 'bridge too far' for some owners of partner

PNFP HTI. Much time was lost waiting for the necessary approvals and thus no progress has yet been achieved in addressing the key issues.

5.4 IMPROVED COHESIVE INTERNAL ORGANISATION AND EXTERNAL ORGANISATIONAL ARRANGEMENTS

The components of this goal were: strengthening governance structures, regulating and enhancing the relationships between different internal actors (mainly between dioceses and congregations), improving the effectiveness of diocesan coordination, enhancing the organisational position of the HTI, and strengthening the legal status of HU's.

All hospitals now have an updated constitution that generally corresponds to the standard recommended by the HC, though six hospitals still have to formally adopt theirs. At DHD level: 12 out of 19 dioceses have an update constitution, and 202 LLU's have a valid charter. All these statutory documents include terms of reference for the Governing Boards and managers. In addition, procedures and tools have been developed to introduce office bearers to their functions and UCMB staff, or advisors, have induced 17 hospital boards and 9 diocesan health boards. Along the same line a format was developed to facilitate accountability for faithfulness to the Mission to Boards (see 5.2.)

In view of regulating / enhancing the relationships between diocesan authorities and congregations, a standard Modus Operandi and format for an agreement was adopted by the HC, the UEC, and the Superiors of the Congregations, in 2003. Unfortunately, though, there is still little progress in this matter. Only a few dioceses have signed such agreements with their congregations working in health. At the same time problems continue to crop up, and recently even some near critical accidents have occurred. This means this subject has to be addressed renewed emphasis in the coming period.

A lot of attention was given to improving the effectiveness of the diocesan health coordination offices, through technical workshops, training in ICT and HMIS, development of tools and indicators, and through financial assistance for five offices. In spite of these efforts, 8 DHO's scored below 50% in 2004/05, compared to a range of indictors. In addition, the performance of the others is not stable as the inter-annual variability was considerable. As the variances can often be retraced to changes in coordinators, we have to conclude that the effectiveness of a DHO largely depends on the person of the coordinator. These findings confirm what was reported under the paragraphs 5.2. and 5.3.: the diocesan coordination is still far from effective. For the next period, this calls for much more attention from all RC actors, and maybe even changes in the structures.

One clear outcome of the Internal Consultation Conferences of the HTI TF was that the schools should remain an integral part of the parent hospital organisation. This is the best way to assure quality of vocational training and viability / sustainability of the HTI. Both internal coordination as coordination with colleague PNFP HTI has greatly benefited from the TF activities. Though the plan to form a legally recognised organisation for the PNFP HTI cooperation did not materialise now, the school managements are resolute: inter-denominational cooperation should continue to be a major objective for the future.

Two objectives could not be brought home: the research on effective implementation of public functions while retaining institutional autonomy and the adjustment of the legal status of HU's to new external cooperation relationships (contracting etc.). Of

these two the latter will definitely have to return on the agenda as new plans of the MOH / GOU developments, such as Social Health Insurance, increase the need again.

5.5 IMPROVED ADVOCACY

This goal and it objectives demanded a huge part of UCMB staff attention and time. Progress in advocating for the RC health network is undisputed if measured by the subjects on the agenda of the national fora, invitations to attend important national and international meetings, and the continuation of the PHC-CG. It is also evident from the above reported results: these would not have been possible without the support generated through successful advocacy.
However, in spite of all the efforts and determination the most important result could not be brought home. This pertains to efforts to obtain an increase in the subsidy allocations to enable the RC HU's to match the salary increase in public service. To some degree the huge efforts caused discontent with the national partners (see End of Term Review report).
The Review and discussions with internal stakeholder also indicated that more advocacy for the RC Mission is needed in the wonder RC internal network to assure adherence by all.

The other objectives concerned forming and maintaining alliances and here also the objectives were achieved as the cooperation with allied organisations continued and most even improved.

5.6 OVERARCHING OBJECTIVES

This goal grouped a number of objectives that overarched all the others, or could not be easily accommodated under any of the other goals, or pertained to a subject UCMB wished to keep on the agenda. The objectives were:
Developing a disaster preparedness plan: this was not realised partly because it could not be given enough attention by the UCMB staff and partly because it did not really match well with the overall orientation of the Bureau. It remains a question whether this objective should be retained for the new period.

Revision of the Mission and Policy Statement and the Development of the new Strategic Plan: these were all delayed for reasons mostly related to external factors. In addition, it seemed more worthwhile to undertake these exercises after the planned Mid-Term Review to ensure that the lessons that could be drawn would feed into the new plans. In turn this review had to be delayed and became an End of term Review, due to the developments at national level. The review was done in April / May 2006: see the Report entitled "UCMB Operational Plan 2004 – 2006 Review, by Ria van Hoewijk (IC Consult, the Netherlands) and George Paryio (Makarere University, Uganda), June 2006. This plan was subsequently developed on the basis of the findings of the reviewers, the insights of a focus group, consisting of representatives all main internal stakeholders, and the lessons learn by the UCMB staff and technical advisors.

Under this goal it was also foreseen that the current Executive Secretary would be replaced by a Uganda successor. This proved unfeasible during a period of important upheaval in the external environment. It is expected that this could be realised in the coming year.

Keeping innovations, in care and management, on the agenda was the last objective here. This proved less evident as expected. On the one hand not many innovations

are occurring in the field of health, if one excludes international developments that enter the agenda in other ways. On the other hand the RC health agenda already comprised a long list of priorities and the external developments brought continuous changes. This meant that insufficient time could be given to this subject. UCMB is convinced though that this objective should be kept on the agenda to ensure that important developments are not missed.

5.7 THE ACTORS AND STRATEGIES USED DURING THE OPERATIONAL PLAN

In the previous section a number of concerns regarding the main actors have already been raised so they will not be repeated.
The selection of strategies was adequate as they enabled UCMB and the RC members to achieve all the above goals and objectives.
The largest stimulant, to improving performance in the health units, proved to be the "Monitoring and Feedback Strategy". This strategy, made possible by the presence of the Information Communication and Data Management Advisor (ICDMA), consisted of putting in place the ICT network, between Bureau and the periphery, building the capacity for communication and data management, collecting and analysing data at central level, and presenting the findings to the member institutions. It also included cooperation with the Health Management Information System department (HMIS) to ensure that the HMIS can also be fully applied in the RC HU's.
The information collected and analysed, at national level, enabled the members to compare their own performance, over time and to that of others in the network, raising the willingness to act. At the same time the results and findings enabled the Bureau to tailor all support better. In addition, the compiled data, or evidence of the improved performance of the RC HU's, greatly supported the advocacy efforts of UCMB at national and international level.

The accreditation system was developed as way to improve the quality of services and management and thus developed as an objective under the goal two. However, during this period it also turned out to be an effective strategy to assure that improvements were actually implemented. In the words of the reviewers: after a period of sensitising and building capacity to implement certain improvements, including these then as accreditation criteria worked as the proverbial stick.

5.8 CAPACITY OF UCMB

During the Operational Plan period 2004-2006, UCMB was able to achieve the above results because the allocated financial resources allowed it to recruit the human resources required. The total number of staff members reached 17, and consisted of:

- five core staff members: executive secretary, assistant executive secretary, administrator, secretary, and driver
- three expatriate technical advisors: information technology and data management (ICDMA), organisational development (ODA), and financial management (FMA)
- four local technical advisors, of which three were recruited to replace the expatriates: human resources (HRA), junior ODA, junior FMA, and junior ICDMA
- three additional support staff members: system administrator, data operator / documentalist, and additional driver.
- two part-time contracted consultants: web-administrator & programmer and ICT system

This present staff number represents a huge increase compared to the period before the implementation of the 2001-2006 Strategic Plan, when the Bureau only counted the core staff. However, that it was needed is proven by the results obtained.
This increase meant that new premises were acquired in 2002 but these are already insufficient.

5.9 UTILISATION AND RETURNS OF FINANCIAL RESOURCES

The estimated budget for the Operational Plan 2004 – 2006 stood at 2.7 Million Euros. The disbursements received and revenues generated are projected to amount approximately to 2.9 Million Euros, by the end of 2006. Of this allocation UCMB is set to use / absorb effectively about 90%.
One can ask what this budget meant per member of the RC health network. Without taking any of the differences between the members into consideration the total number of 'units' is 280 (27 hospitals, 11 schools, 19 dioceses, 234 health centres). Thus the total amount spent by UCMB in support of the members translates into +/- 6.4 M USHS per unit per year (= +/- 3,100 Euro). If the scholarship fund is taken out of the equation this amount is +/- 2,500 Euro per year per unit or 5.2 M USHS.

If we compare the budget to the period before the start of this Strategic Plan: the budget has increased from 500 Million USHS in 2000 to 1.9 Billion USHS. This huge increase does mean that the dependency form external funding has increase enormously and that to an extent the sustainability has decreased as local income represented 13% of the budget in 2002 and in 2005 it resented 9%.
This in spite of the fact that the local income, from contributions of the member institutions, has grown from 5 M USHS to 50 M USHS, which definitely is a sign that the services of UCMB are perceived as useful.

5.10 CONCLUSIONS AND CONCERNS

The above internal assessment shows that UCMB and the RC health institutions have been able to attain nearly all the objectives of this Operational Plan period. In addition if we consider the entire Strategic Plan period they have travelled far towards the strategic goals. It goes without saying that there are still many points of concern and new challenges to be met. These are reflected in chapter 7. Here we merely wish to point at a few overall conclusions and issues directly related to the Bureau.
The first is that the effectiveness of the Bureau, in representing and assisting the RC health network, has increased the demand for its services. This demand is in line with identified internal and external needs and challenges. The increased demand does entail that a high level of rare skills remains necessary. These rare however expensive as hard to find and retain. It also means that a further growth of the capacity of UCMB may be required. This in turn will increase the need for office space and thus costs entailing a higher dependency on development partners.

In the context of developing a new Strategic Plan, it is important to reflect on the principle of growth: Can it occur? Should it occur, even if the demand is evident? In this perspective the larger organisation, to which UCMB belongs (UCS), also needs to be taken into consideration. The essential basis for the decision lies in the Mission of the RC health services, e.g. in the need to contribute to improving the health of the poor and disadvantaged. As this need is still enormous the RC health institutions have to improve their performance and management and thus all the challenges identified under chapter 7 have to be addressed.

6. FINDINGS AND RECOMMENDATIONS OF THE END OF TERM REVIEW OF THE OPERATIONAL PLAN 2004 - 2006

The Health Commission contracted two external consultants to undertake a near End of Term Review[18] of the implementation of the UCMB Operational Plan 2004 – 2006. The terms of reference asked them to

- Assess the effectiveness of the implementation of the Plan, with respect to meeting its operational objectives and advancing the pursuit of the underlying strategic plan
- Identify issues emerging in the ever-changing external/internal environment that may require substantial modification of the Mission and Policy of RCC health services and the new related Strategic Plan 2006-2010.
- Recommend actions and changes where relevant.

The methodologies used in the review were largely qualitative and placed emphasis on triangulation of findings from a range of approaches (document study to interviews with representatives of all the main internal and external stakeholders)

The consultants state that UCMB, and the RC health services network, should be applauded for their achievements, which are un-disputable, both according to perception of the actors interviewed and as can be concluded from objective documentation of progress.

6.1 ACHIEVEMENTS

Their review of the Strategic Objectives and Bureau activities concludes the following achievements:

- The catholic and PNFP health sector receives a non disputed recognition by government and development partners for the important contribution they give to the achievement of the HSSP I (and HSSP II) targets and the health-related Millennium Development Goals (MDG's).
- Faithfulness to the mission of catholic health units has definitely improved and is well documented: improvements are crystal clear on access and efficiency;
- Further improvements on equity are not really achievable by UCMB and the network alone;
- The internal relations, both within a facility and within the network of UCMB, have greatly improved;
- All the afore mentioned achievements were greatly facilitated by the improved availability of accurate and timely data, generated through the unique Information, Communication, and Data Management investments;
- Management processes register an increased transparency and accountability upward (but much less downward, e.g. towards the population);
- The UCMB invented accreditation process greatly enhanced the understanding of the importance of adhering to quality criteria. It gives the UCMB facilities a head start, as accreditation will sooner or later be part of the health quality assurance mechanisms;

[18] For details of the Terms of Reference, and details of the Findings, kindly be referred to the Report "UCMB Operational Plan 2004 – 2006 Review, June 2006, by Ria van Hoewijk (IC Consult, the Netherlands) and George Paryio (Makerere University, Uganda).

- External relations are at the moment a bit strained by the predicament of the units and by the slow progress of the idea and practice of partnership in districts;
- The affiliated units do not question the legitimacy of UCMB's existence and operations, as they perceive the services received as pertinent and precious.
- In addition, the work of UCMB has created a sort of quality yardstick for other internal and external actors;
- The Bureau can count on committed (traditional) donors and partners, whose trust for UCMB is very strong.

6.2 POINTS FOR CONSIDERATION IN THE NEW STRATEGIC PLAN

The report points out a number of issues that may need to be taken into consideration when preparing the plans for the following period:

- The variance in performance between different diocesan health offices and between different hospitals, with respect to putting in practice improvements in management and accountability can often be retraced to weak support from Governors and local church leadership. As UCMB has no hierarchical power this support is essential for further improvement of performance.
- Some of the operational objectives could not be pursued (areas of social welfare, and mental health, disaster plans….).
- As an "agent of change", UCMB seems to have identified the right strategic objectives and methodological approaches (i.e. advocacy and lobbying, capacity building, use of information, hands on technical assistance….), although with perhaps too much emphasis on technical and managerial skills and too little reliance on 'soft skills' or leadership skills.
- Continuous planning, monitoring, and evaluation may be more effective than only an annual review of progress.
- More reliance on softer (conciliatory-constructive) approaches is also recommended vis-à-vis the relationship with Government.
- With respect to the use of resources the Bureau seems to be able to absorb up to 85% of the resources at its disposal.
- Concerning the internal UCMB organisation, the reviewers suggest that it is time for the current Executive Secretary to move towards a more "behind-the-scenes" supportive role.

With regards to the Country context, the consultants advise to take adequate stock of the following developments:

- The increasing economic hardships (with a health budget at historical minimum) that certainly will hamper efforts to further improve equity.
- The fragility of Government commitment to Public Private Partnership.
- The progressive tendency towards global initiatives which all have specific diseases or problems as their main focus and corresponding targeted funding mechanisms (re-verticalisation).
- The increasing costs of health care combined with an often-overwhelming pressure to achieve targets.
- The widespread perception of corruption.
- The huge problem of emergency in the North.

6.3 INTERNAL SUCCESS AND RISK FACTORS

When critical factors of success are considered, the consultants conclude that these critical factors could easily be identified:

a. Quality of data management, which has been outstanding, and has been of essence for the achievements in advocacy and lobbying as well as in organisational capacity building;
b. Reflection and learning capacity and willingness are extraordinary;
c. Clear balance between the 'technical' and the 'spiritual' dimension of UCMB as an organisation;
d. Good mix of high profile professionals, committed, well skilled support staff and competent management;
e. Dedication for the work is high and sometimes possibly even too high
f. Flexible and adaptable funding mechanisms;
g. Backing and trust from the church leaders;

They stressed that for the future these factors need continuous attention and fostering to assure the achievements are maintained and can be extended. If neglected these same factors easily turn into risks.

6.4 RECOMMENDATIONS FOR NEXT STRATEGIC PLAN

The evaluators recognised clearly that the present external environment is far from conducive for a smooth continuation of the development and even poses considerable threats. However, as the RC health institutions are integral parts of the national health system, opting out is not a feasible option. The main thrust should be on continuing to play an active role while at the same time protecting, as far as possible, the autonomy of the network. Generalised adherence to the RC Mission and Policy Statement will be essential here.

For the new Strategic Plan, the report concludes further that the Goals remain valid but the directions, which these should focus on, include:

A. Continued and reinvigorated dialogue within the PPPH partnership
B. Striving for revival of PPPH Desk as essential mechanism for the development of the PPPH.
C. Building new alliances both nationally and internationally to increase the potential to mobilise resources to further enhance the RC health sub-system. This should include enabling the institutions to build alliance at district / diocesan level for the same reasons.
D. Investing in the development of leadership, training, and negotiation skills for change and integration into the national health system at all levels.
E. Supporting the strengthening of the national health system as a whole by piloting co-operation initiatives, like for instance improved HSD functioning
F. Developing the right mechanisms and the capacities that can enable the RC health institutions to include those vertical programmes/projects that match well with the Mission and their status as these programmes are going to stay for the coming years.
G. The situation in the north is now a high priority on the national and international agenda. The UCMB affiliated units should receive extra support from UCMB to deal with the influx of funds as their need to strengthen their capacity is greatest.

The consultants propose a number of practical actions that could assist in increasing the results of these last months as well as be carried forward into the new plan period.

- Stay alert on the quality of the communication and dialogue regarding the PPPH at national and decentralised level to improve the relationship at each opportunity.
- Accelerate the development of adjusted coordination structures for the diocesan health coordination by the Organisational Development (OD) advisors to enhance diocesan coordination.
- Continue the systematic OD approach for the hospitals and diocesan health offices (assessment and feedback) and development of self-assessment tools for these same levels.
- Continue this approach as an interdisciplinary approach with the other UCMB advisors to enhance inter-linkages and comprehensive development of the management structures and capacities.
- Continue the contextualised / tailor made OD and Financial Management approach to assure that these respond to the particular development level of the concerned diocese or hospital.
- Continue support for contingency planning, including the development of various scenario's, in the hospitals instead of embarking on full-fledged strategic plans for every hospital, as the situation is too volatile for the latter at this stage.
- Consider decentralising UCMB's support through either "account managers" (each UCMB technical advisor is first contact person for a number of dioceses and hospitals) or by setting up regional UCMB offices.
- Continue the exercise to review and renew Memoranda of Understanding between the assisted dioceses and hospitals. Gradually shift in these towards a result oriented approach based on capacity assessments instead of needs assessment.
- Develop other strategies that stimulate the institutions to take initiatives and become pro-active for their own development (moving from push to pull).
- Replace gradually the trainer, or advisor, dependent methodologies for capacity development towards more peer-based approaches (learning from each other).

It goes without saying that the consultants realised that the above recommendations have considerable implications. The main conclusion here is that, for the coming three to five years, the joint RC health network – UCMB efforts, should continue at the same level of investment. The overall aim should be to assure that the innovations and capacity improvements take a very firm root. To reach this aim the differences should be in the strategies and methods used. This entails that the professional profile of UCMB needs to be maintained for the medium term to allow for additional learning and institutional strengthening.

The capacities of the present Executive Secretary will be particularly necessary for high level policy analysis and guidance and liaising with the congregations and the church authorities. Crucial areas here will be fostering adherence to the RC Mission in Health at all levels of the church structures and strengthening the modalities to protect the autonomy as integral.

7. CONCLUSIONS AND LESSONS TOWARDS THE FUTURE

In this chapter the key issues that require attention in the new Strategic Plan and Operational plan are summarised. These are largely the issues brought forward by the Focus group members and UCMB staff. Of course there is a considerable overlap with the recommendations of the reviewers. Where the views differ, the reasons or an alternative approach is explained.

Apart from the first, the order in which points are presented follows a logical order rather than an order of priority. They may be identified as separate issues but we need to realise that they are interlinked as one affects, or depends on, the other. This applies to the internal challenges as well as to the combination of the internal and external challenges, or the combination of external challenges.

The external evaluators conclude that the overall strategic goals and the implementation framework developed thus far are still relevant. This is not because nothing was achieved, to the contrary, but because:

- These goals are to a large extent generic and thus remain valid in the life of and organisation. What changes, and should be changed, through time is the ways and means to pursue these goals.
- Moreover, in our present situation, the targets that the RC health network had in view, when the first strategic plan started, may have been achieved but in the meantime internal and external developments call for other, or higher, targets (or as someone put it: the goal posts keep moving!)

7.1 THE KEY CHALLENGE: HOW TO IMPROVE EQUITY?

From UCMB's own internal assessment and from the assessment of the external consultants, we have to conclude that the biggest challenge in the coming time will be: *How to Improve Equity?* Or how to remain faithful to the preferential option for the poor as enshrined in the Mission. Resources are scarce and costs of health service delivery are rapidly rising. All actors in the RC health service network will need work together for a two-pronged approach:

- Improving efficiency further[19]
- Making optimal use of the available opportunities.

The first certainly should include consolidation of the existing services and institutions. The second has everything to do with all the new sources of funding emerging. The most known are the Global Initiatives for specific diseases and health problems such as GFATM: Global Fund for HIV/AIDS, TB, and Malaria: PEPFAR: Presidential Emergency Programme Fund for AIDS Relief, and PMI: Presidential Malaria Initiative. These programmes have very specific diseases or health problems as their focus and have their own funding sources and mechanisms. This "vertical" approach stands in opposition to the system development approach that UCMB has pursued to date.

In most cases the funding that can be obtained mainly covers the variable costs of providing the related services, and then often not all of these. This entails that the health institution has to cover at least all the fixed costs, e.g. the costs to run the systemic parts of the organisation.

Based on the Mission and Policy Statement, RC health actors are convinced that the system development / strengthening approach should remain the overall orientation. This approach is key to ensuring that institutions are enabled to provide integrated curative, preventive and promotional services. The key challenges are therefore:

- Establishing ways to access these funds including the necessary additions for the fixed ("overhead") costs (e.g. be able to argue the case for the coverage of these costs with adequate data);

[19] As the RC units have already achieved considerable efficiency gains it is possible that the law of the diminishing returns soon will apply. However, attention will need to remain focused.

- Using the funds adequately to produce the desired results without crowding out the basic services.

7.2 CHALLENGES WITHIN THE INTERNAL ENVIRONMENT

The following challenges are those faced by the internal actors. Though identifiable as such, they have to be read in the context of the external challenges, as these either put them in evidence or cause / exacerbate them. In all cases most external challenges raise the need to address these internal challenges.

7.2.1 Embedding the RC Mission and Policy

The RC Mission and Policy in Health is part and parcel of the entire Mission and Policy of the Church. Adherence to - and support for – them still need significant strengthening at all levels. In health institutions, the fact that a number of instruments (constitutions / manuals) have been adopted late and more "to please" UCMB, means that they are not yet well internalised, or rooted.

At diocesan level we have seen that a lack of understanding and support from the church authorities hampers the development of better performance of the diocesan health coordination structures and that of the hospitals. In addition, the actions of other church actors (parish priests and congregations), when not sufficiently informed / aware of the demands of the Mission, sometimes impact on the ability of the health institutions to remain faithful to the Mission. As during the past years, specifically the policy to consolidate, has not always been adhered to by others, there is a need to work towards a better understanding and support from the church leaders.
A consistent adherence and full support from these leaders will also be needed for effective advocacy at each level as health issues increasingly move to the political level.

7.2.2 Enabling the RC Institutions to take the Lead Role

Even though, in line with the principles of the Mission, UCMB's main aim was to build the capacity at the level of the RC institutions, it has been very much in the driving seat these last years. It was UCMB who indicated where changes / improvements were called for and who developed the initiatives to address these. This is understandable from the perspective of where the key actors were at the time the Strategic Plan started. It is also understandable from the perspective that UCMB is at the central level. It receives first hand knowledge of what is happening / coming and, through the analysis of data and interactions with various actors, can oversee developments in all the dioceses and hospitals.
However, this has resulted in a certain level of dependency on the side of the other actors, as they tend to wait for UCMB to tell them what to do, what next to improve. To build and embed local capacity it is now time to turn the roles around: the implementers (in the largest sense governors / managers / diocesan coordinators / ….) need to start telling UCMB what they need to address their own problems. Or in other words UCMB needs to change its methods of work to assure that the driving force for change starts coming from the bottom to the top.

This "enabling" is also needed in the context of the decentralisation policy of the government. More and more the district will determine their priorities and budgets and this will certainly call for different responses from the RC and other PNFP institutions.

7.2.3 The Need to accelerate the Improvement of Management Systems and Capacities

The above assessments of the progress (chapter 3) indicate that the uptake of new tools, guidelines, and training content is not always complete and / or the changes are not yet fully internalised. This can have many reasons, of which the previous point may be far from the least (4.2.2), as this dependency could entail that implementers do not really own the changes. All the more reason to initiate a reversal of the driving role.

However, we have to realise that time is against the health units in this. Developments like the new verticalisation of funding (see Global Funds for specific diseases and health problems) and the announced Social Health Insurance Scheme (see next chapter) will result in new strains on the management systems. They may even oblige to revise the systems again. If the hospitals and health centres do not improve their systems and capacities rapidly they will certainly have greater problems in sustaining themselves and may even loose out.
The staff attrition, experienced thus far, magnifies the call to improve systems and tools.

7.2.4 Translating Technical Knowledge into Practice

The evaluators, correctly, conclude that UCMB has mostly concentrated on the development and transfer of technical knowledge in its capacity building efforts. But, in an environment where a few persons gain this knowledge and are then requested to enable others to change, technical know-how, is often not enough. Their recommendation to include “soft” skills is understood by UCMB to mean that more emphasis is needed on developing the skills to lead change (leadership skills and skills to foster change) and to train others in turn (training of trainers). In addition, as the decentralisation progresses, advocacy and negotiations regarding cooperation and integration will need to take place at decentralised level. The diocesan coordinators, hospital managers, and governors will need to acquire these skills to this purpose.

7.2.5 Transfer of UCMB Role in Training

The need to enhance management and governance also means that the new generation of managers / leaders needs to acquire both the technical knowledge and leadership / change skills during their professional or post-graduate training.
Most of the UCMB initiatives in new training programmes (see ICT, HMIS, Financial Management, etc) stemmed from the need to equip the present managers and health workers for the new methods. However, this cannot be a structural role of UCMB. Therefore these courses need to be taken up / integrated into the programmes of institutions that do provide the original professional training.

To this purpose a structural cooperation with other institutions needs to be developed to embed all training efforts of UCMB into ongoing training programmes. This should start with the development and implementation of course in leadership / change skills as this area is new for UCMB.
Efforts in this direction did not succeed in the past, but new ways need to be sought and pursued. A first discussion with Uganda Martyr’s University, Faculty of Health Sciences, promises new openings.

7.2.6 Enhancing the Capacities at level of the Governors

During the last years UCMB has mainly focussed on the managers of the hospitals and diocesan coordinators. Their improved abilities and tools have not yet been matched by similar improvements at the level of the Governors. Effective governance depends on appropriate division of responsibilities and good cooperation between the governors and the managers as well as on transparent checks and balance mechanisms. To assure these, the capacity, in terms of skills and tools, of the Governors, require more attention.

The Health Unit Management Committees (HMUC) are to some extent governors of the Lower Level Units (LLU's). Due to a number of reasons, the plan to train the three core members of the HUMC of all PNFP LLU's, in cooperation with the MOH-PPPH Desk, could not be completed. This plan needs to be continued to raise the level of governance here. Then the capacity, to continue this training, needs to be embedded in the DHO's and / or the Health Training Institutions as the turnover of members of HUMC's is, and will inevitably remain high.

7.2.7 Enhancing the Diocesan Health Coordination

Progress in the four key indicators (access, equity, efficiency, and quality) has been least in the health centres (LLU's), in spite of the fact that they receive relatively higher government subsidies than hospitals. The reasons are multiple, but UCMB's experiences of the last three years have shown that two factors are determinant. These are: weak leadership from the diocesan health board and insufficient technical guidance from the coordination office. In turn these have a lot to do with weak support from the diocesan authorities (see 7.2.1.).

The diocesan coordination is crucial for the health centres, not only because UCMB can hardly reach them. Of more importance is that, in the context of the decentralisation policy, they require technical and advocacy support close at hand to be able to build / maintain an effective relationship with the HSD and Districts.

In addition, staff attrition has a larger impact on small health units / teams and therefore assuring continuity of services demands deliberate support from the diocesan level.

Fostering support from the diocesan authorities and external development partners will have to go hand in hand with capacity building. In addition, new forms of organisation at diocesan level and new forms of cooperation with hospitals should complete these efforts.

7.2.8 Innovating and Enhancing the Roles of the Congregations

During the past years UCMB has not succeeded in enabling the congregations to develop and strengthen their roles and contributions. This has a lot to do with an absence of an adequate forum for discussion and the considerable gap between the traditional roles and the reality, between expectations and capacities.

All actors in the RC health services remain convinced, though, that the congregations are essential actors, if not the backbone of the RC health network. In the coming period new efforts to develop their roles and capacities will need to be sought and implemented to assure that they can contribute fully to the realisation of the Mission.

7.2.9 Improving Holistic Care

The RC health actors and UCMB had planned a number of objectives and activities to answer to the Mission call to provide holistic care. This is an area

where the least progress was made. This is partly due to the absence of appropriate training opportunities. But it is also largely due to a lack of uptake by the implementers, as apparently they have other priorities. It should remain however an important objective, not only because the Mission calls for it, but also because all other efforts to heal people become more effective.
The training of Pastoral Clinical workers has taken off well, but the integration into the daily practice of the institutions still has a long way to go.
The components of social work and mental health need rethinking to develop new approaches.

Similar obstacles hampered the development of Natural Family Planning services. As the main obstacle proved to be the fact that this area belongs to another department within the UCS, other methods of development and implementation need to be found. This is the more necessary, as increasingly the criticism is heard, that the RCC is against all family planning efforts. As the RCC is only against artificial methods, the RC health units should be enabled to provide natural family planning services adequately.

7.2.10 Enabling the RC health services in the North and Karamoja to benefit fully from the new opportunities

The plight of the population in the war torn and insecure areas of the country has been moved to the top of the national and international agenda. New funds are being mobilised to improve their living conditions and their health. The Northern dioceses of Gulu and Lira count 4 hospitals, 2 health training institutions, 21 HC's, and 2 Diocesan Health Offices. The Dioceses of Kotido and Moroto in Karamoja together have 1 hospital, 1 health training institution, 12 HC's and 2 Diocesan Health Offices. These units form essential, and often substantial, parts of the health systems in the concerned districts. They have continued to provide the basic services against all odds and are frequently the only service providers in the most rural and insecure areas.
All partners wishing to scale up health services in these two regions will certainly target them. These new funds will offer significant opportunities towards improving services and enhancing faithfulness to the RC Mission. However, the focus on specific diseases / health problems and the short term - project nature of the planned interventions, combined with rigid funding and spending mechanisms, could pose considerable threats towards longer-term sustainability of the RC health units. These threats will be the larger if the scaling up is undertaken without due attention for absorption capacity and safeguarding basic services.

UCMB agrees with the reviewers that these threats are cause for serious concern. The reason is that the same insecurity situation has meant that, with few exceptions, these RC institutions have, not been able to develop their service provision and managerial capacities. A close and intensified support from UCMB, through a regional office / technical advisor, is called for, to enable them to use the new resources optimally. The aim should be to scale up the provision of integrated basic health services, especially to the under-privileged, while safeguarding their identity, mission, and long-term sustainability.

To this effect the RC institutions will need to be enabled to work closely together, among themselves, to elaborate common policies and responses to the challenges, as well as longer-term reconstruction / development plans. The latter should assist them to focus their cooperation with all the other parties and use the new opportunities towards the above aim.

The abilities of the RC health institutions, to use the opportunities optimally, can also be greatly enhanced if their present cooperation with Catholic / PNFP aid organisations, like AVSI and CUAMM, can be reoriented towards a joint realisation of their structural reconstruction / development plans.

7.2.11 Human Resource Development and Increasing the Contributions of the Health Training Institutions

The shortage and the high turnover of human resources run through all the problems of the health facilities. It has proven a very daunting task to find inroads to address the problem, as it is so complex. The recent aggravation of the staff attrition (Annex X), due to the government actions[20], makes it even more difficult to find and implement adequate solutions in the coming year.

The RC and PNFP sector are however not alone in this. Human Resources for Health has been put high on the agenda since national as well as international actors have realised that the huge shortages represent the major constraint in improving health outcomes in the developing countries. It is a small comfort that the many agencies now tackling the HR subject are not coming up with effective solutions rapidly.

The Governmental Strategic Plan for the Development of Human Resources is presently being developed. The draft plan that became known around the time of the Consultation Conference indicated that the present and expected resource constraints will largely dictate the future. This means that the main scenario presented is conservative and does not foresee a significant increase in the number of health workers, except to follow the population growth. The present health worker / population ratio is 1:453 and the plan aims at a ratio of 1:440 in 2020. The High Level Forum on Health MDG's, Abuja 2004, recommended a ration of 1:400. In other words, Uganda may not be able to scale up service delivery as required to achieve the MDG's.

This certainly means that the PNFP sector can hardly expect much additional government support to pay comparable salaries, leave alone to employ more health workers.
The RC health units and UCMB will there fore have to continue the search for appropriate solutions in the two areas of HR management and HR development, to improve retention.

In this context the Health Commission had, in 2004, installed a Task Force to investigate the problems of the RC Health Training Institutions (HTI) and find appropriate solutions for these[21]. The aim being to assure that the schools contribute optimally towards the availability and quality of professional health workers. The Task Force established that the problems of the PNFP HTI required interdenominational cooperation both, to develop and implement common plans, as to have a professional representation at national level. Unfortunately the plan to set-up a joint, legally recognised, organisation could not materialise. The RC HTI subsequently requested the HC and UCMB to set-up a Standing Committee and desk to support and represent them.
The desk is only just being set-up and thus the actual support and representation tasks will start during the new plan period. The worsening of the confusion at national level increases the need for the desk. This confusion concerns all areas of training: from which Ministry or Professional Body

[20] The increase in salaries in the public sector combined with two large recruitment waves while the PNFP sector could not match the new salaries as the subsidies could not be increased and actually decreased.
[21] The Future of Nurse Training in support of the Mission of the Private Not for Profit Health Care Sector in Uganda, Final Report to the UEC Health Commission of the Task Force, May 2005.

develops / revises curricula, which sets entry requirements and examines students, etc. The lack of a clear strategic plan for the development of Human Resources for health adds to the problems.

A programme of longer standing of UCMB is the scholarship fund. To date the use made of this fund by all the members of the RC health network is large but also varies greatly between hospitals and between diocesan health boards. What is evident is that it has doubled the likelihood that a staff member in RC health network accesses a scholarship compared to their colleagues in the public sector (1.4% compared to 0.7%). This support in career development also has improved retention of staff at least during the first year after the training course ended. A study is required to determine the longer-term effect on retention. In all cases though, this programme should be continued.

7.2.12 The Need for better defined Legal Arrangements

Already in 2001 UCMB had identified the need to establish better-defined legal arrangements for the RC health institutions. This concern emerged from the realisation that the dioceses are the only recognised legal entities (juridical person) under the civil law in Uganda. This means that all diocesan institutions, including the hospitals, fall under this one entity. As hospitals become more complex organisations the risk of liabilities increase.
The National Health Policy of 1999 put the subject of contractual arrangements, for the allocation and use of government subsidies, on the agenda. UCMB recognised that this increased the risk of liabilities further. To protect the diocese, and all its other institutions, against these risks it would be desirable that hospitals and health centres have a separate legal status from that of Dioceses. At the same time, it realised that a more appropriate legal status can enhance the stewardship of boards and managements. However, it proved very difficult to find an adequate solution that fitted both in Ugandan civil law and in the canon law, e.g. that assured separate answerability while maintaining the statutory relationship with the diocese - owner.

The need to find an adequate solution is increasing rapidly. The Global Initiatives funding arrangements are introducing contract type agreements with considerable conditions and thus risks. The announced Social Health Insurance Body will certainly aim to assure value for money through contract with the providers.
As also governmental providers will be subject to such agreements new openings in civil law can be expected. In canon law research is to yield insight into the options that can preserve the “ecclesial” nature of these institutions – and ultimate policy control by the Ordinary – while granting the necessary latitude for autonomous decision-making.

Lastly, the larger RC health institutions feel this need most acutely now, but it represents a challenge most RC institutions will come to face in the coming years. For this reason the development of the solution will need to be undertaken together with the other departments of the Catholic Secretariat to ensure that the option chosen can also be valid for others.

7.2.13 Decentralisation of UCMB versus Member-initiated Forms of Cooperation

The consultants recommend that UCMB decentralise its technical assistance either by installing a system of account managers (each advisor has first responsibility for the institutions in a specific region) or by setting-up regional bureaux. These approaches aim at enhancing an integrated OD development,

assuring that the support is adjusted to the particular situations, and improving cost effectiveness.
Though UCMB fully agrees with these aims, it has difficulty in recognising the appropriateness of the suggested forms of decentralisation. There are several reasons for this.
With respect to the suggestion of account managers the large differences in the technical areas and the important differences in experience of the advisors may cause skewed developments per region.
Regarding the proposal to install regional "UCMB's" the key obstacle is that the organisational structure of the church does not have a corresponding organisational level. This means that recognition and embedding will be complicated. It will add significant costs, as it means four additional offices, and future sustainability will be quite difficult. However, most importantly the latter form of decentralisation would seem contradictory to the role and position of UCMB. The main assignment of UCMB is to enable the other levels to effectively take up the responsibilities that pertain to their level (principle of subsidiarity). The risk is high that these regional offices increasingly take on, or are given, a hierarchical mandate and thus centralise responsibility.

UCMB is of the opinion that it would be more appropriate if groups of members, with similar needs or interests, form a type of association that can enable them to cooperate among themselves. They could then also determine what kind of technical support they require from UCMB. Fostering and harnessing, this type of member-initiatives, matches better with the organisational structure of RC church and with the principles of the RC Mission in Health.

The proposal that UCMB set up an office for the North and Karamoja is specific for the situation (4.2.10). It will, though, enable the RC health institutions and UCMB to pilot this decentralisation approach.

7.3 ONGOING AND EMERGING EXTERNAL CHALLENGES

The last five years have shown that the external environment continues to change, instead of stabilising. It is far from easy to predict what is to come next. The following are the issues that will greatly affect the RC health services and thus require attention, mainly in the short-term.

7.3.1 The Public-Private Partnership for Health

The development of the Public-Private Partnership for Health, in particular the Partnership between the Public and the facility-based PNFP providers, has stalled. The reasons are related to the delay in the adoption of the P-PPH Policy, national budgetary constraints, inconsistent actions from the Ministry and Government, and a hardening of the lobbying tone of the PNFP partners.

On the other hand all external partners, including the MOH, recognise that the PNFP sector contributions are essential towards achieving the national health objectives. The RC health services also recognise that being part of the system is important for their effectiveness and that the government subsidies are essential in the pursuit of equity and sustainability.

Therefore all RC health actors agree that all should continue the dialogue and reinvigorate the PP Partnership at each level. They also agree that new approaches must be developed for the advocacy and lobbying efforts at the various levels. These approaches should enable all to (re-) build and maintain constructive relationships but at the same time preserve the identity and

autonomy of the RC health units. For this purpose, particularly the hospital managers and the diocesan coordinators should be enabled to develop their negotiation skills as more and more decisions are taken at district level.

The Health Commission and UCMB will have to try, together with the UPMB and UMMB, to speed up the adoption of the P-PPH policy, by the cabinet. The same applies to the revival of P-PPH Desk within the Ministry of Health.

At district level the installation of the cooperation structures have stalled as well. The RC health units and diocesan coordinators should actively stimulate the installation of the PNFP Coordination Committees to develop common approaches and liaise with the district P-PPH focal person or District Director for Health Services.

The consultants suggested that the RC health services try to support more actively the strengthening of the system as a whole by piloting co-operation initiatives. This should certainly be tried but the present challenges of staff attrition, re-verticalisation, and the introduction of the social health insurance may make this a very tall order for the first few years.

7.3.2 Cooperation within the Private Not for Profit sub-sector

During the past years Uganda Protestant Medical (UPMB) and UCMB have worked closely together in all matters concerning the P-PPH and national developments. In the first years the Muslim Medical Bureau was also an active partner but the last two years it has been mostly absent in the national fora. This has probably been caused by changes in staff and a high dependency on project funding.

There is an increasing call from donors to form a Christian Health Association (CHA), comparable to the surrounding countries. The Ugandan actors show little interest in a formal structuring of the cooperation. One of the Protestant churches has given a clear signal in this direction when it decided against the Partnership of the PNFP HTI. In addition the recently revised NGO legislation that has been presented to the President has not addressed the concerns of the Churches that, already in 1989, decided not to register. The Churches' refusal to comply with the NGO statute (at the time as it is now stems from the fact that the Statute mainly reflects internal security concerns rather than being a tool for the orderly development of organisations in society) was possible because the existing dioceses were already legally established under the Trustees Incorporation Act. However, new organisations such as a new diocese, a Christian Health Association, or any other Church related entity, wishing to obtain legal existence needs to be registered as NGO before applying for incorporation. This is not acceptable to the Church, for understandable reasons. In this situation, the development of legally established joint ventures proves to be an extremely laborious task. Also operating without the protection of legal existence proves to be a very risky venture for the founding members of the new organisation, in their individual capacity.

The best way forward is strengthening the existing cooperation.

7.3.3 System Strengthening versus Re-verticalisation

In chapter 1.9. the origin of the new Global Health Initiatives has been described. As already indicated in 7.1. these funds have, and will continue to have, considerable consequences RC health services.

The Global Initiatives have in common a return to tender - project type funding and a high result orientation. In combination this means that individual institutions or groups have to apply for the funding, win awards in over-competitive bids, to set up specific accounting arrangements, and are subject to strict conditions.
When, in 2003, UCMB became aware of the opportunities and threats of these new funds it initiated the installation of the Global Initiative Fund Management Unit (GIFMU) within the Catholic Secretariat. This positioning of GIFMU has two reasons. The first GI's mainly concerned multi-sectoral approaches to fight HIV/AIDS, malaria, and TB, and this type of cooperation could best be initiated and coordinated at a level above UCMB. Secondly applying, channelling, and accounting for funds used by third parties did not match UCMB's core functions.

During the last two years new threats have merged that require a new response:

- On the one hand the national budget for health is not growing, and thus the subsidies are not increasing. In fact this means a reduction as costs of service provision rise, not in the least because of the salary increases in the public sector. As increasing user fees is hardly an option, this entails that the GI's represent the only new sources of income for the health units.
- On the other hand the International Agencies increasingly target the Faith-Based organisations (FBO's) and providers to scale up services. This is related to deliberate policies of the American government, a recognition of their capacity to deliver, and because they were not equally accessing these funds through government channels.
- In this period the Anti-Retroviral Treatments became available for developing countries and both the Government and the International Agencies have set ambitious targets in making these available. As 50% of the hospitals in the country are PNFP hospitals it goes without saying that they increasingly solicited, when not pressurised, to scale up this service.
- Lastly it is rapidly becoming apparent that the funding, provided by the GI's, only cover the variable costs directly related22 to the targeted services. The institutions are not able to cover the ensuing fixed costs from other income sources. If they are not enabled to collect and present the evidence and develop common standpoints the future looks bleak.

The above developments put the subject of the GI's squarely back on UCMB's agenda. Not in the least because all internal actors agree that the main orientation should remain that of strengthening the system / strengthening the institutions. A two-pronged approach is called for. The first being a close cooperation with GIFMU and the UEC HIV/AIDS Focal Point to jointly advocate for the interests RC health services and to support the units in developing solutions. This cooperation needs to be extended to the Inter-religious Council of Uganda (IRCU). The IRCU is increasingly being given the lead role in the discussions between the Global Initiative agencies and the Faith Based organisations, as well as in the channelling of funds.

[22] During a recent meeting with one of the International agencies funding ART's it proved that the funding could not even be increased to cover drugs for opportunistic infections. These were to be covered by the own income of the hospital. As the main source of income is user fees, these programmes seem to bank on a sense of solidarity that is out of proportion with the abilities of the rural population in Uganda! They also seem to assume that these service delivery organizations have a capacity to raise additional resources through own channels that is utterly unrealistic.

Secondly, in the context of improving sustainability of the RC health services, UCMB will need to develop mechanisms and tools that can enable the units to access and use these funds optimally.

7.3.4 Responding to the Social Health Insurance Scheme and Community Health Insurance Initiatives.

In July 2006, the Ministry of Health launched the plan to set up a Social Health Insurance System (SHI) (see 1.10.2). As al the details are yet to be developed, it is difficult to predict what this new funding mechanism will entail for the RC and PNFP health providers. One thing is certain they will have to be able to cost their services correctly and be able to account for these to avoid that the Insurer reimburses the fee charges only. The latter are far from the actual costs, not in the least because of UCMB's past efforts to convince all the units to use the government subsidies to reduce and flatten the user fees.

From the start in July 2007, though, it will affect labour cost, as the employer and employee contributions will be mandatory. This will add an additional obstacle to the efforts to match the government salary levels.

Potentially Social Health Insurance scheme could change the funding mechanism of the RC health services completely. The reason is that government may decide, as payment through the scheme increases, to phase out the allocation of subsidies. As the majority of the RC units are located in rural areas, where the number of salaried workers is low, this could become a threat to access for the main target group of the RC health services, the poor. The time until the scheme becomes fully operational will have to be used to advocate for this group and to develop, together with all stakeholders, proposals for additional funding mechanisms to safeguard their access.

A limited number of RC Hospitals and LLU's, especially in the South West of the Country, are also involved to a various degree and with variable arrangements with Community Health Insurance Schemes (CHI). Although at a different scale, CHI's pose, for the health providers, the same type of management challenges as that posed by SHI, calling for attention by UCMB.

7.3.5 Cooperation with other Partners

UCMB already works together with an important number of colleague organisations of which UPMB, UMMB, AVSI, and CUAMM are the most important. Internationally the bond with CORDAID, the core donor has remained strong. Other important donor partners are IICD, DKA and SVFOG. The first is already committed to continue supporting the ICT component of the Plan (until late 2007); the availability and interest of the other two needs to be assessed.

In any case, in the light of all the new developments mentioned before, new alliances will be sought in support of the RC health services. Among the new alliances, the IRCU will need to figure prominently as it is more and more becoming the "gateway" to the Global Initiative agencies.

In the interest of the RC health services in the North and Karamoja, UCMB, AVSI, and CUAMM would like to add a new dimension to their cooperation. The latter two organisations already heavily support member institutions in these areas. A closer cooperation could enable all three to ensure that the influx of new funds can be used optimally for service delivery and for strengthening the member institutions.

At the level of the districts the most important alliance is that with the other PNFP health institutions and programmes. During the past years not much

progress has been achieved in strengthening these. As the mentioned developments increase the need, for a strong common voice also at district level, the formation of PNFP Coordinating Committees should be strongly stimulated in the years to come. A common approach with the GIFMU and HIV/AIDS Focal Point, to stimulate PNFP cooperation for the Global Fund multi-sectoral programmes, could both improve implementation and strengthen the alliances between the PNFP actors at this level.

Still at peripheral level, another important partner for a sizeable number of Hospitals is CRS, the lead agency of a consortium of US NGOs managing a large programme for the scaling up of ART funded by PEPFAR. As CRS is also the official aid agency of the US Bishops' Conference, it will be useful to explore how better synergies can be realised.

In line with the recommendations of the consultants of the End of term Review, the peripheral actors will also be stimulated to seek new alliances with national and international development actors. The aim should be threefold: improving service delivery, strengthening governance, and enhancing the abilities of the communities to demand affordable and quality health services.

Section Three:

The RC Mission and Policy Statement 2007 – 2011

All internal actors and the external evaluators agree that the Mission and Vision Statement do not require re-formulation at this point. The formulation of the main tenets and core values befit the present time-spirit in Uganda and are recognisable at each level. There is a call, though, to add a brief summary, or motto, that reflects the essential message but is easy to memorise and thus to recall by everyone at any moment. It should also clearly indicate to the public what the RC health units and workers stand for.

The motto chosen is:
In Faithfulness to the Mission of Christ, we provide professional and sustainable holistic health services, through partnership, to enable the population to live their life to the full.

The Policy Statement counted three sections:

Section B: the main policy directions:
- coordination of services
- consolidation of existing services / institutions
- professionalism, quality of care and training
- equitable sustainability
- integration and cooperation.

Section C: summarised the priorities for the period 2000 – 2005:
- consolidation
- implementation of the policy planned and implemented by the dioceses and hospitals
- monitoring of the implementation by the Boards of the Hospitals and the Diocesan health Departments based on objectively verifiable indicators and with assistance of the Coordinators and UCMB.

Section D: consisted of a set of more specific objectives under the headings:
- Content and quality of services
- Management
- Training
- Coordination and integration.

The latter of course largely coincided with the goals of the Strategic Plan.

The internal stakeholders decided that the policy directions (Section B) remain valid and applicable for the coming years. The main reason is that the changes in the external environment (see summary of the End of Term Review) challenge the RC Health System to keep them well in focus and find new ways to maintain them, or to implement them.
The internal weaknesses and external challenges do call for a renewal of the policy priorities (section C).

The revised Policy Priorities are:

I. Consolidation of the existing RC health units and services is to form the primary objective of all the internal partners, in the coming five years, to assure that the entire RC Health Service Network can be sustainable in response to external developments.

II. In support of the first objective, the Diocesan and hospital governance and coordination structures / mechanisms, as well as governance capacities will be strengthened to ensure adequate participation in the policy dialogue and in the partnerships with all external actors.

III. Transparent and strong management instruments will be embedded in the dioceses and hospitals to ensure integrated service delivery and complete accountability.

IV. All internal stakeholders are called to actively advocate for the RC health services to ensure that the RC Mission in health can be pursued.

Section D will now be replaced by the Strategic Goals set for the new period.

A synopsis of the summarised purpose, aim and mottos used in the course of the previous strategic are presented in annex V.

Section Four:

The Strategic Plan for the RC Health Network 2007 – 2011

8. The Mission and Purpose of this Strategic Plan

The Mission of the RC Health Services is summarised in its new motto:
In Faithfulness to the Mission of Christ, we provide professional and sustainable holistic health services, through partnership, to enable the population to live their life to the full.

The purpose of this Strategic Plan is:
To enable the RC health service network to increase its contribution to the attainment of the Uganda Health Sector objectives and the Millennium Development Goals in Uganda.

The choice for this purpose stems first of all from the Mission of the RC health services: all the objectives, set out in the above-mentioned plans, aim at improving the health of the population, particularly of the less advantaged and the vulnerable. The Uganda Government and the RC health network share this important common goal. This common interest exactly represents the second reason for this choice as the RC health services wish to work with the public health system and all other health actors to assure that together they can realise it.

9. Rationale of the Strategic Plan 2007 – 2011

The goals of this second Strategic Plan of, and for, the development of the RC Health Service Network remain largely the same as those of the first plan.

The main reason is that these goals are more or less generic for an organisation in an ever-changing environment. These changes entail that the goals remain valid, not because nothing has been achieved, but because the end points are continuously extended and the ways to reach them need to be adjusted to new opportunities and threats.

The seemingly increasing pace in which new national and international policies emerge make it difficult to predict what will need to be realised in the coming five years. In particular the present fragile Public-Private Partnership for health and the re-verticalisation (or return to project mode) pose considerable challenges for the sustainability of the RC Health services. They will largely determine the agenda for the first years, e.g. the objectives of the Operational Plan 2007 – 2009 and thus demand a high level of activities.

For the longer term of this Strategic Plan, only the general directions can be indicated here. The Operational Plans as well as the Annual Plans will need to be flexible to be able to respond rapidly to new developments.

Though the end points, aimed at in 2001, have been reached to a large extent, there are also internal reasons to maintain the same strategic goals. The most important is that the improvements in management and performance have not yet taken effective root in the majority of the RC institutions. These institutions may not be able to respond to the challenges and compounded pressures of rising costs, re-verticalisation and Health Insurance Scheme, if the embedding is not pursued consistently and rapidly. At the same time these types of challenges demand continuous adjustment of the governance and management as well as service delivery systems and capacities.

Keeping the basic system goals in focus aims to ensure that each RC institution, and the network as a whole, is strengthened and developed in an integrated, coherent, and consistent manner. Or in other words, by maintaining these goals the RC network underscores its orientation towards system approach.

10. Strategic Goals

In this chapter the main thrust and areas of work for each Strategic Goal will be described. Each of the Strategic Goals addresses an aspect of the development of the institutions. It should be noted though that these aspect have overlaps and are often interdependent, therefore there are inevitably also overlaps as well as interdependencies between the goals. In some instances the choice to locate an area of work under one goal has to be arbitrary to avoid duplications.
The implications of interdependencies will be mainly addressed in the operational and annual plans, as they can influence sequencing of actions as well monitoring of progress.

10.1 The RC Health Service Network has enhanced the Partnership with the Public Health actors, at national and district level, and with other actors in faithfulness to the Mission.

The end point of this goal is that all RC health institutions are recognised as full operational partners of the national and district health systems and contribute to the national health objectives in accordance with their status and the RC Mission. This aim has everything to do with the dual responsibilities, towards the catchment population, of being effective in service delivery and being able to access their share of the national budget for health. The latter is a necessary prerequisite to being able to assure access and equity.
The main areas of work, before reaching there will concern adherence to the P-PPH policy, participation in national and district policy, planning, monitoring, and evaluation fora, and correct use of - and accountability for - the government subsidies. In the light of the Global Initiatives and Social Health Insurance plan it will also cover development of the contractual approach, also in cooperation with UEC-GIFMU and the UEC-HIV/AIDS Focal Point. In addition, cooperation with other actors that can enable the network to attain this goal will be fostered.

The new area of integration, to be developed in this period, pertains to the Health Training Institutions. To this effect cooperation will actively be sought with the Ministry of Education and Sports, Ministry of Health, Professional Councils, and the development partners involved in Health Training. The objectives and activities are developed under the fourth goal.

Contributing to strengthening the system, as a whole, will be pursued when opportunities are identified.

10.2 The RC Health Services have improved their sustainability as well as the range and quality of their services in Faithfulness to the Mission.

This goal pertains to the core of the work of the RC health services. Two distinct, but highly interlinked, areas are covered here: the actual service delivery and their funding. This is not to say that sustainability is only viewed from the financial aspect. The aspects of social and institutional sustainability form the underlying aims of the first goal (operational integration into the health system) and the next goal (enhanced governance and management).

These two areas are addressed in combination because of their close inter-dependence, as developments in one directly impact on the other. But more importantly, they need to be considered together because they have very strong influence on accessibility and equity. Where accessibility and equity are the key assignments that emanate directly from the RC Mission in health, improving performance in these two areas, or at least maintaining the present levels, has to guide all in the choices to be made. In the present resource constraint environment, improving efficient use of the resources has to be the main strategy available, to assure access and equity.

The objectives and actions that are to contribute to financial sustainability concern financial management and accountability, access to - and use of - new funding mechanisms (Global Initiatives and Social Health Insurance), including mechanisms for costing of services and assessing the feasibility to add new services, or scaling up existing services. The latter should also facilitate the selection of services focussing on those that can be rated "low cost – high output / outcome".
As the present economic environment puts such heavy constraints on the viability of Not for Profit health units, the RC Policy priority is on consolidation of existing services. To this purpose a tool to assess financial viability of an existing, or planned new, health unit is also foreseen, together with a guide for possible responses if a unit cannot survive in its environment. This could lead to some trimming in the number of RC units and / or reconfiguration of service levels in others.

With respect to the range of services the aim is to enable health units to increase the degree of completion of the Uganda Minimum Health Care Package (UMHCP), in its adjusted form[23], at each level. It is expected that the revised package will also indicate the priorities of the MOH with respect to the selection of Global Initiatives to be implemented, including the implications per level of service delivery.
A new approach will be developed to assure that all RC units provide Natural Family Planning services.
In addition, increasing the capacities to provide Clinical Pastoral Care, mental health services, social support, to complete the holistic care package, will remain on the agenda.
To continue the improvements in quality of care the main objective will remain to enable health units to assess their quality against the norms and in comparison to others, in an increasing range of aspects. To this purpose the accreditation system will increasingly focus on quality of services and the key indicator related to quality will be further refined per level of care.
It goes without saying that improving performance in these areas, particularly completing the range of services, has implications for the costs of services delivery in the units. This means that the financial developments may form an important obstacle to further improvements.

10.3 THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES.

Under this goal the aspects of institutional sustainability are addressed. The aim is to equip and strengthen the key actors who can assure that the institutions perform optimally and who should answer to the population and their partners in health. On the basis of the RC Mission the underlying themes, or guiding principles, are Stewardship and Fiduciary Assurance.

[23] The MOH plans to revise the MHCP in the first year of the HSSP II, e.g. in 2007. At this point in time the new package is not yet known. The 2006 survey of the implementation of the MHCP forms the baseline for the efforts during this plan period.

The expertises of organisational / institutional development, human resource management, financial management, as well as information, communication and data management, will be combined to align practises towards an integrated systemic development.
The objectives and actions will focus on building and enhancing governance and management capabilities as well as instruments that facilitate and support effective implementation.
An essential ability for governance and management is the ability to analyse and use information for effective decision-making. Therefore the further refinement of the management information systems as well as building capacities in this area remains high on the agenda.
To enable the key actors to implement organisational changes and advocate for their target populations, the development of skills in leadership and training, will be pursued under this goal. As the style of management is often cited as one of the reasons for attrition, the accent will be on more democratic and participatory leadership.
The development of advocacy and negotiations skills is also given attention. Though these skills are also meant to strengthen internal relationships, they are mostly needed in the external relationships. Advocacy and negations will namely be crucial for the contractual approach to be pursued under the P-PPH policy implementation as well as in the development of the relationship with the Social Health Insurance.

To ensure that future generations of managers are well equipped for their work, the embedding of training programmes aiming at developing new skills and practices is essential. To this effect structural cooperation with training institutions also falls under this goal. For this aspect, it is to be noted that there is an overlap with the next goal.

In view of improving support to - and performance of - the health centres new organisational structures for the diocesan health departments form an additional area of work.

10.4 THE RC HEALTH SERVICE NETWORK HAS IMPROVED THE DEVELOPMENT OF ITS HUMAN RESOURCES AND ITS CONTRIBUTIONS TOWARDS PROFESSIONAL TRAINING.

This goal is new for the RC Health Services and UCMB. Both areas were hitherto addressed as implicit parts in other areas. However, own experiences and developments in the national and international arena have put Human Resource Development high on the agenda.
It should be noted that Human Resource Development (HRD) belongs, and should belong, closely together with Human Resource Management (HRM) at institutional level. HRD is considered here separately because it represents the main strategy available to the RC health services to improving the quality of staff and to improve their retention. By combining, this area of work with that of the support to the development of the training schools, the aim is to assure that synergies are recognised and used to enhance the outcomes.

The objectives for HRD will pertain to developing strategies and approaches that will enable institutions to plan and implement HRD plans in direct relationship to their institutional development plans. Efforts will also include enhancing the use of the scholarship fund to improve staff retention. Research may be required for these areas of work.

Following the work of the HC's Task Force on the future of the Nurse Training Schools, the RC Health Training Institution have requested the HC / UCMB to assist them. The HC's Standing Committee and UCMB Desk for Health Training Institutions & Training

are to become fully operational in this period. The first aim is to enhance the capacity of the schools to provide professional training programmes that match with the needs in HR in PNFP and national health institutions. In the context of the National Human Resource Development Plan, which does not aim at increasing the number of health workers to scale up service delivery, this aim will, for now, not include increasing the number of training places. The focus will be on optimising the use of the present training capacity, improving the quality of the training, and broadening the range of course offered.
The second aim is to assure that they become a full partner in the national policy and planning fora.
The objectives and actions here concern improving school management capacities and systems within the context of the larger hospital organisation, and installing ICT equipment and training tutors for effective use to improve management and training quality. Other important objectives will be fostering cooperation and coordination between the schools, facilitating the transition to Enrolled Comprehensive Nurse Training, and the development and / or implementation of new training programmes.
With regards to national representation the focus will be on developing constructive relationships with the partners at national level (MOES, MOH, Professional Councils, and the DP's EU, Danida and DCI), recognition of the schools in the budget of the MOES, and assuring that the policies and plans take the interest of the RC HTI and health institutions into consideration. In support of these two areas consensus building and coordination within the network of PNFP HTI will also be an important area of work. In line with the request of the schools, the aim here will be to continue to foster the plan of a legally recognised association of the PNFP schools.

10.5 THE RC HEALTH SERVICES HAVE IMPROVED THEIR ADVOCACY FOR THE TARGET POPULATIONS AND INSTITUTIONS.

In the present context, advocacy is increasingly important as tool to pursue the interest of the poor and of the RC institutions. In the past period UCMB lead these efforts at national level. However, as the devolution of powers to the districts is being accelerated, the district authorities will soon be the main decision makers with respect to the division of budgets for health. Already the next phase of decentralisation is being prepared. In this phase the sub-counties will take on more and more responsibilities. Both scenarios entail that the main onus, to defend the work of RC institutions, has to shift to the actors at this level (hospitals and dioceses). Key to enabling these members is providing the training in advocacy and negotiations as foreseen under 10.3. In addition, UCMB should assist with concept and position papers that can be adjusted to local level.

The lessons from these past years also show that advocacy for the RC Mission in the internal network requires more specific attention. Specifically strengthening the diocesan health coordination and assuring consolidation of existing services need the support from the RC authorities at every level.

During the past year, UCMB has learnt that relying on technical information and arguments is less effective as advocacy method in situations of high pressure on both sides. The focus should be on conciliation of interests of opposing partners and the development of constructive proposals as well as relationships. The above training should include this approach and UCMB staff may need to develop its own skills to assure that its support to the internal actors is based on this approach.

During the Consensus Conference for this RC Health Service Strategic Plan, the participants requested that more insight be gained regarding the actual access of the poor. They urged the RC health institutions and UCMB to undertake more deliberate

research, through ongoing data collection and / or operational studies, to establish which poor and vulnerable groups do or do not access RC services. Better information will enable them to improve advocacy for these groups as well as the development of solutions to improve access.

10.6 OVERARCHING AND CROSSCUTTING OBJECTIVES

This area is included as experience has shown that, during each Operational Plan period, specific issues need to be addressed, which do not easily fit within one of the above generic goals, or cut across all.
For the priorities in the first three years we refer to the operational plan.

In every Operational Plan, however, an objective concerning innovations in health care and in management will be included. Though, not many innovations could be identified, during the past three years, the fact that it is an objective did assure that it was kept on the agenda. The main tools for this will continue to be support to operational research, literature search, and close attention to reports from the members. Dissemination will mainly be via the Bulletin.

11. The Main Actors in the Strategic Plan

The main actors in the RC Health Service Network Strategic Plan are the institutions that provide care. As the group name indicates these are more or less autonomous institutions that belong to the same family but are not governed by one single authority.
The group consists of the twenty-seven hospitals, of which eleven include a health training school, the nineteen diocesan health departments, the two hundred and thirty four health centres. When the entire group is meant they are indicated as “Peripheral level” to distinguish then from the Health Commission (HC) and UCMB as “Central level”.

The Health Commission is the national health policy making and coordinating body for the Uganda Episcopal Conference. The Bishops Conference is in turn a coordinating body as dioceses are autonomous entities in the organisational set-up of RC Church. This means that the decision, to implement policies and guidelines adopted by the HC belongs, to the individual Bishop, as owner of the institutions.

UCMB is the technical executive of the HC and as such its core functions are representing and coordinating the RC health institutions at national level, preparing policies and guidelines, and providing technical advice to all internal stakeholders, and building internal consensus on key subjects.

For this Strategic Plan period the extended role of UCMB as initiator, technical advisor, and facilitator of change is to be continued. The reasons for this are the high need to adjust to the current developments and the need to accelerate the embedding of the changes (see section 2 and chapter 2 of this section).
Whether this extended role will be needed for the entire five-year period of this plan is difficult to determine at present. The experiences of the last years, when just as everything seemed settled the GI’s appeared and caused considerable changes in the directions of health services, taught UCMB to be careful. Such changes demand a continuous a high level of attention and ability to translate policies for the members. Thus it will depend on the developments in the external environment and on the speed with which the member institutions can develop their abilities to cope with the present and new threats. The HC and UCMB will, however, continue to aim at returning to the core functions.

In line with the principle of subsidiarity, and with the decentralisation policy of the Ugandan Government, the HC and UCMB will continue to orient all interventions towards enabling the actual implementers to do what they can do best. This naturally implies that they should be willing to change / improve their performance and mode of operations, e.g. to take up the technical advisory support UCMB offers.

In other words the direct target groups of the HC and UCMB are the institutions mentioned above, more precisely the members of boards of governors of the hospitals and the diocesan health, the hospital and school managers, and the coordinators. As the focus and nature of the cooperation can differ per operational plan period these are described more extensively there.
The more indirect target groups of the HC and UCMB are the Boards of Trustees, owners of the institutions, the congregations, which are active in RC health care institutions, and the wider church actors. The aim is to foster their adherence to the RC Mission and enlist their active support for its realisation.
The relationship with the institutional partners, such as Joint Medical Stores and Uganda Martyrs University (UMU), can vary per period depending on specific objectives. An example is the objective to embed training courses in formal training programmes. This calls for a direct cooperation with UMU, faculty of Health Sciences during the 2007 – 2009.

12. Main Implementation Strategies

In view of the organisational structure of the RC health service network and the principles of the RC Mission, the main role of UCMB for the implementation of this Strategic Plan, is that of enabler and provider of technical services.

12.1 Capacity Building

The above-mentioned role dictates that capacity building is the main strategy to be used. The selection of the methods will be determined by the objectives, the phase of development of the particular technical area, or the phase of development of the particular institution. Specific attention will also be paid to adjustment to the local situation (contextualisation) and the integration of the four technical areas (OD, HRM, Financial Management, and Information and Data analysis).

12.2 Monitoring, Evaluation, and Feedback

As reported, this strategy proved highly effective in the past, largely due to the investments in Information and Communication Technology and capacity building in Data Management. Therefore this strategy will continue to be used to monitor and assess performance and to tailor all capacity building efforts, both to improve the content as to enhance the outcomes. Where the peripheral units need to improve the use of information for planning, the emphasis will move more and more towards Continuing Education.
It will also be used to feed the advocacy and negotiation processes as accurate and timely information will continue to be valuable to argue the case of the RC health services.

12.3 ACCREDITATION

In the past the accreditation system that UCMB developed has proven an effective strategy to underpin the other strategies. It stimulated the RC institutions to implement the improvements developed and tested as valid. Therefore the gradual extension of the accreditation system for hospitals and health centres will be continued.

12.4 RESEARCH

Lastly operational and other types research will be used when more in depth information and / or an extensive comparative assessment of available options is required to establish the appropriate response to an identified problem.

12.5 ADVOCACY AND NEGOTIATION

This strategy is at the same time a goal and an implementation strategy as the outcomes of advocacy efforts enable the RC health services to realise the Mission, Policy, and other strategic goals. The information generated and analysed at national level through the monitoring and evaluation strategy will be used to support the advocacy efforts at national as well as peripheral level.

13. Planning, MONITORING, AND EVALUATION

This Strategic Plan will be implemented through two rolling over Operational Plans. The first operational plan is presented here after. It will contain the objectives and targets, per strategic goal, for that period as well as the activities required to achieve these. The operational plans are then detailed per year into annual activity plans.

13.1 LEVELS OF MONITORING AND EVALUATION

In line with the above monitoring and evaluation has to take place at several levels:

A. Progress toward the Purpose of the Strategic Plan
The indicators are determined by the Health Sector Strategic Plan II (HSSP) and the Health Millennium Development Goals (MDG's) and aim to measure the contribution of the RC health services towards their attainment. These include two of the key indicators that aim to measure the faithfulness to the RC Mission: access and equity.
Annex I and annex IV present the indicators selected for this purpose.

B. Progress towards the Strategic Goals
Together with the monitoring the progress towards the purpose, this level is the main level to monitor and evaluate progress on for the strategic and operational plans. The annual reports will concentrate on these two levels.
The indicators, developed to monitor Faithfulness to the RC Mission, access, equity, efficiency, and quality will continue to form the key outcome indicators to monitor progress towards the goals. In view of the economic threats to sustainability of the health institutions, the possibilities to develop an index to measure sustainability will be investigated. If proven feasible / reliable this indicator may be added to the key outcome indicators.
Next to these a number of output and process indicators have been selected, per strategic goal that can provide more detailed and

intermediate insight into progress towards these goals. These indicators have been selected taking into consideration that outcome and effect may not become measurable during the time of the plan and / or because the end result also depends on other factors. Thus these indicators are mostly proxies for the end result wished for.

In this perspective it should be noted that the outcome and effect indicators have three levels: those that can be directly related to the inputs and outputs of UCMB, those that directly depend on the uptake / implementation of services by the RC health institutions, and those that are largely determined by other actors and or developments (see annex VII for the flow chart of the strategic plan). UCMB wishes to monitor each level to be certain that, though it may not be able to influence the factors directly, it has to be able to understand what hampers or stimulates progress.
Where possible, targets have been set to assure that the strategic goal can be achieved by the end of the strategic plan period.
Part one of the logical frame work in annex I, and part one of the list of indicators in annex IV, present the overview of the indicators and targets for the strategic plan level.

C. Progress toward the objectives and targets of the operational plans
The operation plan translates the strategic goals and the targets set into objectives for the operational plan period. These will not be formulated in measurable terms but each is further specified in activities and primary and secondary targets. The reason for this is that experience has taught that an important level of flexibility is required to be able to adjust the plan to the developments.
The indicators to monitor progress toward the operational objectives are derived from these targets. It goes without saying that in a number of instances there is an overlap between the operational output and outcome indicators and those of the strategic level.
In principle the detailed indicators for monitoring and evaluating progress towards the operational objectives will be for internal use, except of course for those that are identical for both levels.
The parts two of the logical framework and indicator list present these indicators plus the primary targets (see annex I and IV) .

13.2 ANNUAL PLANNING

The annual review of the achievements compared to the annual activity plan, progress towards the targets of the operational plan, and progress towards the strategic goals, will form the basis for the development of the next year's annual plan. The main focus will be on the achievement of strategic goals and the purpose of the plan.
If new issues, or new developments, require an immediate adjustment to the operational objectives and targets these will be undertaken.

13.3 METHODS

Internal review:
The UCMB team will review progress annual using the selected indicators. The annual reports of UCMB will present and explain the progress compared to the indicators selected with respect to the purpose of the plan and the strategic goals. It will also provide insight in the main lessons emerging from the implementation of the

operational plan and review the internal and external developments that may affect progress. During the year the UCMB team will regularly monitor the implementation of the activity plan, using the primary and secondary indicators / targets as well as the issues emerging in the internal and external environment.

The end of term review of an Operational plan period will be an internal exercise involving the main RC health network actors. The objectives will be twofold: determine the progress towards the strategic goals and determining the objectives for the next operational plan.

External Review

Toward the end of the second year of each the Operational plan an external mid-term review will be commissioned, which will consider progress towards the Operational Objectives in the context of the Strategic Goals.

If internal and / or external developments dictate the need the UCMB team may opt to have an independent external review at the end of the operational plan period. The same may be considered at the end of the Strategic Plan period.

SECTION FIVE:

THE OPERATIONAL PLAN FOR THE RC HEALTH NETWORK 2007 – 2009

14. THE PURPOSE OF THE OPERATIONAL PLAN 2007 – 2009

The purpose of the Strategic Plan 2007 – 2011 is also the purpose of the first operational period under this plan:
To enable the RC health service network to increase its contribution to the attainment of the Uganda Health Sector objectives and the Millennium Development Goals in Uganda.

Based on the experiences gained during the Strategic Plan 2001 – 2005 this Operational Plan period will have the Motto:

Enabling All for Faithfulness to the Mission

With this motto UCMB wishes to convey the main strategy it aims to follow during this period. As technical arm of the Uganda Episcopal Conference and the RC Health Services Network, UCMB essentially is a provider of technical services to autonomous institutions. During the past five years it took the role of initiator of change because of the need in the network to catch-up with developments. In the coming years the initiative has to return to the actual implementers and to this purpose UCMB should concentrate on "enabling" instead.

15. RATIONALE OF THE OPERATIONAL PLAN

This Operational Plan foresees a similar level of technical and financial investments as the previous Operational Plan period. The reasons are:

- Though the Strategic Goals of 2001 – 2005 and the Operational objectives of 2004 – 2006 were achieved to a large extent, the assessment indicates the need to set the targets higher to enable the RC Health Institutions to respond to the call of the Mission;
- An important number of institutions have implemented key instruments in a perfunctory manner and now need to root them in their institutional culture, if they are to be efficient and accountable;
- The high-turn over of staff, including managers, means that the systems, methods, and culture that should support effective governance and management are the more important;
- The targets also have to be set higher and the support accelerated to enable the RC health actors to respond adequately to the new developments in the environment.
- Lastly, but far from least, all the changes in the national environment (see chapter 1 and 7), demand that UCMB maintain a high level of expertise to be able to monitor and assess developments and assure rapid determination of the implications for the RC network. Timely responses and adjustments to new challenges will continue to be key to sustaining the services and institutions.

16. OBJECTIVES AND ACTIONS PER STRATEGIC GOAL

As introduction it should be noted that, as there are overlaps and interdependencies between the goals, these also inevitably occur at level of the operational objectives.

In addition in some objectives of the former period reappear here. This is because they have proven effective towards the goal, they remain relevant, or they still need to be achieved.

The objectives that follow are deliberately not formulated in complete measurable terms. However, for nearly each one or more targets are stipulated and these will form the basis of the indicators for monitoring and evaluation. The targets / indicators for process, or output, have been chosen selectively to reflect the pertinent areas of work, not with the purpose of being exhaustive. When the achievement of the desired end result is far from UCMB's own sphere of influence, the nearest target that UCMB can measure / influence has been chosen, or no target has been set. In other cases, when the desired end result, expressed in the objective, may take longer to become apparent, or hardly be directly measurable, a proxy target / indicator has been chosen.

These targets have then been divided in two groups: primary targets and secondary targets. The primary targets are those that are most important and most indicative for the desired end result. These primary targets are presented here below per objective, highlighted grey**.** The second group consists of intermediate, and /or process related, targets that are important for the annual planning and ongoing monitoring of UCMB.

The reasons for this approach are that UCMB wishes to ensure that:

- maximum flexibility can be maintained to adjust to the needs of the peripheral units and to changes in the environment.
- monitoring and evaluation efforts are as focussed as possible and not encumbered by a multitude of indicators each requiring its own registrations and analysis, and thus taking time away from actual implementation.

In the same line the activities are not minutely listed, but the focus is on the essential activities and those that have budgetary implications. **The latter are also highlighted grey and in bold fonts.**

This approach is based on the experience gained during the Operational Plan 2004/06. UCMB then had 112 indicators to monitor together with a long list of detailed activities. It proved difficult to monitor on a regular basis and thus it could only be done annually. But most of all the high need to respond rapidly to new developments and challenges entailed continuous changes in the activity plans and meant that some indicators became redundant.

NB: If no time specification is presented in the objective / target it is to be achieved by the end of this operational plan period.

16.1 THE RC HEALTH SERVICE NETWORK HAS ENHANCED THE PARTNERSHIP WITH THE PUBLIC HEALTH ACTORS, AT NATIONAL AND DISTRICT LEVEL, AND WITH OTHER ACTORS IN FAITHFULNESS TO THE MISSION.

16.1.1 Representation of UCMB in - and policy advice to HPAC and related working groups and fora is ensured.

Activities

- *Participate in the meetings of Health Policy Advisory Committee – HPAC -, Health Sector Working Group – HSWG -, Public Private Partnership (Facility based PNFP) for Health Working Group – PPPHWG -, Development Partner Working Group – DPWG, Joint and Technical Review Missions.*
- *Consult the Diocesans Health Boards and Coordinators and the Hospital Boards and Managers*
- *Exchange information between these fora and the RC institutions*

Target

1) Attend 75% of the occurred meetings of the National Health Policy Advisory Committee (HPAC) and Health Sector Working group.

16.1.2 The revival of Public-Private Partnership in Health Desk at the Ministry of Health and the functioning of the Public-PNFP working group are pursued.

Activities

- *Advocate with MoH senior management for appointment of a substantial desk officer.*
- *Participate in the meetings of the P-PNFP working group*

Target

1) Information concerning PHC CG allocations is provided by the PPPH Desk annually.

16.1.3 The Public – Private Partnership Policy and the guidelines for the implementation of the P-PNFP partnership are officially approved by the Ministry of Health.

Activities

- *Advocate for the adoption of the PPPH Policy and Guidelines with Ministry Officials and Members of Parliament if applicable*

Target

1) PPP Policy and guidelines published.

16.1.4 If the previous objective is achieved: The P-PPH Policy with FB-PNFP health sector is consistently implemented.

Activities

- *Disseminate the Policy*
- *Monitor implementation*
- *Provide technical advice to members concerning implementation*
- *Encourage cooperation with the district PPPH desk officers*
- **Organise, or contribute to the organisation of, workshops to sensitise all actors and facilitate implementation**

Target

1) Two regional workshops per year have been implemented for sensitisation / facilitation of implementation.

16.1.5 Diocesan Health Offices / Co-ordinators have consolidated the integration of Health Units into the District Health System.

Activities

- *Offer training in leadership, advocacy and negotiation skills to DHCs (see also 16.3.1. and 3.2.)*
- *Promote the installation of PNFP Coordinating Committees at District/Diocesan level*
- *Disseminate and / or adapt MOH guidelines*
- *Provide collective and / or individual technical advice*

Targets

1) The total percentage of released PHC CG to Lower Level Units remains above 75% every year of the Plan.
2) 80% of the DHC's attend the annual DHMT planning meetings
3) 60% of the DHC's report having attended at least one PNFP Coordinating Committee meeting in the districts covered by the diocese.

16.1.6 RC HSD Leaders have improved their capacity to implement all the HSD leadership functions (planning, support supervision, monitoring and advocacy).

Activities

- *Provide targeted / specific training to managers of HSD leader units in data management and use / planning, support supervision, monitoring, advocacy, and leadership (see 16.3.10.)*
- *Promote integration of the HSD into the hospital public, or community, health department*
- *Disseminate information and guidelines on HSD published at national level*
- *Assure that the accrual based accounting system allows to cost, monitor, and steer cost HSD function*
- *Provide targeted / specific feedback on the annual reports*
- *Develop a tool to assess completeness of implementation of HSD*
- *Monitor the opportunities to involve members of other PNFP or Public HSD teams in the training.*
- *If opportunities are arise: make use of these*

Targets

1) One member of the management team of each HSD leader unit has attended a targeted / specific training workshop
2) The tool has been developed
3) The HSD leaders can cost the HSD function.

16.1.7 Contractual Approaches (taking developments regarding GI's and the Social Health Insurance into account) are being implemented.

Activities

- *Advocate for Contractual Approaches at National Level*
- *Participate in the development of contract formats*
- *Prepare position/concept papers on contractual approaches*
- *Provide explanations on contract formulation / adjustments during technical workshops for hospital managers*
- *Offer training in negotiation skills to managers of the RC hospitals and HC4 (see 16.3.1)*

Target

1) In each diocese at least one (but preferably more) Health Units has signed a service delivery contract with its District to replace the old Memorandum of Understanding.

16.1.8 GIFMU, HIV/AIDS Focal Point, and UCS are implementing harmonised policies and strategies to enable the RC institutional levels to respond to the challenges of the GI's?

Activities

- *Develop concept papers and presentations illustrating GIs rationale of operation and consequences for RC HUs*
- *Assure UCS representation in national fora regarding GI's (IRCU, UJCC, CCM and other relevant fora/bodies)*
- *Hold regular discussions with GIFMU - HIV/AIDS FP and UCS staff on the evolving problems concerning GI's and the effects on RC health institutions*
- *Develop common policy proposals / strategies*
- *Include presentations on GI developments and effects in TWS of DHC's and HM's (see also 16.2.13 for TW)*

Target

1) GIFMU, HIV/AIDS FP and UCMB together present at least one position paper / agreed strategy per year on issues related to effects of GIs on RC HUs.

16.1.9 RC HUs have been enabled to take part in the Social Health Insurance (SHI) scheme constructively.

Activities

- **Hire expertise for costing studies** *(see also financial management objectives and targets under 16.2., particularly 16.2.5)*
- **Organise the relevant costing studies** *(see also financial management objectives and targets under 16.2., particularly 16.2.5)*
- *Develop the methodology / guidelines to enable the RC institutions to establish contracts with SHI*
- **Organise a technical workshop to explain these, before the Scheme becomes operationa**l *(foreseen for July 2007)*
- *Monitor developments closely to adjust guidelines*
- *Provide technical advice during TWS, or hold a specific follow-up workshop.*

Targets

1) Guidelines are published (before end of FY 2006/7).
2) The technical workshop has been implemented
3) At least once a year the topic is addressed during the TWS for hospital managers.

16.2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION.

Financial Management:

16.2.1. Cost based (accrual) accounting practices are followed in RC Hospitals

Activities

- *Encourage hospitals to develop a plan on financial management improvement which states the hospital's intention to change from cash based to cost based accounting.*
- *Facilitate implementation of the procedures recommended in the manual on management of financial and material resources adopted by the hospitals.*
- *Develop self-study materials for Board members, managers and departmental in-charges in form of: booklets, fliers, CD-ROMs and placing some on the website.*
- **Organise annual follow-up financial management technical workshops for managers.**
- **Organise a training workshop for peer reviewers from successful Hospitals to support hospitals still in the process of implementing the accruals concept**.
- *Facilitate peer review visits by the peer review team (see also 16.3.9.).*
- *Provide distance based support through email, website and telephone.*
- *Support supervision visits.*
- *Prepare a step-by-step procedure on building a fixed asset register.*
- *Facilitate the implementation of the recommendations of the procedures for building fixed assets register.*
- *Develop tools for self-assessment on the progress made.*

Targets

1) By the end of the plan 10 hospitals are able to produce reports according to accruals (cost based) accounting concept having implemented recommendations of the manual.
2) By the end of 2007 each of the 10 Hospitals has a financial management improvement plan stating the intention to change their accounting policy from cash based to cost (accruals) based accounting.
3) By the end of 2009 self-study materials for board members, managers and in charges are available in form of booklets, fliers, CD-ROMS and on the website.
4) By the end of the plan 75% of the hospitals (20) have consistently sent one of their managers to attend the annual financial management technical workshops.
5) By the end of 2007, a team of 2 Management Team members, 2 Administrators, and 2 Accountants has been trained as peer reviewers.
6) By the end of 2009, 6 hospitals have been visited by a peer review team.
7) 10 hospitals access support through email, website and telephone.
8) Annually each of the 10 hospitals has received support supervision visits on average four times.
9) 27 hospitals have developed a fixed assets register.
10) 10 hospitals have an up-to- date fixed assets register, which is used as a basis for the fixed assets figure in the financial report as well as computation of depreciation.
11) By the end of 2007, a self-assessment tool in form of a matrix on the progress made has been developed.

16.2.2. Hospitals using ABC_Fipro are able to produce relevant reports for monitoring and management decision-making processes.

Activities

- **Hire external expertise on Financial Management and its electronic processing** *(see also 16.2.1.) (to cover also advice on other FM processes – see also 16.2.6)*
- **Hire local programming expertise for ABC_Fipro servicing**
- **Employ local financial management expert** *(see all objectives from 16.2.1. to 16.2.10.)*
- *Improve on the technical feasibility and user friendliness of ABC_Fipro the software developed for UCMB network hospitals.*
- *Develop ABC_Fipro stand-alone modules according to specification from users.*
- **Organise training for focal persons on the use of electronic tool developed.**
- Develop electronic back-up services for financial management databases directly on the UCMB-server via internet.
- Provide distance based support through email, website and telephone.
- Support supervision visits.
- Dev*elop a self-assessment tool for developments in implementing ABC_Fipro.*

Targets

1) At least 5 hospitals are using ABC_Fipro effectively using all the modules and producing reports through ABC_Fipro.
2) At least 3 hospitals use stand-alone modules of ABC_Fipro integrated to the current system.
3) All the new focal persons have been trained in ABC_Fipro once.
4) 10 hospitals utilise electronic back-up services of financial management databases directly on the UCMB-server via internet.
5) 10 hospitals access support through email, website and telephone.
6) Annually each of the 10 hospitals has received support supervision visits on average two times.
7) By the end of 2007 a self-assessment tool has been developed.

16.2.3. Fiduciary assurance has been enhanced in RC Hospitals. (the key elements of transparent financial accountability are in place in RC hospital)

Activities

- Prepare a standard list of activities envisaged from a process audit function.
- Facilitate the implementation of this procedure through the (finance committee of) the Boards (see also 16.3.4.)
- Maintain continuous working contact with groups of hospital external auditor by organisi*ng a meeting at least twice a year.*

Targets

1) By the end of 2007 a schedule of the process audit function is available.
2) By the end of 2008 10 Hospitals have had a process audit carried out..
3) From the end of 2007 27 Hospitals produce evidence of external audit of their accounts annually.

16.2.4. Hospitals accessing funds from GIs are able to meet the specific demands of financial accountability of GIs.

Activities

- Get acquainted with the contract (MoU) between GI project agencies and the concerned units during meetings or through correspondence.
- Discuss the demands of GI's concerning accounting in HM-TWS
- Incorporate GI project fund demands in the system of financial recording and reporting of the unit.
- Monitor *compliance to the stated terms quarterly (or bi-annually).*

Targets

1) By March 2007 the schedule of all hospitals accessing GIs and copy of the MoU available.
2) The requirements on the MoU have been discussed in the first HMTW of 2007.
3) By June 2007 the GI project fund has been included in the quarterly financial reports of the beneficiary hospitals.
4) Every year all hospitals accessing funds through GIFMU are compliant to the respective reporting guidelines.

16.2.5. Cost implications are taken into account when scaling-up, adding new services, or extending the package of services is decided in RC hospitals.

Activities

- **Hire expertise for "quick and dirty" costing studies** *(with TOR including tool for quick costing) (see also 16.1.7. and 16.1.9.)*
- **Carry out a "quick and dirty" study to provide first insight into approximate cost of three sets of frequently occurring treatments** *(see also 16.1.7 and 9.)*
- *Develop tool for facilitating costing and assessing feasibility of scaling up-adding of a specific service-extension of the package of care*
- *Insert presentation of tool in technical workshops*

Targets

1) By the end of 2007 report of "quick and dirty" study on costs is available ready to be presented in the technical workshop.
2) Evidence of the presentation of the tool developed is given in the Bulletin and/or Website
3) Five hospitals have costs of at least 3 frequently occurring treatments.

16.2.6. Health Unit managements are trained to assess financial sustainability of own unit and to decide upon the scope of the care package offered.

Activities

- *Develop a tool to assess financial sustainability of health units (using also hired FM – TA expertise) (see also 16.2.2.)*
- *Develop brief training module on the assessment of financial sustainability and the use of the tool (using also hired FM- TA expertise) (see also 16.2.2.)*

Targets

1) The training of module on the assessment of financial sustainability has been inserted in one of the Hospital technical workshops
2) The training of module on the assessment of financial sustainability has been inserted in one of the DHC's technical workshops

16.2.7. The financial management guidelines/manuals are in use in the Diocesan Health Offices.

Activities

- *Encourage the DHC / DHB to develop a plan for financial management support needed*
- *Develop a financial management guideline specifically for the DHO as tool to improve financial management of the office*
- **Training of DHC's on financial management of the DHO**
- **Support supervision visits.**

Targets

1) By the end of 2007 6 DHOs have developed a financial management improvement plan for the DHO and the LLU's
2) At least 6 DHC have been trained in financial management
3) 30% (6) Diocesan Health Offices are implementing financial management guidelines for their office.

16.2.8. The financial management guidelines/manuals are in use in the Diocesan Health Units.

Activities

- *Encourage each DHC to develop a financial improvement plan for the LLU's*
- *Facilitate the implementation of financial guideline in LLU's using the financial management-monitoring tool*
- *Develop a simple electronic scoring tool for the financial management-monitoring tool*
- **Support and/or facilitate training workshops on financial management organised by DHO's for their LLU's in-charges**

Targets

1) By the end of 2007 6 dioceses have a financial management improvement plan for the DHO and the LLU's
2) By the end of 2008 all Dioceses have adopted a financial management manual for LLU's in their Dioceses as indicated by the reports from the monitoring tool
3) At least 6 DHO can carry out monitoring on financial management of all the LLU's
4) At least 6 DHO's report 100% adherence to the established manual of their LLU's
5) At least 6 DHC are able to use the electronic scoring tool
6) At least 6 training workshops have been facilitated.

<u>Efficient Use of Resources</u>

16.2.9. The RC Hospitals are making efficient use of their resources in the given circumstances.

Activities

- *Provide feedback on analysis of annual report comparisons*
- *Provide technical advise on cost containment and improving efficiency during HM TWS*
- *Promote the use of workload based staff establishments*
- *Promote correct drug prescription and management practices*
- *Promote the use of JMS as main supplier*
- *Develop a tool to identify were costs can be contained*

Targets

1) The median values of staff productively (SUO per staff) have increased, or at least remained at the level of 2005/06
2) The median values of cost of production (cost per SUO) have not exceeded values justifiable by annual headline inflation rate.

16.2.10. The LLU's have improved the efficient use of their resources.

Activities

- *Provide feed back to DHC's regarding the annual performance regarding cost per SUO and SUO per staff of their LLU's*
- *Provide technical advice on cost containment and improving efficiency during DHC TWS*
- *Promote the use of workload based staff establishments*
- *Promote correct drug prescription and management practices*
- *Promote the use of JMS as main supplier*

Targets

1) In 75% of the LLU's the SUO per staff member is six or above per day .
2) In 70% of the LLU's the SUO per day, for the health unit, is 26 or above.

Access and equity:

16.2.11. Improved access to - and equity in – health care for vulnerable groups are actively pursued by RC Hospitals

Activities

- *Advocate for access and equity as priority choices for hospitals*
- *Identify and promote new opportunities/ possibilities during HM-TWS*

Target

1) The observed trend of median value of access (total SUO) remain above the baseline data of 2005/06
2) The observed trend of median value of equity (fee per SUO) remains stable or increase to levels justifiable by annual headline inflation.

16.2.12. Improved access to - and equity in – health care for vulnerable groups are actively pursued by RC LLU's

Activities

- *Advocate for access and equity as priority choices for LLU's*
- *Identify and promote new opportunities / possibilities during DHC-TWS*

Targets

1) The observed trend of median values of access (total SUO) remain above the baseline data of 2005/06
2) The observed trend of median values of equity (fee per SUO) remains stable or increase to levels justifiable by annual headline inflation

Range and Quality of Services:

16.2.13. Quality of care and quality of management parameters are established in the process of accreditation

Activities

- **Organise the group related Technical Workshops** (*HMTW plus HC4, DHCTW) (see also 16.6.6.)*
- **Facilitate annual mini-surveys for Drugs' prescription practices and patients' satisfaction (LLU's)**
- *Promote execution of annual mini-surveys for Drugs' prescription practices and patients' satisfaction (Hospitals)*
- *Obtain approval from relevant fora for annual extension of accreditation criteria to include quality of care and quality of management components*
- *Sensitise RC health services about new criteria*
- *Collect information, assess, accredit, sanction non adherence*
- *Develop criteria of accreditation for units / organisations providing special services (which cannot be assessed as "typical health unit")*

Targets

1) Annual addition of at least 1 quality of care and 1 quality of management criterion to the accreditation criteria
2) Drops in accreditation rates do not exceed 5% from the baseline of 2005/06)
3) Criteria of accreditation of "specialised units" are approved by the HC.

16.2.14. The capacity to provide Pastoral Care of the Sick in hospitals has been enhanced

Activities

- **Provide permanent secretariat to the Pastoral Care of the Sick Standing Committee (PCS-SC) (see also 16.6.7.)**
- **Provide funds for ordinary running of PCS secretariat and committee** *(see also 16.6.7.)*
- *Identify and contract Clinical Pastoral Education (CPE) Facilitators*
- **Organise in Country CPE courses (units)**
- **Organise pre-training screening, refresher, follow-up courses for trainees**
- *Facilitate access to CPE courses in other countries (through Scholarship Fund)*
- **Facilitate the recognition of the CPE certificate awarded**

Targets

1) The number of CPE trainees presented for training by hospitals annually exceeds 5.
2) 27 hospitals have an established chaplaincy (at least 1 member of the team trained in CPE).
3) A desk/secretariat for Pastoral Care of the Sick is established at UCMB.

16.2.15. The capacity to provide basic mental health care has been enhanced in RC units

Activities

- **Hire expertise to develop a training module and training tools for refresher courses and institutional training in mental health (basic and TOT)**
- *Identify schools willing to host refresher course*
- **Train tutors of the selected (and other) schools to enable them to provide the training in mental health care of nurses and other health professionals**
- *Train students and graduated nurses and others in mental health.*

Targets

1) Two UCMB affiliated HTI offer refresher courses in Mental Health
2) 70% of nursing tutors in RC HTI have attended the TOT in mental health
3) 50% of the Hospitals have staff trained in provision of mental health services.

16.2.16. The capacity to provide NFP in RC units has been increased.

Activities

- **Hire expertise to develop a training module and training tools for institutional training in Natural Family Planning (NFP) (basic and TOT)**
- *Identify schools willing to host refresher course for fellow Tutors*
- **Train tutors of the selected (and other) schools to enable them to provide the training in NFP of nurses/midwives**
- *Train students and graduated nurses, and other health workers in NFP.*

Targets

1) Two UCMB affiliated HTI offer basic and TOT training in NFP
2) 70% of nursing / midwifery tutors in RC HTI have undergone TOT in NFP
3) Provision of NFP is reported in 27 hospitals
4) Provision of NFP is reported in 75% of HC3.

16.2.17. The capacity to provide palliative care has been increased in RC units

Activities

- *Identify and advertise available courses*
- *Solicit applications for these courses from units*
- **Financially support access to training in palliative care (through scholarship or by direct financing of candidates with Hospice and other training institutions).**

Target

1) All 27 hospitals render palliative care services.

16.2.18. The degree of complete implementation of the Minimum Health Care Package by RC HU's has increased.

Activities

- *Disseminate the findings of the MHCP survey 2006*
- *Plan for enhancement of critical elements of the package by Diocesan Co-ordinator*
- *Add criterion concerning completion of the MHCP to the annual accreditation criteria*
- **Hire expertise for training of surveyors of MHCP survey in LLU's (including EmOC provision) and report**
- *Repeat MHCP survey before the end of the plan*
- *If necessary develop a MHCP for hospitals (this activity will be pursued if the new MHCP definition does not include clear indication for hospitals).*

Target

1) The median value of the degree of completeness of the package for HC3 has increased to 85%.

16.2.19. RC HU's comply with Emergency Obstetric Care (EmOC) criteria

Activities

- **Carry out assessment surveys (2007 LLU's and Hospitals; and** *2009* **Hospitals)**
- *Sensitise Diocesan Co-ordinators about EmOC criteria*
- *Monitor compliance*
- *Stimulate hospitals with HTI to become training centres*
- **If necessary: source or provide short courses on specific topics for EmOC.**

Targets

1) A clear increase of the % of RC HC 3 which satisfy the basic EmOC criteria
2) All hospitals and HC 4 satisfy the comprehensive EmOC criteria.

16.2.20. RC Health Services' Network makes effective use of ICT to improve performance and faithfulness to the mission

Activities

- **Employ local expertise for maintenance of ICT service at premises**
- **Employ local expertise in data analysis**
- **Hire local expertise for website maintenance**
- **Hire local expertise for maintenance of ICT service at periphery**
- **Hire expatriate expertise to transfer skills and competencies to local established staff to sustain capacity in ICT and Data Management**
- **Maintenance and running the ICT service and website at UCMB is secured**
- *Develop suitable web based reporting formats*
- *Publish documents of UCMB, CME/CNE and other continuing education materials on the website (or distribute through e-mail.)*
- *Make documents of UCMB (report, circulars, studies, CME/CNE material etc…) accessible by users on the UCMB website)*
- **Organise support and maintenance supervision visits to peripheral sites** *(see also 16.3.10. and 16.4.7.).*

Targets

1) Visits of users to the UCMB website increase in time
2) E-mail feed-back loop between UCMB and network remains constantly above 80% (see also 3.11 and 3.15 and the monthly test on the reposes rate within three days)
3) Number of report, circulars, studies, CME/CNE material etc… published on the website increases over time.

16.3. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES

16.3.1. The advocacy, negotiation and leadership skills of RC Hospitals/HC4 managers have been strengthened.

Activities

- **Hire expertise to develop a training module and teaching tools in advocacy, negotiations and leadership skills**
- **Organise courses in advocacy, negotiations and leadership skills for hospital managers/HC4**
- *Integrate the module into the UMU - HSM training programmes.*

Target

1) At least one manager of each hospital has attended the advocacy-negotiation-leadership skills course (preferably the leader of the management team).

16.3.2. The advocacy, negotiation and leadership skills of DHCs have been improved.

Activities

- **Organise courses in advocacy, negotiations and leadership skills for diocesan health co-ordinators**
- *Integrate the module into the UMU - HSM training programmes.*

Target

1) All DHCs have attended the advocacy-negotiation-leadership skills course (preferably the leader of the management team.

16.3.3. The high compliance of RC HU's with labour legislation is upheld

Activities

- *Update the standard Manual of Employment*
- *Identify areas where the present manuals of employment of hospital and diocesan health departments do not comply with new Employment Act 2006*
- *Present the identified gaps in compliance to affected hospitals / dioceses and boards*
- *Develop assessment tool for Manual of employment.*

Targets

1) 27 Manuals of Employment of Hospital Manual (100% of all hospitals) have been assessed as aligned with the new legislation requirements.
2) 15 Manuals of Employment of Diocesan Health Departments (+/- 80% of all dioceses) have been assessed as aligned with the new legislation requirements.

16.3.4. Good corporate governance has been firmly established in the RC Health network.

Activities

- **Hire TA in Organisation (Corporate) Governance and Development**
- **Employ local expertise on Organisational Governance and Development**
- *Develop induction and corporate governance module for seminar for boards, hospital managers, and diocesan health coordinators*
- *Develop corporate governance guidelines (board guidelines)*
- **Organise regional seminars on push basis, on corporate governance for Boards and managers**
- *Organise ad hoc seminars courses on pull basis on cost shared arrangement*
- *Embed training in good corporate governance the curriculum of the HSM MSc and Diploma course of UMU*
- *Advocate for revision and implementation of the Charter of Hospitals in the course of the Plan period*
- *Advocate for revision and implementation of the DHD Constitutions in the course of the Plan period*
- *Develop tools for assessment of Hospital Management by the Hospitals Boards*
- *Develop tools for assessment of DHOs / DHD's by the Diocesan Health Boards*
- **Train peer review teams on regional basis**
- **Facilitate exchange visits or group visits with peer review**
- *Provide on demand technical assistance, guided by a result oriented and time limited agreement (MoU).*
- **Conduct support supervision visits from centre, including Boards' and managers' induction sessions when applicable** *(see also 16.6.6.).*

Targets

1) Before the end of 2008 Four Regional Courses have been organised on push basis
2) At least 4 Hospitals have requested course for self on cost shared basis
3) The MSc and Diploma courses of HSM at UMU include the module on Corporate Governance
4) All hospitals have revised their Charter
5) All Diocesan Health Departments have revised their constitution
6) At least 13 Hospital Boards (50%) give evidence of assessment of their hospital management teams
7) At least 9 Diocesan Boards (50%) give evidence of assessment of their co-ordination office
8) 70% percent of the DHO's/DHD's (13/19) score good to very good, using the assessment tool agreed.

Hospitals

16.3.5. Accountability of Hospital Managements to Boards vis-à-vis performance/faithfulness to the Mission (access, equity, efficiency and quality) is established.

Activities

- *Develop a training module on the calculation of the four key indicators*
- *Train hospital managers during HMTW's*
- *Induce Hospital Boards to a better understanding of the key indicators*
- *Embed training modules in the UMU HSM Courses.*

Target

1) 100% of Hospitals managements show evidence of the accountability they provided to Board.

16.3.6. Adequate internal and external accountability of RC hospitals is ensured.

Activities

- **Conduct refresher-trainings on HMIS with focus on Planning, Monitoring and Evaluation, Data Management with focus on MDGs, HSSP and faithfulness to the Mission indicators (also for HC4 staff)** *(see also 16.3.10. and 16.3.14.)*
- *Introduce HMIS Annual Health Unit Report (HMIS 107) to all Hospitals and HC 4 as format for the annual comprehensive report*
- *Identify and integrate along side the HMIS annual reports, indicators to be monitored at Hospital level in line with HSSP II and RC Mission*
- *Develop electronic tools helping Hospital managers to monitor HSSP and RC Mission indicators (4 RC key indicators plus 3 key HSSP indicators - OPD coverage, DPT3 coverage and % of deliveries in Hospitals)*
- *Refine the Annual Hospital Analytical Report format*
- *Provide feedback on annual comprehensive and analytical reports*
- *Encourage establishment of hospital external accountability fora.*

Targets

1) At least 3 refresher training sessions for Hospital and HC 4 Managers on HMIS have been conducted
2) At least 3 refresher training sessions on data management and use, focusing on MDG's and HSSP indicators have been conducted
3) The training modules on HMIS and data management and use have been incorporated into the UMU-HSM courses
4) 100% of the Hospitals report using the HMIS 107 HU Annual Report form
5) 100% of the Hospitals report on (3) PEAP / HSSP II indicators
6) 100% of the Hospitals adopted HMIS electronic analysis tools
7) 80% of the Hospitals publish annual analytical reports according to the agreed format.
8) 50% of the Hospitals organise at least one external accountability forum.

16.3.7. Professional management of the RC Hospitals is enhanced.

Activities

- *Identify and/or advertise and/or run and/or encourage attendance and/or sponsor participation to a range of recognised management courses for Hospital Managements.*
- **Contract UMU organisation for the provision of annual Certificate Course in HSM for mandatory attendance by newly appointed managers (including HTI's)**
- *Identify and/or advertise and/or run and/or encourage attendance and/or sponsor participation to a range of recognised basic management courses for mid-level managers (ward in charges).*

Targets

1) In 80% of the hospitals (22/27) the three core managers (Medical, Administrative, and Nursing Director) have attended a recommended management course.
2) In 80% of the hospitals at least one middle manager has been trained in basic management skills. (baseline: 0).

16.3.8. RC hospitals have been enabled to develop / implement plans that can guide emergency and / or development decisions.

Activities

- *Develop modules of training and teaching materials/presentations for strategic planning courses (see also 16.3.4. for necessary expertise)*
- *Develop modules of training and teaching materials/presentations for contingency planning courses (see also 16.3.4. for necessary expertise)*
- **Offer tailor-made training in developing and implementing strategic planning on a pull basis**
- **Offer tailor-made training in developing contingency plans on a push basis**
- *Provide on demand technical assistance guided by clear terms of reference and a signed MoU*
- *Support supervision visits (see also 16.3.4.)*
- **Facilitate exchange visit between hospitals in the process of developing / implementing a strategic plan.**

Targets

1) All hospitals have a contingency plan to assure continuity of essential services in case of HR or financial crisis
2) 10 hospitals are implementing a strategic plan. (Baseline: 0 / 6 are in preparation)
3) These 10 hospitals have received at least one supervision visit annually
4) The training modules on developing and implementing a strategic plan have been integrated into the UMU training programme as stand-alone course or as modules in the HSM courses.

16.3.9. RC hospitals have been enabled to improve their organisational structures / performance.

Activities

- *Provide on demand technical assistance guided by clear terms of reference and a signed MoU*
- *Support supervision to hospitals with weak performance according to the annual report analysis*
- *Develop a tool for self-assessment of hospital organisational structures / performance*
- **Organise a training workshop for peer reviewers of hospital performance**
- **Facilitate and support peer review visit for performance** *(see also 16.2.1.).*

Targets

1) The tool has been explained during HM TWS
2) All hospitals have undertaken one organisational assessment, using the self-assessment tool
3) Annually at least three hospitals with weak performance, and / or a low score according to the self-assessment tool, have received tailored organisational development advice during a site visit.

16.3.10. The RC Health Centres Four (HSD) are governed and managed as professionally as hospitals.

Activities

- *Invite HC IV to all HM TWS*
- *Provide support supervision in close cooperation with the DHC*
- *Develop adjusted annual analytical report format for HC IV*
- *Promote the adoption of charters comparable to hospitals*
- *Enable HC IV managers to access the recommended management training courses*
- *Include HC IV managers in essential other training courses for hospital managers (leadership / advocacy and negotiation / HMIS / Data management and use, HSD leadership, HSM certificate) (see also 16.1.6., 1.7., 3.1., 3.6., 3.7.)*
- **Provide ICT equipment to HC IV (computers and e-mail facilities)**
- **Train HC IV-HTI records officers and managers in use of ICT equipment** *(see also 16.4.7.)*
- **Train HC IV records officers in electronic registration of HMIS data**
- *Organise support and maintenance supervision visits (see 16.2.20).*

Targets

1) The Five HC IV have revised charters
2) **At least one manager of each HC IV has attended a recommended management course**
3) The five HC IV make use of ICT equipment for HMIS reporting.

16.3.11. The management of ICT is sustained by the RC Hospitals.

Activities

- *Facilitate the contacts between the Hospitals and the various ISP*
- *Facilitate the transition of recurrent cost management to hospitals*
- *Facilitate the identification and selection of reliable IT firms for equipment management*
- *Formulate a "standard" ICT policy template to be adapted by Hospitals*
- *Facilitate the process of adaptation of the ICT policy*
- *Ensure the adoption of the ICT policy.*

Targets

1) 100% of the hospitals have taken up the management of e-mail service cost
2) 100% of the hospitals have taken up the cost to manage the ICT equipment
3) 90% of the hospitals make effective use of e-mail in Hospitals (measured by response to monthly tests by UCMB i.e. reply within 3 days)
4) 100% of the hospitals have adopted an internal information and communication policy.

Diocesan Health Departments:

16.3.12. Effective Diocesan Coordination of Health Centres is established in the majority of the dioceses.

Activities

- *Develop a proposal for a diocesan coordination structure for dioceses with less than 8 HC's*
- *Investigate the problems of DHO's that are embedded in Diocesan Development / Social Service Departments*
- *Develop a proposal to address the key problems*
- *Develop a proposal how to integrate hospitals into the diocesan health coordination structure*
- *Revise the standard DHD constitution to cover the proposal adopted*
- *Provide on demand technical assistance to reorganise diocesan health coordination structures guided by terms of reference and a MoU.*
- *Advocate for the establishment of adjusted structures for diocesan coordination*
- *Advocate for adequate support from the diocesan authorities for the diocesan health coordination*
- **Provide two year financial support to DHD's which need to improve their performance before accessing external funding, guided by an agreement which includes a set of targets to be achieved per quarter** *(see also 16.6.1)*
- *Provide technical assistance, or training, to DHC's in developing longer term plans and / or contingency plans.*

Targets

1) All 19 dioceses have adopted a clear diocesan health coordination structure
2) 70% percent of the DHO's/DHD's (13/19) score good to very good, using the assessment tool agreed
3) Between four and six dioceses have been supported financially to improve their performance.

16.3.13. Accountability of Diocesan Health Offices to Diocesan Health Boards vis-à-vis performance/faithfulness of own LLU's to the Mission (access, equity, efficiency and quality) is established.

Activities

- *Develop training module on calculation of four key indicators for LLU's*
- *Train co-ordinators during DHC TWs*
- *Induce Diocesan Health Boards to a better understanding of the key indicators*
- *Embed training modules in the UMU HSM Courses.*

Target

1) 70% of DHO (13/19) show evidence of the accountability they provided to their Boards.

16.3.14. Adequate internal and external accountability of diocesan health network is ensured.

Activities

- *Conduct refresher-trainings on HMIS with focus on Planning, Monitoring and Evaluation, Data Management with focus on MDGs, HSSP and faithfulness to the Mission indicators (see also 16.3.6.)*
- *Introduce HMIS Health Unit Annual Report (HMIS 107) to all DHO's as format for the annual comprehensive report*
- *Identify and integrate along side the HMIS annual reports, indicators to be monitored at diocesan level in line with HSSP II and RC Mission*
- *Develop electronic tools helping the DHO's to monitor HSSP and RC Mission indicators (4 RC key indicators plus 3 key HSSP indicators - OPD coverage, DPT3 coverage and % of deliveries in HC III)*
- *Refine the Annual Hospital Analytical Report format for DHD's*
- *Provide feedback on annual comprehensive and analytical reports*
- *Encourage establishment of diocesan health external accountability fora.*

Targets

1) At least 3 refresher training sessions for DHC's on HMIS have been conducted
2) At least three refresher-training sessions on Data Management with focus on MDGs and HSSP Indicators have been conducted
3) 60% of the HU's report using the HMIS 107 HU Annual Report
4) 70% of the DHO's report on 3 PEAP / HSSP indicators
5) 75% of the DHB's publish an annual analytical report
6) 25% of DHO organise one external health accountability forum.

16.3.15. The management of ICT is sustained by the Diocesan Health Offices.

Activities

- *Facilitate the contacts between the Diocesan Health Offices and the various ISP*
- *Facilitate the transition of recurrent cost management to DHO*
- *Facilitate the identification and selection of reliable IT firms for equipment management*
- *Formulate a "standard" ICT policy template to be adapted by DHO*
- *Facilitate the process of adaptation of the ICT policy*
- *Ensure the adoption of the ICT policy.*

Targets

1) 100% of the DHO's have taken up the cost of management of e-mail services, e.g. have a functional ICT equipment
2) 80% of the DHO's use the email effectively (measured by response to monthly tests by UCMB i.e. reply within 3 days)
3) 100% of the DHO's have taken up the cost to manage the ICT equipment
4) 85% of the DHO's have adopted an internal information and communication policy.

16.3.16. The management capacity of the HUMC's of RC LLU's has been enhanced.

Activities

- **Hire expertise to adjust the existing AMREF training curriculum for HUMC to current needs and develop modules and training materials for TOT of HUMC**
- **Train HTI Staff, DHC and other diocesan training actors or other training institutions (UMU?) as Trainers of HUMC's.**

Target

1) In 60% of the RC LLU's at least two members of the HUMC have been trained.

16.4. THE RC HEALTH SERVICE NETWORK HAS IMPROVED THE DEVELOPMENT OF ITS HUMAN RESOURCES AND ITS CONTRIBUTIONS TOWARDS PROFESSIONAL TRAINING.

16.4.1. The sustainability and effectiveness of the Scholarship Fund and other scholarship investments have been assured (see also 16.6.7.).

Activities

- **Hire expertise to carry our a research to determine the effect of the scholarship on retention of staff at the end of the bondage period and one year after it has expired**
- *Revise the criteria for short listing, prioritisation, and award of scholarships*
- *If necessary align the statute of the Scholarship Fund) to the findings and recommendations of the study*
- *Market the scholarship fund to external and national donors and to other partners to obtain their contributions*
- **Provide permanent secretariat to the SFMC and Fund** *(see also 16.6.7.)*
- **Provide funds for ordinary running of SFMC secretariat and committee** *(see also 16.6.7.)*
- **Award and finance scholarships.**

Targets

1) The study on the effect of the scholarship fund on retention of staff has been undertaken in 2007
2) The Statute of the Scholarship Fund has been revised
3) National donors/partners have contributed to the Fund's endowment
4) Scholarships are awarded according to Fund's capacity
5) Specific secretariat for the fund is established.

16.4.2. The capacity of RC hospital managers and diocesan coordinators to plan for human resource development has been enhanced

Activities

- **Identify and recruit an expert to advise and assist in the development of methods and tools to identify training needs, guide the determination of priorities and feasibility, and elaborate human resource development plans**
- *Disseminate findings and recommendations of the expert*
- *Develop tools for assessing training needs in institutions*
- *Explain the tool during TWS of HM and DHC's*
- *Provide technical advice for the use of the tool*
- *Provide technical assistance for the development of workload based staff establishments*
- *Improve the central HR data-base and assure annual update*
- *Provide feed back to RC hospitals and DHO's on key HR data.*

Targets

1) Guidelines for the elaboration of HR development plans available
2) The central HR data-base is up to date.

16.4.3. The RC Health Training Institutions (HTI's) are effectively co-ordinated and assisted by UCMB

Activities

- **Acquire Technical Assistance for the induction of the HTI&T Desk person and Committee**
- **Provide permanent secretariat to the Health Training Institutes and Training Standing Committee (HTI&T-SC)** *(see also 16.6.7.)*
- **Provide funds for ordinary running of secretariat and committee** *(see also 16.6.7.)*
- **Support core coordination activities of the HTI&T-SC secretariat and committee** *(see also 16.6.7)*
- **Organise one annual technical workshop for tutors (HTI-TW's) with respective managements** *(see also 16.6.6.)*
- *Ensure representation of the interests of RC HTI's in relevant fora*
- *Disseminate information.*

Targets

1) The HTI&T Coordinator attends 90% of the occurred meetings concerning HTI
2) One technical workshop for HTI's organised annually.

16.4.4. Inter-denominational collaboration with other HTI's has been pursued

Activities

- *Organise and attend regular meetings with UPMB desk for HTI's*
- **Organise at least one annual joint consultation of PNFP HTI's**
- **Support process leading to the establishment of formal partnership for PNFP HTI's.**

Targets

1) At east one annual joint consultation, with al PNFP Health Training Institutions, has been held together with UPMB and UMMB
2) Formal partnership of PNFP HTI's established.

16.4.5. Fiduciary assurance has been enhanced in RC HTI's. (the key elements of transparent financial accountability are in place in RC HTI)

Activities

- *Encourage the school to have a deliberate plan on improvement of financial management in liaison with the HTI & T desk and respective hospital.*
- *Develop an integrated reporting format in line with the MoH/MoES*
- *Develop electronic tools to facilitate the financial reporting and analytic processes*
- *Adapt the UCMB Financial Management Manual to suit HTI's requirements*
- *Ensure implementation of the adapted Financial Management Manual*
- *Develop tools for managers to address the concerns of HTI's Principal Tutors regarding financial management*
- *Involve the HTI's focal persons in all the trainings and workshops on financial management organised for hospitals.*
- **Support supervision to hospitals with HTI's (see also 16.4.10.)**
- *Sensitise the school managements on the importance of process audit function*
- *Facilitate the implementation of the recommendations of the procedures for building a fixed assets register.*

Targets

1) Each of the 11 schools has developed a plan to improve financial management
2) Each of the 11 schools produces an integrated report in line with MoH/MoES guidelines / formats
3) Each of the 11 schools uses the electronic tools for reporting and analysis
4) Each of the 11 schools developed a Financial Management Manual

5) 75% of the HTI's implement the recommendations of the Financial Management Manual
6) In each HTI at least one member of the HTI Management has attended at least 3 Trainings / Workshops on Financial Management
7) Each of the 11 HTI's has received on average at least 4 support visits.

16.4.6. The organisational unity between each RC hospital and HTI has been maintained

Activities

- *Advocate with Hospital Boards to assure that the governance of school is an integral part of the Board functions*
- *Advocate with hospital management teams to assure that the management of the schools is an integral part of the management functions*
- *Suggest modification of terms of reference of boards and school management committees if necessary*
- *Develop a tool for the accountability of the HTI's to the Boards*
- *Explain the tool during HM TWS.*

Target

1) Tool to ensure HTI's accountability to Hospital Boards is available
2) 50% of the HTI's produce evidence of the accountability presented to the Board.

16.4.7. The use of ICT technology has been established in RC HTI's

Activities

- **Provide ICT equipment to each HTI (computers and e-mail facilities)**
- *Establish e-mail connections for the schools according to available ISPs*
- *Link with administration for the payment of recurrent cost for the school e-mail system*
- *Establish a mechanism for cost recovery from the schools*
- *Assure financial sustainability of the e-mail system*
- *Facilitate the process of phasing out of recurrent cost to the schools*
- *Organise training for HTI personnel on the use of ICT equipment (see also 16.3.10.)*
- **Offer basic training to HTI (hospitals) record officers in electronic registration and analysis of HTIS data**
- *Organise support and maintenance supervision visits (see 16.2.20)*
- *Provide technical advise on possibilities of system expansions.*

Targets

1) Each school has received ICT equipment
2) Each school is connected to e-mail and internet
3) Each school has a staff trained in the use of ICT equipment
4) 80% of the HTI use the email effectively (measured by response to monthly tests by UCMB i.e. reply within 3 days)
5) Each school has a staff trained on data analysis processes
6) Each school has taken up the running cost of the system.

16.4.8. The RC HTI's have improved the quality of training and management

Activities

- *Facilitate access to professional tutor training courses (see also Scholarship Fund at 16.4.1.)*
- *Facilitate access to clinical instructor courses, or develop and implement a clinical instructor course*
- *Conduct technical workshops for tutors (see 16.4.3.)*
- *Facilitate access of tutors to HSM training (see 16.3.7.)*
- *Provide technical assistance in the elaboration of school development plans*
- *Develop an HTI accreditation approach that can be gradually extended*
- *Agree annually with the HTI and hospital managers, and Standing Committee on the criteria for accreditation for the next year*
- *If possible agree the accreditation approach and criteria with UPMB HTI&T Standing Committee*
- *Include the subject of quality of training and management in the technical workshops*
- *Collect information, assess, and accredit, or sanction non-adherence*
- *Disseminate information from MOH and MOES on quality standards.*

Target

1) 80% of RC HTI's have trained one of the Tutors in management
2) 50% of the HTI's have a development plan.
3) An accreditation process for HTI has been developed and published
4) At the first round in 2008/09 at least 70% of the HTI are accredited
5) Annually at least one quality of training and one quality of management criterion are added to the list of criteria
6) 80% of the RC HTI have a tutor / student ratio of 1:30.

16.4.9. The RC HTI's are training Enrolled Comprehensive Nurses in correspondence to the national strategic plan for HR development.

Activities

- *Establish the number of ECN training places required according to the MOH Strategic Plan for HR development*
- *Establish the number of registered nurse training places required*
- *Agree with MOES how many of the planned training places can be assured by the RC HTI's*
- *Advocate for a ECN curriculum that corresponds to the needs to HC's and hospitals and is affordable*
- *Develop a proposal for an equitable the division of the ECN and Registered training places among the RC HTI's*
- *Promote the implementation of the plan once adopted by Standing Committee and HC*
- *Advocate for adequate support to the RC HTI's transiting to ECN training*
- *Provide support supervision.*

Targets

1) The RC HTI's have an assigned number of ECN training places
2) A proposal for an equitable division of the ECN and Registered Nurse / Midwifery training places has been adopted.
3) All RC HTI's training ECN's have been visited once annually
4) The number of ECN's graduating annually from RC HTI corresponds to the national planning (or if not known yet by July 2008: reaches not less than 480 graduates by the end of the plan).

16.4.10. The RC HTI's have broadened the range of training programmes for health workers

Activities

- *Promote the addition of refresher training courses per HTI (see objectives 162.15 and 16.2.16)*
- **Develop curricula, training modules and teaching material for new training courses to improve the skill mix in hospitals and HC's (for instance: bedside care; specialised HIV/AIDS nurse; HIV/AIDS coordinator; clinical instructor course)**
- **Train the tutors for the new courses**
- *Motivate the HTI's to implement the new courses*
- **Mobilise, or provide, start-up financial support to HTI accepting to implement new courses**
- *Develop the independent examination procedure and quality assurance approach for each new course*
- *Provide support supervision to facilitate implementation of the new courses (see also 16.4.5.)*
- *Monitor implementation and assist in adjusting the curricula in accordance with lessons learnt*
- *Once the national strategic plan for HR development is known: establish whether the RC HTI's should take on Allied Professional and / or Specialised Nurse training courses*
- *Assist RC HTI interested in taking on Allied Professional, or specialised Nursing, Training Courses to start these.*

Target

1) Two new curricula are being implemented by RC HTI.

16.4.11. The RC HTI's have improved their sustainability while remaining accessible for candidates from the rural areas

Activities

- *Assist the RC HTI's to use their resources efficiently (see also 16.4.5., 16.4.6., 16.4.7. and 16.4.8.)*
- **Undertake a training costing study that will enable the HTI's to analyse the gap between their present income and the budget required** *(the costing study will only be done if the announced plans to undertake a costing study, of external partners, do not materialise. If this study is done by others, only the second part of this activity will be retained)*
- *Develop an indicator to monitor efficiency*
- *Negotiate with interested and willing parties (Global Initiatives, Development partners, or MOES) on a feasible result oriented allocation of subsidies (bursary system for a defined number of students)*
- *Assist RC HTI's in developing a student fees policy and structure that takes subsidy allocations into consideration and facilitates access for poor students*
- *Enable the RC HTI's to use and account for the subsidies in accordance with the agreements reached with the partner.*

Targets

1) All RC HTI's receive recurrent cost subsidy from one, or more, partners.
2) A result oriented subsidy allocation mechanism has been agreed with the partners
3) 80% of the RC HTI's provide evidence of a policy that assures access to poor candidates
4) An indicator to monitor efficiency of HTI's has been developed.

16.5. THE RC HEALTH SERVICES HAVE IMPROVED THEIR ADVOCACY FOR THE TARGET POPULATIONS AND INSTITUTIONS

16.5.1. A focused advocacy agenda has been developed and implemented

Activities *(see also 16.1.5., 16.1.7., 16.3.1., 16.3.2.)*

- *Identify topics for advocacy agenda targeting external actors*
- *Identify topics for advocacy agenda targeting internal actors*
- *Consult and inform RC hospital managers and diocesan coordinators*
- *Annually compile list of issues and plans for lobby and advocacy for the network (UCMB, hospitals, DHO) to be presented and discussed during the 1st DHC TW's and HMTW's*
- *Prepare concept / position papers*
- *For crucial topics an advocacy plan is developed including strategies for constructive reactions in case a worse case scenario develops*
- *Prepare standard presentations if the subject is to be addressed at peripheral level as well*
- *Provide technical advise to RC managers and diocesan coordinators on advocacy content matters*
- **Hire expert advice for advocacy as needed.**

Targets

1) One agenda for advocacy per year documented and shared with hospital and diocesan coordinators.
2) UCMB has undertaken at least one advocacy action each year.
3) Annually at least one diocese and one hospital report to have carried out an organised advocacy activity.

16.5.2. Strategic partnerships and alliances have been enhanced

Activities

- *Intensify formal collaboration with other Medical Bureaus*
- *Formulate joint advocacy agendas with the other Bureaus*
- *Formulate position/concept papers on selected agendas*
- *Identify other partners with whom common agendas can be pursued*
- *Encourage the DHC's and Hospital Managers to participate in the District PNFP coordinating Committees*
- *Disseminate information on potential partners are district level*
- *Provide technical advice on possible alliance at district level, if requested.*

Targets

1) If developments in the external environment call for it: Joint advocacy action(s) is pursued, together with the other Bureaus
2) In the course of the Plan period two formal new partnerships have been established on specific agendas by UCMB.

16.5.3. The UCMB team has maintained a conciliatory advocacy approach, also under pressure.

Activities

- *Identify suitable training options for advocacy and negotiation skills*
- **Pursue specific training, separately or together with hospital managers / diocesan coordinators** *(see 16.5.4).*

Target

1) Before mid 2008 at least two UCMB advisors have attended advocacy and negotiations coaching sessions / or a training course.

16.5.4. Advocacy and negotiation (and leadership skills) of RC HU managers have been improved.

Activities *(see also 16.3.1. and 16.3.2.)*

- *Develop a training module in leadership, advocacy and negotiation skills*
- *Organise courses for hospital / HC 4 managers and diocesan health co-ordinators*
- *Integrate the module into the UMU - HSM training programmes.*

Target

1) At least one manager of each hospital / HC 4 has attended the advocacy and negotiation skills course
2) All diocesan health co-ordinators have attended the advocacy and negotiation skills course.

16.5.5. The RC Mission Statement and Health Policy priorities are owned by the UEC.

Activities

- *Present revised RC Mission and Policy priorities to the Plenary UEC*
- *Report annually to the plenary on the performance of the RC network compared to the four indicators for faithfulness to the Mission*
- *Advocate for compliance with policy priorities during the plenary and during meetings with individual bishops*
- **Organise annual sensitisation fora for religious leaders** *(see also 16.6.7.).*

Targets

1) The Health Commission expressed agreement on RC Mission and with Policy priorities for the period 2007-2011
2) UEC receives and acknowledges the annual report on the RC Health network performance in Faithfulness to the Mission.

16.5.6. The awareness of the RC Mission Statement and Health Policy priorities has increased among catholic actors at local level.

Activities

- *Sensitise DHC on need to make the RC Mission and Policy Priorities, including their implications, known within the diocese*
- *Prepare standard presentations for awareness raising meetings*
- *Ask Bishops to "cause" meetings on the topic at diocesan level.*

Target

1) 70% of the DHCs show evidence of an activity to raise awareness for the RC Mission and Policy Priorities in their diocese.

16.5.7. A study has been undertaken to determine which poor population groups are presently not accessing the RC health services and which feasible strategies exist to increase their access.

Activities

- *Develop the terms of reference for the study*
- **Hire expertise to carry out the research into which groups are not accessing RC health services and how to increase their access**
- *Disseminate the results of the study.*

Target

1) The study to improve the accessibility for poor groups presently not accessing RC services has been undertaken
2) The report of the study is available in all hospitals and Diocesan Health Offices.

16.6. OVERARCHING AND CROSSCUTTING OBJECTIVES

16.6.1. A suitable format for enhanced UCMB Coordination and Support for the RC health institutions in conflict ridden dioceses, of Gulu, Lira, Moroto, and Kotido, is operational.

Activities

- *Discuss options for enhanced co-ordination with RC actors in the North and Karamoja*
- *Agree on a suitable/acceptable option*
- *Develop ad hoc activity plan*
- **Provide initial / partial funding for the option / plan**
- *Implement the plan*
- *Monitor and evaluate implementation of the plan*
- *Monitor and evaluate the experience of this decentralisation pilot in terms of feasibility for replication in the other regions.*

Targets

1) The four Diocesan Health Offices are functioning well according to the UCMB assessment tool.
2) The DHO's of Lira and Kotido receive and use the financial support for their normal operations effectively and efficiently.
3) Each of the four DHO's has developed a three-year development plan for their LLU's and implementation is mid-way.
4) For the funding of these development plans they have accessed funds from development partners active in the area.
5) Each hospital has developed a rehabilitation / development plan and is mid-way in the implementation.
6) The HTI are contributing to the development plans of the hospitals and the DHO's both in terms of increased number of students from the region and by providing refresher courses.
7) The pilot experience in decentralisation of UCMB has been evaluated.

16.6.2. Congregations in Health have been assisted in re-defining / re-focusing their own mission in the healing ministry

Activities

- *Establish contacts for sensitisation of Congregations on RC Mission and Policy*
- **Organise an annual ad-hoc Forum of exchange of experience for congregational actor** *(see also 16.5.5. and 16.6.7.)*
- *Provide on demand technical assistance to congregations wishing to redefine / refocus their own mission in the healing ministry*
- *Promote uptake of CPE by members of Religious Congregations*
- *Promote uptake of training in social medical work by members of Religious Congregations*
- *Promote establishment of Memoranda of Understanding between Dioceses and Religious Congregations.*

Targets

1) Formulated Memoranda point at a clear understanding of the Managing Agency role
2) One exchange forum per year organised.

16.6.3. Options for own legal status for large RC health institutions are identified.

Activities

- *Advocate for - and facilitate the establishment of - an inter-departmental legal committee at the Catholic Secretariat*
- **Identify and recruit Expert legal advice** *(if possible in collaboration with other departments of the Catholic Secretariat)*
- Develop TOR for the needed researches
- Under take legal research on current and possible evolution of the relationships *between civil and canon law in Uganda.*

Targets

1) UCS interdepartmental legal committee or equivalent is operational
2) Options for solution of the identified legal bottlenecks are presented to UEC.

16.6.4. Strong bonds of collaboration with UMU department of health sciences have been established.

Activities

- Integrate HSM related training modules developed by / for UCMB into the UMU programme either as stand alone courses or as module in the HSM courses
- Develop new modules to address specific issues (f.i. leadership skills, training of trainers, advocacy and negotiations skills, …..) and assure their integration into the standard management training
- Review regularly the content of the HSM training programmes to improve their adjustment to the management demands in the institutions
- Develop a joint research agenda that aims at addressing issues of importance to the RC health network
- Carry out *a feasibility study for a joint UCMB-UMU training centre.*

Targets

1) Annual publication of one jointly agreed/identified study/research agenda
2) Cost analysis module integrated in the HSM MSc course
3) Management performance assessment module integrated into all HSM courses
4) The report of the feasibility study for a joint training centre has been presented to the HC and the Senate of the University.

16.6.5. Innovations in health care delivery by - and management of - RC hospital and LLU's have been pursued

Activities

- *Identify innovative approaches in areas of health care delivery and* management
- **Promote and partially fund operational research to improve services and / or management.**

Target

1) One article annually published on the Bulletin concerning innovation.

16.6.6. Core functions of UCMB are carried out (See Section 19)

Activities

- **Established personnel is employed**
- **Running of office is secured**
- **Ordinary supervision and advisory visits to the dioceses and hospitals** *(see also 16.3.4.)*
- *Organise the group related Technical and policy Workshops (HMTW plus HC4, DHCTW, HTI technical workshops – HTI-TW) (see also 16.2.13 and 16.4.3.)*
- **Publication of the news letter, the Bulletin, at least twice a year**
- *Data collection, analysis and feed back provision;*
- *Dissemination of national policies and guidelines;*
- *Information exchange between the RCC health services and with the external partners*
- **Ad hoc support to peripheral level**
- **Safeguard of physical assets is guaranteed**
- **Unforeseen events are adequately addressed.**

Target

1) All reflected by the annual work plans.

16.6.7. Governance of UCMB is secured (See Section 20)

Activities

- *Update terms of reference of Health Commission and Committees as necessary*
- **Organise and facilitate HC meetings, Executive Board (EB) meetings, Finance and Planning Committee (F&P) meetings**
- *Organise annual sensitisation fora for religious leaders (see also 16.5.5. and 16.6.2.)*
- *Organise and facilitate Pastoral Care of the Sick Standing Committee (PCS-SC) meetings (see also 16.2.14.)*
- *Provide permanent secretariat to the PCS-SC (see also 16.2.14.)*
- *Organise and facilitate Scholarship Fund Management Committee (SFMC) meetings (see also 16.4.1.)*
- *Provide permanent secretariat to the SFMC and Fund (see also 16.4.1.)*
- *Organise and facilitate the Health Training Institutes and Training Standing Committee (HTI&T-SC) meetings (see also 16.4.3.)*
- *Provide permanent secretariat to the HTI&T-SC (see also 16.4.3)*
- **Organise and facilitate Annual General (AG) meetings**
- **Organise induction of the HC appointees to the governing and management bodies of JMS**
- *Renew the Health Commission and its committees' membership*
- *Organise induction of the newly appointed members of the HC and committees*
- *Monitor and evaluate UCMB performance, including the external review of the Plan.*
- **Audit UCMB accounts**
- **Hire expertise for Operational plan mid term review**
- **Hire expertise for drafting of Operational Plan 2010-12**
- **Organise Operational plan end of term review and evaluation conference / consultation conference for new Operational Plan.**

Targets

1) TOR of statutory organs of UCMB governance have been updated
2) Meetings of all statutory organs have been held as foreseen by statutes
3) Membership of the Health Commission has been renewed at its expiry
4) New members of the HC have been inducted
5) Membership in the JMS statutory organs have been renewed as necessary
6) HC appointed members of JMS statutory organs have been inducted
7) The report of the Mid-term Review of the Operational plan is available by the end of the second year of the plan
8) The Operational Plan 2010-12 is approved before the end of 2009.

17. The Main Actors

All the RC health service actors are reviewed here below with a particular emphasis on their roles for this Operational Plan.

17.1 THE HEALTH COMMISSION AND UCMB

As indicated under the Strategic Plan chapter, the Health Commission and UCMB will lead and manage implementation of the Operational Plan. For UCMB the above objectives entail that its extended function is continued. The capacity it will require for this is described in chapter 20.
As indicated earlier, the RC Mission and the set-up of the RC church organisation determine the ways through which the Health Commission and UCMB implement their functions. Thus UCMB will continue to act as policy and technical advisor, facilitator, and coach to the actual decision makers and implementers.

17.2 PERIPHERAL IMPLEMENTERS

17.2.1. Hospitals

The hospital Owners, Boards and Managers are the key actors in ensuring that the hospital can realise the RC Mission. They are therefore the actual implementers of required changes and improvements. The decision to take up the technical proposals and advisory services of UCMB belongs to them. The need to accelerate the improvement of the systems will have to be carefully balanced with the need to assure that their commitment is genuine so that the improvements will really take root. The Governors will be targeted specifically to enhance their capacities to enact their responsibilities to guide, supervise, and assess the performance of management team members and assure transparent accountability.

17.2.2. Health Training Institutions

This group has asked to become a separate beneficiary of UCMB's support. The principal tutors became convinced of the need to improve their capacity, enhance their cooperation with other PNFP schools, and improve their integration into the national system. The active involvement of the hospital board and management will be essential as all are convinced that the RC HTI should remain integral parts of their hospital organisation.

17.2.3. Diocesan Health Departments

The Diocesan Health Boards and Diocesan Health Coordinators have the assignment to support and develop the lower level health units. As improvements in performance in the latter have proven too slow, while the need to improve increases rapidly, these two groups will be given high priority.

17.2.4. Health Unit Management Committees and Health Centre In Charges

These two groups are normally not direct target groups for UCMB support. For this period they will be targeted for specific training activities to accelerate improvement. Where possible this will be done via the Diocesan Health Coordinators / Offices.

17.3 CONGREGATIONS

In the past period the roles and contributions of the congregations have not really been clarified or enhanced. The standard Modus Operandi and Memorandum of Understanding, adopted by the Bishops and the Superiors, to enable the parties to organise their relationship and mutual obligations, has not really been taken up. Other attempts to engage the congregations in a dialogue about their roles did not succeed either.
However, the HC and UCMB remain convinced that the congregations have a major role to play towards realising the RC Mission. For this reason new efforts will be deployed to enable the congregations to develop their own views and plans and assist them in realising where they match with the needs of the health institutions.

17.4 INSTITUTIONAL PARTNERS

These are colleague RC affiliated institutions that will play important roles during the implementation of the Operational Plan.

17.4.1. Uganda Martyr's University, Faculty of Health Sciences

The UMU Faculty of Health Sciences will be a major partner during this operational plan. The aim is to develop a structural cooperation to embed the ad-hoc / tailor-made training courses UCMB has developed in answer to specific needs in management and data analysis and utilisation. This cooperation will also cover adjustment, of the Health Service Management and other courses of the Faculty, to the actual needs on the ground. The third area will concern joint research efforts in support of the development of the institutions and in support of their operational integration in the national health system.
Both partners are well aware of the great need to extend and improve the training programmes and opportunities for the RC health services managers as well as for managers from partners. Apart from all the training needs mentioned above, they realise that there are no specialised programmes for nurse-managers and the capacity, in the country, to train tutors is very limited. As the physical training capacity at UMU is limited – and is matched by equal scarcity of adequate training sites in Kampala -, they are contemplating a joint training centre in the capital. During this operational period it should become clear whether this would be feasible.
Because of the special relationship and the joint recognition of the needs, the above-mentioned plans will be pursued under crosscutting objective 16.6.4.

17.4.2. Joint Medical Stores:

Enhancing the relationship with JMS will continue to be pursued in the interest of improved drug availability and drug management in the RC institutions. The only objective that this sustained and fruitful collaboration will require is the induction of the appointed members of the Health Commission to the governance and management structures of JMS (see Objective 16.6.6). Otherwise the current statutory meetings ensure that exchange of information and views takes place.
Very recently an important new initiative has been taken towards institutionalising the relationship. An agreement has been reached between the representatives of Church owners, UCMB and UPMB, and the Board of JMS, that stipulates that JMS includes in its annual budget a contribution to the scholarship funds of the two Bureaux.

17.4.3. Global Initiatives Fund Management Unit

The installation of GIFMU, as department of the Uganda Catholic Secretariat, was initiated by the HC and UCMB, together with the HIV/AIDS FP, to facilitate access to Global Initiatives Funds for the entire RC network. The new developments concerning the GI's as well as the impact of these vertical funds on the RC health Institutions call for a much more intensive cooperation between UCMB and GIFMU. The aim is to develop common positions and policies in response to developments as well as advocate together for the interests of all RC actors actively engaged in implementing these projects.

17.4.4. National HIV/AIDS Focal Point

Where the main focus, of the Global Initiatives Funds projects, seems to be shifting towards HIV/AIDS care and treatment, the UCMB, GIFMU, and the UEC Focal Point need to work more closely together. The aims are the same as for the cooperation with GIFMU.

In addition as the RC organisational structure to respond to the multi-sectoral challenges of HIV/AIDS is gradually including Diocesan Focal Points cooperation at national level can enhance the cooperation at diocesan level. In many cases the DHC is also the FP for HIV/AIDS.

17.5 RC CHURCH LEADERS

Experience has shown that realisation of the RC Mission cannot be the domain of the health institutions alone. They need the support of the wider church network. In addition key decision makers at diocesan and parish level have to be better aware of the key tenets and the policy priorities to ensure that their actions are in line with the policy. For these reasons advocacy for the RC Mission will be extended to all church leaders.

17.6 EXTERNAL PARTNERS

This category of RC Health Network Partners is of great importance to the success of this Operational Plan. Their contributions have varied in the past but one thing is evident: the relationships have grown and matured and this is the essential reason why the cooperation will include new forms in this period. The first two especially relate to the plans in the north as they have a longstanding relationship both with UCMB as with the RC institutions there, as well as a wealth of experience in the north. The following partners are valuable partners for the total operational plan.

This listing does not imply that new partnerships will not be sought to support the overall plans, either in support of particular elements already recognised or which may emerge during the implementation of the plan.

17.6.1. CORDAID

This Dutch Catholic Organisation has been the main Development Partner of UCMB since 1996 (then still named Memisa and Bilance). Without its financial assistance, UCMB and the RC health services would not have been able to achieve what they did. Though very important the financial support is only one aspect of the strong relationship that has grown between UCMB and Cordaid. Over the years the moral support and the trust given have been as important, if not more. Then, the continuous open dialogue, the challenging questions, the willingness to think with, instead of for, UCMB, and the flexibility allowed, have all contributed to succeeding the high level of performance.

For this new Operational Plan period we only wish to strengthen this broad cooperation further.

17.6.2. AVSI

This Italian Catholic NGO has been operational in Uganda since 1984. Its Mission is to promote and support human growth in Uganda (and neighbouring countries) along the lines of the Social Doctrine of the Catholic Church, through different modalities, activities, and actions, in a dynamic and functional link and strong partnership with civil society organisations, the non-profit sector, and the private sector as well as with government institutions.
Guided by this Mission cooperation with and support to the institutions of the RC Church in Uganda has always been high on the agenda of AVSI. For the RC health network and UCMB it has meant various forms of support, of which the most important of the last five year is the technical assistance and financial support for the development all the aspects of the Information Technology / Data Management (ICDMA). Individual RC institutions, especially in the North, have been supported with wide range of resources to enable them to continue to provide services during the war period.
During this period the support to the ICDMA will be phased out in line with the plans of UCMB (see objectives and chapter 20.2.2).
However, in view of the increased need for specific support to the institutions in the north, AVSI and UCMB plan to establish a new form of cooperation. The aim is to ensure together that the institutions in the north can make optimal use of the new funds and opportunities (arising out of various post-conflict / recovery phase initiatives), while at the same their institutional capacity is increased and their identity safeguarded. This calls for harmonisation of policies and support strategies and joint action. It is also hoped that AVSI will be able to technically and / or financially facilitate the support of UCMB's to the northern dioceses.

17.6.3. CUAMM

CUAMM is also an Italian NGO with a very long experience in Uganda, dating from the early '60ies. As Catholic organisation targeting structural development of health care services, it has been involved in a large number of RC hospitals and diocesan health units, all over the country. Presently CUAMM concentrates it support to RC institutions and other partners in the Dioceses of Lugazi, Hoima, Lira, Moroto, and Kotido. It is also a development partner of Uganda Martyr's University, Faculty of Health Sciences. In addition CUAMM has assisted the entire RC health network through its support to UCMB operations (funding for technical assistants, scholarships for HSM training, etc, etc.)
In the perspective of the increased attention for the north and Karamoja (dioceses of Moroto and Kotido), UCMB and CUAMM would like to develop a similar form of cooperation, as envisaged with AVSI.

17.6.4. International Institute for Communication and Development (IICD)

This Dutch organisation started its support to the RC health network / UCMB ICT and Continuing Medical Education programme in 2003/04. With financial assistance from DFID and Cordaid it contributed largely to the present level of performance. Its support to the hospitals and diocesan health offices is to be phased out during the first two years of this Operational Plan. However, before that they have agreed to assist the schools in accessing ICT equipment and training.

18. IMPLEMENTATION STRATEGIES

A range of strategies will be used to implement this operational plan, as was done during the past operational plans. The strategies that have proven valid are listed below complemented with the new insights, or adjusted, where applicable. However, where new strategies prove necessary / of value these will certainly also be put to use.

18.1 CAPACITY BUILDING

As indicated the main role of UCMB for its extended support is Capacity Building. The methods to be applied and / or be developed during this period are:

- Hands-on technical support to develop and implement improved instruments and enhance capacity through a learning process;
- Development and implementation of tailor made training courses;
- Facilitating access to formal / professional training courses through the scholarship programme;
- Actively offering training programmes opportunities and sponsorships in areas that are underscored by the institutions (pastoral care, palliative care, mental health, social work);
- Annual support supervision visits with feedback reports;
- Development and testing of self assessment tools in OD and Financial Management;
- Piloting an approach for peer reviews among hospitals and diocesan health offices.

When individual support processes are required the local actors have to enter such process voluntarily to assure that they are fully convinced to the need to change / and improve. However, the experience has shown, that embedding these into the institutional systems and culture, demand an even stronger commitment. To this effect UCMB proposes to work with formalised commitments (signed agreements or Memoranda of Understanding) that include targets / results to be achieved and a timeline. When it is evident that certain conditions need to be in place and / or when a former attempt has failed, the institution will be requested to meet these conditions prior to starting the process.

18.2 MONITORING, EVALUATION, AND FEEDBACK

The experience has shown that, real time information exchange, data analysis, and feedback on performance, have important positive effects at peripheral level. Not in the least because they motivate managers and diocesan coordinators to strive towards improving their performance. Therefore this strategy will continue to form the most important support strategy during this operational plan period.
Just as, or even more, importantly, the information collected and analysed, will be used by the Bureau to adjust and improve the content of its support services and capacity building in the areas of organisational development, human resource management, and financial management. This information will also continue to form the basis for the advocacy efforts, as before, at national level and increasingly at district level.
During this period, the improvements in the ICT and data management support will gradually shift towards continuing education in using data for planning, local performance appraisal, and local advocacy. For this and for the other key areas distant learning approaches and materials will gradually be developed and made accessible to the members through the website.

In line with the important positive impact in hospitals the ICT network will be extended to two new groups: the HC IV and the HTI. The aims here are the same as for the hospitals and diocesan health offices.

18.3 ACCREDITATION

As indicated earlier, the accreditation system has proven of great importance to ensure that essential improvements are implemented. Therefore this strategy will be further developed to support the attainment of the operational objectives as well as the capacity development efforts. Annually criteria will be added that match the need to improve the quality of care and the quality of management, the need to "bring changes home", e.g. institutionalise them.
Following the positive experiences with the accreditation system for health units, a similar accreditation system will be developed for the HTI. The aim is the same: stimulate the required intuitional improvement and enhancing quality of education and management.
In addition, a specific accreditation process will be developed to accredit organisations operating within the Mission of the Church in health addressing specialised areas of service delivery (e.g. AIDS only, rehabilitation and disabilities, eye care etc…), which, at the moment, do not find suitable placement in the modus operandi of the Bureau.

18.4 RESEARCH

As in the past, UCMB will use operational and other research to establish how best to solve a particular problem, or innovate methods of work, both within UCMB as at the level of the peripheral actors. In the chapter covering the objectives (16) several are listed (costing of services, human resource development, and legal options). It may prove necessary to add others as implementation progresses, particularly in view of the new funding methods government is proposing.
In addition to own use of research, UCMB is also in favour of promoting operational research in the Health Units, as a way to enhance the institutional capacity to solve problems. In both areas the cooperation with UMU Faculty of Health Sciences will be pursued.

18.5 ADVOCACY AND NEGOTIATION

During this operational plan the objectives (see 16.5.) are crucial as so much is at stake. This underscores the reason to also consider this a strategy because, the attainment of the majority of the objectives, will depend on the outcome of the advocacy and negotiation efforts. Enhancing the skills and developing common agenda's will be important as will be the approach to always attempt to "go for a win-win" situation.

19. The Core Function of UCMB: Continuing Institutional Support Services

The structural roles (core functions) of the Health Commission and UCMB are to guide, coordinate, represent, and technically facilitate the institutional operations of the RC health services. This set of functions continues as during the former period. The content of the pertaining activities will, however, also be largely determined by the strategic goals and operational objectives as these have everything to do with the institutional functions of the RC health facilities.
Though the underlying aim, for the HC and UCMB, has to remain the return to the core functions, this is not foreseen for the period covered by this Operational Plan. The need

to accelerate the institutional development of the institutions and to find adequate solutions in response to the new development is too high.

The bodies through which the core functions are implemented are the Annual General Assembly, ad hoc committees, diocesan co-ordinator meetings, hospital managers meeting, and the Plenary Meeting of the Episcopal Conference. These will continue and constitute the main fora for the decision-making processes also for the implementation of the Operational Plan.

The standard institutional support activities will be continued (see objective 16.6.6), in the interest of the overall purpose of UCMB, but they will also enhance the achievement of the specific objectives. These are:

- General supervision and advisory visits to the dioceses and hospitals;
- Policy and technical workshops;
- Publication of the news letter, the Bulletin, at least twice a year;
- Data collection, analysis and feed back provision;
- Dissemination of national policies and guidelines;
- Information exchange between the RCC health services and with the external partners.

Targets for each of these activities will be developed in the annual work plans.

20. The Organisational Capacity and set-up of UCMB

The strategic plan aims at enabling the RC health service network to lift their performance and institutional functioning to a higher level in view of realising the RC Mission. The operational plan aims at accelerating the development and embedding of the key capacities in combination with developing adequate responses to new, potentially threatening, development in the external environment.
To ensure effective implementation of the Operational Plan 2007 – 2009, in the context of the Strategic Plan 2007 – 2011, the Health Commission and UCMB require a flexible organisational set-up and a flexible multi-disciplinary team with an adjusted set of technical expertises.

20.1 THE HEALTH COMMISSION

The Health Commission is the “board of governors” of UCMB in the name of the UEC. The chairperson is the bishop that has been elected to this office by the UEC Plenary. The Commission is composed of representatives of the key internal stakeholder groups: the hospitals, the diocesan coordinators, UCS, UMU, and JMS.
Since 2004 the Health Commission realises its responsibilities through its bi-annual meeting and statutory committees. The Executive Board and Finance & Planning Committee support the Commission in its ordinary functions. The first meets twice a year thus alternating with the meeting of the full HC. The F&P committee sits quarterly.
The Scholarship Fund Management Committee is third statutory committee of the HC and its functions are focussed on awarding scholarships, managing the scholarship budget, monitoring implementation, and advising the HC on all matters pertaining to the Scholarship Fund.

During the past five years, the HC used Task Forces when a specific subject required in depth investigation and development. These Task Forces receive specific Terms of Reference and an assigned time schedule to develop their advice. This approach has proven appropriate to ensure structural and timely consultation of the RC health service network and other internal stakeholders concerning the specific issue.

Where the need for a Task Force has already been identified, during the development of the operational plan this has been indicated.

The two most prominent examples of the use of a Task Force are the TF for the development of the training programme for Clinical Pastoral Workers and the TF on the future of the Nurse Training Schools. Both now have a structural place in the work of UCMB and the institutions. In view of their importance and the need to develop the areas further, the HC has installed a Standing Committee for each. The role of these Committees is to lead processes and advise the HC regarding policy and implementation decisions.
In the last phase of the operational Plan 2004 / 06, the HC assigned specific budgets to the committees to facilitate the implementation of their fairly extensive mandates. These indirect "budget management" functions will be further enhanced in the course of the 2007 / 09 Operational Plan.

In the course of this Operational Plan, the membership of the Health Commission will be renewed. This implies that all the new members will require adequate induction. The same applies to the Health Commission appointments in the Governance structure of JMS. The related activities have been reflected in objective 16.6.7.

20.2 CAPACITY OF UCMB

To enable the institutions to achieve the operational objectives UCMB has to continue a high level of technical support. This sub-chapter is described extensively in view of the considerable changes required.

20.2.1. The Core Team

This team consists of Executive Secretary (ES), an Assistant Executive (AES), an administrator, data processor / documentalist, secretary, and driver. In line with the core functions the ES will be main spokesperson with the external partners, especially the MOH and Development Partners. He will lead the implementation of the Operational Plan. Both core tasks and specific tasks, with respect to the Operational Plan, will be divided between the ES and AES. The core tasks include, among others, the ordinary administration of the Bureau, the fairly intensive involvement in the governance of JMS, the sometimes rather demanding participation in the life of the mother organisation - the Uganda Catholic Secretariat (UCS) -, and specific assignments (not easily foreseeable but demanding) by the Episcopal Conference.
The specific tasks will include the development of policies, approaches, and guidelines that can assist the institutions to access and use the GI's and the same for the Social Health Insurance.

20.2.2. The Team of Technical Advisors

In the former period the Health Commission / UCMB succeeded in attracting Ugandan technical advisors in Financial Management, Organisational Development, and Information, Communication, and Data Management (ICDM). By the end of 2006 the first two will have practically taken over the ongoing advisory tasks from the expatriate advisors.
Regarding ICDM, the Information - Communication Technology (ICT) component has already been handed over to Ugandan staff, and operations are running smoothly. In the coming period the use of ICT equipment, email, and internet will now be introduced in the Health Training Schools, and, if possible, also in HCIV. In addition the responsibility for the running and maintenance of

the ICT systems, in the hospitals and diocesan health offices, is to be handed over to them in the course of 2006/07.
However, the handover of the Data Management and Analysis (DM&A) component requires more time still. The main reason is that the development of the systems and capacities, for data management and use in the institutions, still needs considerable strengthening and the successor requires support in this.
The Human Resources Management Advisor has been a Ugandan expert from the beginning. During the past few years the task of managing the Scholarship fund has grown to such an extent that it takes nearly 60% of his time. This means that developing new approaches / solutions for HR development may require additional person time. As this is also quite a specific expertise it may prove necessary to recruit part-time external expertise for this. This part-time expertise could also accelerate the process of integrating HRH development capacity into the work of the multi-disciplinary team of UCMB.

20.2.3. The support desk for Health Training Institutions and Training

For purposes of easy identification this desk is singled out here. It should be stressed, though, that this desk has to function as integral part of the technical advisor team of UCMB. The reason is that to enable the HTI to develop and enhance their capacities in management all the other expertises are also required. An integrated approach is also called for to ensure that the schools are given their rightful place in the organisation structures of the hospital.
This desk requires an officer who has been trained as a tutor and has experience in running school or in managing a health institution. As one of the main areas of work concerns building relationships and negotiations with partners at national level, the person needs to be knowledgeable about training and health policies. The development and advisory support to the schools and the tasks in representation also demand that the person be mature and assertive.

Technical assistance is foreseen for the entire period, although in a progressively reducing time-frame, to assist the HTI &T Standing Committee and Coordinator in setting up the desk, developing a strategic position for the dialogue with the external partners and initiating the dialogue. The latter is of great importance as the present confusion is greatly hampering the schools.

20.2.4. External Expertise

There are an important number of new factors that complicate the taking-over by the technical advisor team. These mainly pertain to the new approaches and tools required to access and to use GI ('vertical' project) funds and the Social Health Insurance. These same developments, combined with the budgetary and HR constraints, demand an acceleration of the systems development in the institutions. Lastly, there is a clear need to use new capacity building strategies to assure that the system improvements really become embedded in the institutions.
In this complex situation the technical team should have access to coaching support and assistance in developing and testing new strategies. The expatriate OD and Financial Management Advisor will be requested to provide this support, on a part-time basis, also in a scaling down time frame.

If the additional expertise in Human Resource Development cannot be found locally, part-time external assistance will be sought.

20.2.5. Special Policy Advisor

The present ES is to handover to a successor in the course of the plan. It is likely, but not certain, that the new ES will be the Assistant Executive Secretary who joined the Bureau in January 2006. Even then, but more so if a totally new ES will be appointed, it will be far from easy to take over completely in the midst of the present tumultuous developments. To facilitate the taking-over in all aspects, including the transfer of the institutional memory, it is of importance that the outgoing ES remains available within UCMB as coach to the new ES.

More importantly the particular characteristics, combined with the wealth of experience at national level, place the outgoing ES in the optimal position to tackle two sensitive issues.
The first concerns the congregations. As member of a religious congregation, and former Medical Superintendent of an RC hospital, he is best suited to assist all concerned in bringing the dialogue with the congregations to a fruitful end.
The second subject is that of finding a solution for the legal status of the RC health institutions. The solution has to match with both, civil and canon law and his knowledge in both areas will greatly assist in identifying the best option.

There are other / new areas UCMB has to venture into, which could benefit largely from the expertise of the outgoing ES to speed up implementation. These are the start-up of enhanced support for the north and Karamoja and the development of a cooperation agreement with UMU, Faculty of Health Sciences.

Lastly the training of Clinical Pastoral Care workers is reaching a level at which it would be possible to have the training accredited. Finalisation of the programme, the negotiations with the accrediting body and the first peer review could be sped up through the intervention of the former ES.

If time allows, there is one more area that, hitherto, could not be tackled while many recognise the need. This pertains to supporting Catholic health workers to organise themselves and guiding them in their efforts to champion the Mission of the RC in health. Also in this area, the experience and status of the outgoing ES would be invaluable.

20.2.6. The format for enhanced UCMB Coordination and Support for the North and Karamoja

This new venture is to enable the four diocesan coordination offices and health institutions to respond adequately to the new opportunities emerging. The actual format for this support will be decided in dialogue with them.
In all cases it will require at least one Public Health expert, with experience in emergency / rehabilitation situations as well as experience in working with church owned health institutions. The latter is of particular importance, as the institutions need to be assisted in safeguarding their identity and basic autonomy amidst a multitude of actors and funding mechanisms.
Basic support staff may also be required (secretary and driver).

21. Assumptions and Preconditions

The assumptions and preconditions that are essential to the successful realisation of this Operational Plan can be divided into three sections: external / beyond the RC direct influence, RC internal, and directly related to the Bureau.

The assumptions related to the external environment are:

- the economic environment, in which the RC health services operate, does not worsen compared to the assessment in this plan;
- the political stability of the country remains as it is;
- the security in the north and north east really improves following the outcome of the peace negotiations;
- the Sector Wide Approach remains the key strategy for the implementation of the National Health Policy and Health Sector Strategic Plan;
- the political commitment for the Public-Private Partnership in Health is fully regained and maintained;
- the subsidies to the PNFP health facilities are continued at least at the present level;
- the Development Partners of the RC health service network will support the plan with the required external funding;
- the Development Partners continue their open dialogue with UCMB and accept to continue flexible funding arrangements so that the implementation can be adjusted in response to developments on the ground;
- the technical staff required can be recruited, or retained, at reasonable rates.

The assumptions and preconditions related to the RC internal environment are:

- the RC health institutions remain faithful to the Mission and Policy Statement as well as to the new Strategic Plan 2007 – 2011;
- the RC authorities and other internal stakeholders actively support their health units in striving towards realisation of the Mission;
- the RC leaders enhance their active support to the Bureau's efforts to improve performance.

The preconditions directly related to the UCMB are:

- the relevance, timeliness, and accurateness of the data, obtained from the member institutions, is maintained, when the responsibility for the operation of the ICT technology is handed over to them;
- UCMB can preserve the effective mix of skills of the professionals and support staff and they, in turn, continue to be highly committed and dedicated to the realisation of the aims of this plan;
- the UCMB team and the RC member institutions retain the balance between the spiritual and technical, e.g. the Mission continues to inspire them while they strive towards technical excellence;
- the UCMB team maintains it willingness and capacity to reflect on - and learn from – its own experiences.

22. Indicators and Means of Verification

As described in chapter 13 of the Strategic Plan indicators are set for three levels:

A. Purpose of the plan:

These indicators are determined by the HSSP II and the health MDG's.

B. Strategic Goals:

First of all the four key indicators that UCMB developed to monitor "Faithfulness to the Mission" (access, equity, efficiency, and quality) will used as key outcome indicators to monitor progress towards the strategic goals as well as the operational objectives. The plan is to gradually improve the quality indicator (or index) by including more aspects than qualified staff. If necessary, and if possible, an index to measure sustainability may be added.

These indicators are complemented by additional outcome, output, and process proxy indicators that enable to assess progress towards the strategic goals.

For these all indicators targets have been set, per year of the operational plan, to maximise the possibility that the goals will be achieved. Where progress may not be forthcoming or delayed the aim is to gain insight into the factors that cause this to determine whether they can be influenced.

C. Operational objectives and targets:

A different approach was chosen to determine the results that need to be attained during this operational plan period. This consists of a more general formulation of the operational objectives complemented with a set of measurable primary and secondary targets, per objective. This approach aims, first of all, to assure the necessary flexibility for implementation. Secondly it is meant to facilitate monitoring and evaluation of progress, during the implementation, as well as facilitate the process of monitoring itself. The indicators are easily derived from the targets.

To complete these levels the annual work plans will reflect primary indicators / targets together with the secondary targets / indicators. These will be used mainly internally for ongoing monitoring and performance appraisal.

The logical framework and list of indicators reflect all the indicators, and targets for the Strategic level as well as the primary targets per Operational objective, with their corresponding indicator and means of verification.
For the details kindly be referred to chapter 16, the logical framework in annex I and the list of indicators in annex IV.

23. Annual Planning, Progress Monitoring, and Evaluation

UCMB and the RC members have learnt in the past that a high degree of flexibility is needed to ensure that the intended results of a plan are brought home. This is also essential to being able to respond adequately to new developments, or challenges that emerge internally or externally. For this reason planning, monitoring and evaluation are deemed of utmost of importance.
The Strategic Goals and Operational Objectives, with their targets, will form the basis for the annual work plans. After the first year (e.g. from 2008) the progress achieved and the developments in the internal and external environment will also be taken into consideration for the annual plan. These will be determined through the ongoing monitoring and the annual evaluation exercise using the indicators derived from the primary and secondary targets (see chapter above, the Logical Framework in annex I, and the list of Indicators in annex IV).

The main focus for monitoring and evaluation, as well as reporting and accounting, to internal and external partners, will be on the indicators and targets set for the purpose and strategic level.
This approach has been chosen to ensure that the process of annual evaluation and reporting provides the required essential insight in progress and remains manageable. The total number of indicators for all three levels is namely 158. During the former plan period we learnt that such a high number of indicators is too cumbersome for annual reporting and too extensive to enable external partners to really keep abreast with the developments. The number of indicators, which will allow all to monitor and evaluate progress towards the purpose and the strategic goals, is 59 which is more reasonable.

An external review will be undertaken in the third quarter of 2008 (mid term) to have an independent assessment of progress towards the objectives of this operational plan as well as towards the realisation of the Strategic Goals. This review should provide insight on how to ensure that the intended results are really achieved by the end of 2009.

Depending on developments internally and externally, the End of term review will either be internal or external. The latter will done if the developments in the country seem to call for major changes in the strategic plan and / or if the progress achieved at Midterm had been unsatisfactory.

24. Feasibility and Sustainability

This Operational Plan for 2007-2009 covers the first period of the Strategic Plan 2007-2011. This plan builds on the experiences gained and lessons learnt during the implementation of the preceding Strategic Plan, as assessed by external consultants and representatives of the internal stakeholders. This plan included a high level of support from UCMB to the hospitals and diocesan health coordination structures, as they needed to correct the erosions of a long period of neglect and to catch-up rapidly with new demands. This high level of inputs and investments was always meant to be temporary as the underlying aim was to enable the members to take charge of the responsibilities that are best effectuated at their level. (see principle of subsidiarity and governmental decentralisation policy).

The review of the progress towards the goals set in the first Strategic Plan indicates that these goals had been achieved to a large extent. However, the assessments of the internal and external challenges (see chapter 5, 6, and 7) indicate that a strong strategic orientation and high level of development and support activities remain necessary. The reasons are:

- The existing challenges and new developments in the external environment represent new threats and opportunities, for the RC health network. They require new responses to ensure that the RC Mission can be pursued;
- New developments, such as the Global Initiatives, challenge the RC approach of developing the system as a whole, before it has been well established. As no precedents exist additional capacity and efforts are required to assure that the system can be developed integrally and consistently also by using the opposing approach in support of the system.
- The improvements in management and performance in the RC health institutions have yet to be well rooted to be effective and enable the institutions to respond effectively to the need to adjust in response to new challenges.

The overriding conclusion of all parties is that the strategic goals remain valid because the end points have, and will continue to be, extended. Thus the original Strategic Goals have been largely retained for the coming five years. For the operational plan period the

identified challenges demand a continued high profiled and high intensity of support activities from central level. Thus the capacity of UCMB needs to be maintained at the level it reached during the last period and the budget required for the activities has to be extended to 3.1. Million Euros (compared to 2.9 M during 2004-2006)

24.1. Feasibility

The UCMB team and the RC representatives are of the opinion that this Operational Plan is feasible, on condition that the assumptions and preconditions recognised in chapter 21 are met. The arguments are:

- The internal credibility of UCMB as lead agent / enabler has been well established and the demand for assistance from members is evident.
- The external credibility of UCMB as representative / spokes person of the RC health services, at national land international level, is clearly recognised giving it the necessary authority to negotiate in their name.
- The capacity UCMB requires for this plan has been developed during the past operational plan and the present team is committed to continuing their involvement.
- The strategies that will be applied, to achieve the objectives, remain identical to the ones used during the previous period. These strategies have all proven to be effective not only for the specific objectives but also towards the goals and underlying principals.
- The capacity at the level of the RC hospitals and diocesan health coordination has increased sufficiently to ensure adequate uptake of new initiatives and assure participation in new activities.

24.2. Institutional Sustainability

This is an often-underrated aspect of sustainability. However, in the case of health care services in developing countries it is the most important aspect. It consists of two aspects:

Integration into the national health system:

- The provision of health care services in these countries in general depends largely on external funding. In Uganda, development partners fund approximately 50% of the annual health budget. In the case of Private Not for Profit Health care providers, becoming an operational part of the national health system is a must both to be able to provide effective services, as to be able to access the fair share of the national budget for their target populations.
- The main aim of the Strategic Plan is therefore to ensure that the RC health units maintain, their now established, structural role in the Ugandan health care system as well as enhance it.
- This aim is fully conversant with the GOU's, intended, policy regarding Public – Private Partnership in Health, in view of improving coverage and effectiveness of services as well as efficient use of all resources.
- The purpose of this Strategic Plan is explicitly to increase the contributions towards the HSSP objectives and MDG's. This is not only to improve the own effectiveness, but also aims at underscoring and enhancing the integration into the system and the cooperation with the public health system.
- The first strategic goal of this plan, and its operational objectives for this period, then concentrates on further improvement of cooperation and integration at central and peripheral level. It also intends to ensure that all opportunities are used to be part of new plans and developments.

- The close cooperation, at central and peripheral level, with colleague PNFP institutions, intends to assure that common interests can be pursued in view of strengthening the sub-sector and the joint integration into the national system.

Internal institutional development:

- The systemic approach to the development of the health institutions of the RCC, also as a sub-system of the national health system, is intended to enhance the sustainability of the RC network as a whole.
- The main thrust of the Strategic and Operational Plan is to build the capacity of the RC institutions to take full responsibility for their own development, performance, and integration into the national health system.
- The aim remains to reduce the high-level support and investment from UCMB to the periphery in accordance with the increase of their capacity to take care of the above responsibilities.

24.3. Financial Sustainability

As indicated above the provision of health services, at a level that really contributes to reduction of poverty, cannot be financed from local revenues in developing countries. In Uganda, even with extensive external financial support, the annual budget for health stands at 9 USD per capita. However, the costs of the Minimum Health Care Package were estimated, in 2003/04, at 28 USD per capita per annum, excluding ART's.
To a certain extent the RC health institutions are financially better sustainable than public health units, as the subsidies from government / MOH reach 25-30% of their recurrent cost budget. The income from patient fees ranges around 50% of their recurrent cost budget, the balance being represented by a variety of (unevenly distributed) input from different donors and support initiatives. As patient fees represent a significant obstacle to equity, and as the RC institutions wish to pursue improved access and equity, increasing fees can only be a last resort option.
These observations underscore the fact that however hard they would try, the RC health services would not be able to fully cover the budget for the support to their development and capacity building by UCMB.

However, this plan does aim to enhance their financial sustainability:

- The participation of UCMB in the national policy making fora and its advocacy efforts have, and will hopefully continue, to generate returns for the entire network. Comparing the budget of UCMB in 2006 of about 2.2 billion USHS to a monetary benefit to the RCC institutions of around 13 billion USHS (from GOU subsidies and other allocations directly through UCMB or advocated by UCMB) the cost benefit ratio stands at 17%. This is a coarse measure but it does show that the investment pays off for the RC network.
- Improved involvement of the hospitals, HSD leaders, and DHC's, in the district planning, should enable them to argue the interests of their target populations and institutions, as gradually the budget decision devolve to this level.
- During this period, major increases of the government subsidies can be expected only if the overriding critical economic situation of the Country is overcome. Therefore the efforts, included in this plan, are geared to accessing other sources that are allocated to – and / or developed by - the country (GI and SHI) and increasing efficiency.

- As the fundamental assignment of the Mission is to improve access and equity and the ceiling for efficiency gains is near, care has been taken to avoid actions that may increase the cost of services.

24.4. Sustainability of UCMB

UCMB is the technical arm of the Bishops Conference and thus its core function is to coordinate and represent the RC health institutions at national level. This Strategic Plan and Operational Plan are built on an extended role of UCMB in view of building the capacity of the members. Sustainability of UCMB, in the given resource constraint of a developing country, should therefore not be considered from the point of view of the extended role but from the core functions:

- During the past operational period the contributions from the RC institutions amounted to an average 64 M USHS per year. Compared to the average annual expenditures for the core (skeleton) operations of 180 M USHS, this represented 36% local coverage. Compared to the average total annual expenditures of 1.86 billion the contributions from health units represent 3.4%. If the entire locally generated income is considered (an average of 245 M per year in the plan period) this represents 13% of the average annual expenditure.
- At the start of the 2004-2006 operational plan the annual income from local contributions was estimated at 40 M USHS, e.g. 2.2% of the budget. The actual realisation is thus far above what was foreseen and this clearly indicates the value the RC members attach to the services.
- In the beginning of the period UCMB had been able to expand its financial basis through prudent management of its treasury (investment of reserve funds) and favourable exchange rates. The possibilities for both these avenues to continue benefiting UCMB has greatly reduced during the last couple of year. On the one side treasury bills have become less profitable and on the other side the conversion policies adopted are less favourable.
- The efficient use of the resources has been greatly facilitated by the funding policies of the major donors. They agreed to a kind of SWAp approach and contribute to the total budget for the operational plan, instead of allocating funds for specific projects. This funding strategy enabled UCMB to use the funds flexibly and thus use them optimally.
- Since 2002/03 the MOH allocated a subsidy to UCMB to facilitate coordination at central and district / diocesan level. This still is an important sign of recognition as well as an important opening for future local sustainability of the core activities. However, as for the HU's, this allocation has not increased, and it will probably not increase during the coming three years. In addition the effective use of this subsidy is hampered by the unpredictability of the disbursements and uncertainty whether they will be disbursed completely.

In conclusion the potential to increase local income of UCMB is restricted. Therefore it will continue to depend on the external funding for the extended level and intensity of the support to the RC health service network.

Note:
To put the investments in perspective a crude calculation shows that the budget of 3.1 M Euro, for the 2007-2009 Operational Plan, translates into an annual contribution of 3.690 Euro per RC institution (280 in total). Another measure could be the ratio between the budget of UCMB and the number of patients served by the network. A crude assessment of this, by using only OPD contacts of 2004/06 – i.e. 2.1 million of contacts - translates into an approximate investment of 50 Euro cents per OPD contact per year.

Section Six:

The UCMB Operational Plan 2007 – 2009

Budget

25. Introduction

25.1. Generalities

The institutional role of UCMB in the RCC health services organisation is to provide services to diocesan health offices and the health units in order to improve their functioning and facilitating the functioning of the structures that guide the RCC health Network (Health Commission and Plenary of the Episcopal Conference). The scope of the services provided to the peripheral level (diocesan health offices and health units, with direct focus on hospitals and a mediated support to units of lower level through the diocesan co-ordination) can vary from a mere "hands-off" secretariat function to a scaled up and "hands-on" support. This latter has been the choice of the previous Strategic Plan and of the last two Operational Plans. The fundamental assumption that is held to be valid also in the forthcoming period is the same. The only change – of no little import, though – is that a more "hands on" support is now expected to occur on a "pull" basis. The experience of the past strategic period has confirmed that changes do occur, but at a much slower pace than expected. The respect of the longer timeframe is assumed – as experience seems to suggest – to make change a more durable and sustainable process.

In this Plan period the level of activity is therefore still maintained at high level.

The budget has been formulated in its entirety from an activity perspective (save for the running cost and salary of the core staff of the Bureau, for which the historical approach has been followed). It is possible in fact to relate activities in each objective to corresponding budget lines (annex III).

The resulting budgetary implications appear to match those of the plan just concluded in its "ideal" – and eventually realised – scenario, with the +15% variation on the total in foreign exchange falling within ranges acceptable for mid-long term forecast.

It has also become increasingly patent that the financial sustainability of the UCMB – at the current level of operation - is not in sight, and any attempt to pursue it beyond symbolic levels would only endanger the processes hitherto established. On the other hand, the Bureau operates in a Country whose budget for social services – far from being anywhere close to the levels demanded by the MDG – is financed at levels well exceeding 50% from foreign donors.

Yet it would be incorrect not to make the effort of – at least – monitoring sustainability levels, at least for those functions of UCMB deemed to be permanent. For this reason the budget of the Operational Plan 2007-09 will maintain a cost centre for the core functions.

The structure of the budget is in any case slightly different (and hopefully clearer) than the previous versions. This has been made possible by the evolution of the financial accounting system (now entirely computerised) and the introduction of clearer financial management procedures. In this version of the budget, cost centres are more visibly reflecting the objectives of the plan and the methodologies of intervention.

It is anyway maintained that the Bureau intends to avoid, as much as possible, any type of "verticalisation" of the budget – i.e. introducing in the budget rigid "project-like" distinctions, procedures, ring fencing – unless this latter is explicitly demanded by donors wishing to support specific components/objectives of the Budget. In the frame of the Strategy outlined and the Operations thus planned for the mid-term, "tout se tient". It may become necessary, though, to solicit inputs to the Budget from different donors using "projects" extracted from the strategic framework – and sometimes extended beyond the financial forecast of the Plan: this is not new in the experience of the Bureau and it has so far been managed to the satisfaction of all partners. The areas of operations particularly amenable to this kind of approach/development are: Health Training Institutions co-ordination and management, Pastoral Care of the Sick, Scholarship Fund [i.e. operations in each of these areas are now supervised by a specific committee and served by a desk], the Special Programme for the North, ICT, and Natural Family Planning. The emphasis placed on the accountability for the results to be achieved and the fairly explicit linkage between

inputs and outputs/outcomes has made it possible and the Bureau intend to enhance this approach further.

25.2. Budget assumptions

Inputs to the budget

The budget presented assumes that the donors who have so far expressed pledges/qualified intentions for the next (up to) three years – to the tune of about € 1.54 M - will be able to honour their commitment and, perhaps extend it further. The expected local contribution is of € 0.237 M., thus bringing the assumed available resources to about € 1.78 M., out of a total budget forecast of about € 3.1 M., and leaving a gap of about € 1.32 M. It is therefore assumed that within the first year of its implementation, it will be possible to mobilise additional resources from either the same donors or/and identify others willing to bridge the gap. Additional resources may have to be mobilised also through formulation of specific projects: the areas of operations particularly amenable to this kind of approach/development are: Health Training Institutions co-ordination and management, Pastoral Care of the Sick, Scholarship Fund [i.e. operations in each of these areas are now supervised by a specific committee and served by a desk], the Special Programme for the North, ICT and Natural Family Planning.

Type of inputs

All the resources contributing to the implementation of the Plan are kept into account: labour or material resources provided in kind are monetised and appear both on the income side and the expenditure side of the budget. Contributions in kind[24], which were very important during the previous strategic period, are anyhow progressively becoming less important.

Rates of exchange

The main inputs for the budget is foreign exchange (namely €). For this reason the overall three year budget summary is presented in this currency and the overall performance of it will be referred to €. A mirror budget in UgSh is also provided, in detailed and commented form, as basis for the annual planning. The rates of exchange applied are conservatively assumed as follows: 2007 1 € = 2,250 UgSh; 2008 1 € = 2,300 UgSh; 2009 1 = 2,350 UgSh.

25.3. Budget structure

Expenditure

In line with the general introduction, the budget of the Operational Plan 2007-09 has been structured along cost centres, reflecting – as far as possible – the key functions/methodological approaches of the Bureau. It is impossible to draw a perfect line of separation between different areas of intervention/focus in an organisation with such high degree of integration of skills and a continuous effort of cross-fertilisation. Nonetheless, they intuitively reflect the main/fairly well identifiable areas of intervention, and their names are self explanatory. The overview of the Expenditure Budget is found in Annex II.

A Core functions. This cost centre covers the core functions of the Bureau as technical arm of the Health Commission; i.e. the essential staff for the representation and secretarial service of the Bureau, including the long term support staff.

B Organisation Governance and Development. This cost centre covers all cost related to the "hands on" support to the peripheral level (hospitals and diocesan co-ordinations) in view of strengthening their governance and further developing the organisational capacity. Within this cost centre the specific areas of Pastoral Care of the Sick and Natural Family Planning enhancement are amenable to become stand alone projects.

C ICT. This cost centre covers the specific aspect of development of Information and communication technology-skills-use. It is a cost centre that has attracted a lot of attention and has potential for attracting further resources in the future. It is a cost centre amenable for the development of specific projects, either for covering the foreseen cost or for further expansion.

Capacity Building.

[24] Deployed staff/expertise, equipment supplies, payment of services/activities on behalf of the Bureau.

Capacity building is the heart of the "scaled up" Bureau. It has different components/aspects that have been developed into different cost-centres. As cumulative cost centre of the other three here below, it accounts for 43% of the projected expenditure, and is certainly the largest centre.

D Capacity Building – Training. This cost centre reflects the cost of the various training initiatives of the Bureau, and complements cost centre B for its more specific training components.

E Capacity Building – Scholarships. This cost centre is perhaps the first well identifiable/ied cost centre in the history of the Bureau. It covers the cost of awarding, administering and financing scholarships. It is amenable to further expansion and diversified funding; on occurrence it may be formulated as specific project, as both the previous project funding – DKA and SVFOG – have terminated. It is controlled by a committee who operates independently from the leadership of the Bureau.

F Capacity Building - HTI&T. This cost centre covers an aspect of capacity building that has only recently been addressed: i.e. the life of the health training institutions of the network. It also reflects the activities of a committee with its secretariat. This cost centre is amenable for development into a fully fledged project (to finance the projected cost and/or to fund further activity expansion as need arises).

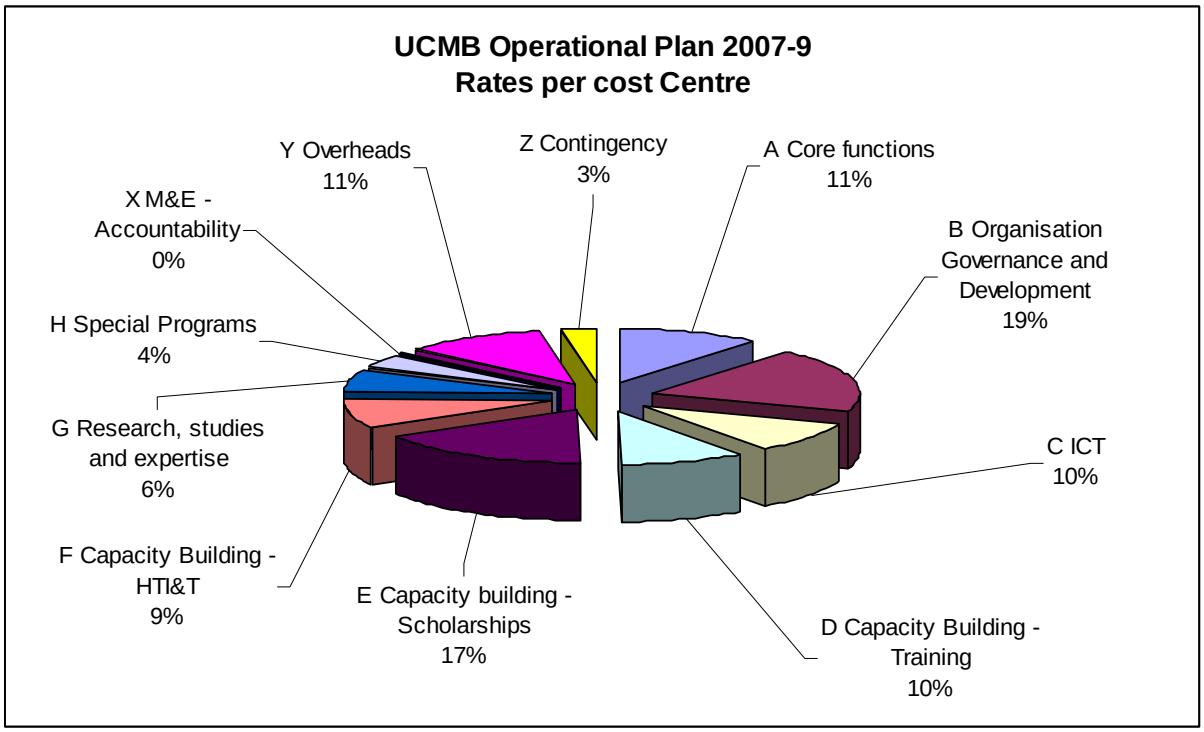
G Research, studies and expertise. This cost centre accommodates, as necessary complement to activities accommodated in other cost centres, the researches and studies identifiable as stand-alone activities. Other minor research activities, studies and expertise are covered by other cost centres.

H Special Programs. At the moment this cost centre has been conceived to cover the seed cost of the activities in favour of the co-ordination of the Northern Region's Dioceses. It is a cost centre amenable to further development and also "transformed" into a project, if need arises.

X Monitoring and Evaluation (M&E) – Accountability This cost centre covers the activities of accountability (audit, monitoring and evaluation and the fora related to the latter). Given the strict relationship it has with the future outlook the cost of future planning is included here.

Y Overhead. For the first time the overhead cost of the Bureau have been attributed to a stand alone cost centre, covering the cumulative cost of running of the office and the cost of depreciation of assets. It amounts to 11% of the total budget and, strictly speaking, it should be re-apportioned, proportionally, to the other cost centres.

Z Contingency. It is not a cost centre per se, but a simple additional budget line. It stands at 3% of the overall budget.



Income

The Income budget follows the traditional approach, well established by use, of distinguishing local from external resources. This distinction does not necessarily portray the sustainability level of the income. At the moment the only really sustainable source of Income are the fees paid by affiliated institutions. Yet, even these depend on whether the Bureau function is perceived as useful, relevant, and "paying off". But on the whole there is absolutely no proportion between the benefit that the work of the Bureau attracts – in a way or the other, directly or indirectly – for the affiliated institutions and willingness and/or capacity to pay. Even the modest attempt made in the past, to recover part of the recurrent cost of services provided (mainly ICT), was met with scantly albeit – eventually significant results. The elasticity for the demand of the services the Bureau offers, even the most patently advantageous for the units, is high. The Bureau is dealing with a severely resource constrained environment, which is still largely determined by survival strategies. In any case the Bureau will make efforts in attempting to increase local revenues from fees and services, although no target is fixed. The last year has been too un-favourable for the health sector and the PNFP health sector in particular – and the future for the mid-term is not expected to be more favourable – to permit more daring attempts.

The structure of the Income budget has two main Income centres (local and external) with several income sub-centres, namely:

A Local Income.

This centre reflects the Income generated in the Country and, more specifically

AA Local Income carried forward

This income sub-centre reflects the accruals of local income that were unspent in the previous year.

AB Local donors

At the moment these are represented by Joint Medical Store earmarked contribution to capacity building and the contributions from GoU.

AC Local revenues

This is a mix of revenues related to services the Bureau offers, refunds received and the fees paid by units. It is better specified in the detailed budget.

B External Income

The main Income centre reflects all revenues coming from outside the Country, in monetary or in kind form.

BA External Income Carried Forward

These are the unspent balances on the donors and projects accounts carried forward from previous exercise(s). The sub-centre is further divided per source.

BB External Transfers

These are revenues in monetary terms received in the course of the year. They are further specified per source (i.e. Donor agency)

BB External revenues in kind

This income sub-centre reflects the monetary value of services, goods, works supplied to the Bureau "in kind", and specified by source (donor).

26. Expenditure Budget per Group of Expenditures

The total expenditure Budget is of € 3,087,719 corresponding to UgSh 7,095,911,121.

16.3.1 A CORE FUNCTIONS.

Total forecast excluding share of overheads **UgSh 830,172,652** **€ 360,843**
Share of running cost and depreciation **UgSh 124,200,000** **€ 54,000**
Budget share 12%

The expenditure for core functions includes the salaries of the "permanent" staff of UCMB, the cost of the statutory organs of the commission (HC, EB and F&P Committee, Annual General Meeting), ordinary supervision visits, Bulletin and a limited amount of ad hoc support to the peripheral functions.

Employment cost

The packages offered to the staff of the Bureau include insurance (medical and risk, according to legislation), annualisation of gratuity, social security fund. The annual increase applied is 5%. The net take home package after deductions is about 55% of the amount indicated here below.

Item line details	1	2	3	Grand Total
Personnel - ES	44,040,000	46,242,000	48,554,100	138,836,100
Personnel - AES	68,826,000	72,267,300	75,880,665	216,973,965
Personnel - Administrator	20,712,000	21,747,600	22,834,980	65,294,580
Personnel - Data Manager	17,067,000	17,920,350	18,816,368	53,803,718
Personnel – Drivers (3)	15,042,600	15,794,730	16,584,467	47,421,797
Personnel - Secretary	9,777,000	10,265,850	10,779,143	30,821,993
Ad hoc labour	7,000,000	7,350,000	8,060,500	22,410,500
TOTAL	182,464,600	191,587,830	201,510,222	575,562,652

Health Commission functions

The functions of the Health Commission include the cost of the meetings of the same and of its Executive Board and Finance and Planning Committee, extra meetings for the induction of the members, and the cost of the Annual General Meeting (almost totally self financed). The transport refund rates and accommodation rates are revised by the Finance and Planning committee and maintained at a bare cost recovery level.

Item line details	1	2	3	Grand Total
Annual General Meeting	7,875,000	8,050,000	8,225,000	24,150,000
Induction of commission and committees	4,500,000	4,600,000	4,700,000	13,800,000
Statutory meetings of Commission	24,750,000	25,300,000	25,850,000	75,900,000
TOTAL	37,125,000	37,950,000	38,775,000	113,850,000

Supervision

This item line captures the direct cost attributable to ordinary supervision visit at a unit cost of 500 € per visit (inclusive of fuel, accommodation, per diem of an average of 2-3 people per visit). Each year 20 such visits are envisaged.

Item line details	1	2	3	Grand Total
Supervision	22,500,000	23,000,000	23,500,000	69,000,000

Support to peripheral level
It happens that some key activities whose occurrence the Bureau has to ensure (e.g. surveys, ad hoc meetings in dioceses etc..) require small amounts of money as co-contribution. This item line sources the amount.

Item line details	1	2	3	Grand Total
Ad hoc financial support	11,250,000	11,500,000	11,750,000	34,500,000

Bulletin
Each issue of the Bulletin has a cost varying between 4.5 M Ugx and 5.5 M, depending on the number of pages. The Budget includes also distribution cost. Two issues (ab. 1,400 copies each) are produced every year.

Item line details	1	2	3	Grand Total
Bulletin Printing-distribution	12,150,000	12,420,000	12,690,000	37,260,000

16.3.2 B ORGANISATION GOVERNANCE AND DEVELOPMENT.

Total forecast excluding share of overheads UgSh 1,349,147,343 € 587,266
Share of running cost and depreciation UgSh 180,780,000 € 78,600
Budget share 19%

The expenditure for Organisation Governance and Development is the largest ticket in the budget. It reflects the cost of employment for the professional positions of Financial Management and Organisational Development, their respective Technical Assistance includes the salaries of the "permanent" staff of UCMB, the cost of the statutory organs of the commission (HC, EB and F&P Committee, Annual General Meeting), ordinary supervision visits, Bulletin and a limited amount of ad hoc support to the peripheral functions.

Employment cost
As for the permanent staff of the Bureau, the cost reflected in this item line are gross and al inclusive. The three positions included are the local counterparts of the TA in Financial Management and Organisational Governance & Development. In addition, the new desk person for Pastoral Care of the Sick is included here, starting from mid-2007.

Item line details	1	2	3	Grand Total
Personnel - FM	16,338,000	17,154,900	18,012,645	51,505,545
Personnel - OG&D	21,441,000	22,513,050	23,638,703	67,592,753
Personnel - PCS	8,169,000	17,154,900	18,012,645	43,336,545
TOTAL	45,948,000	56,822,850	59,663,993	162,434,843

Technical assistance
The expatriates whose input is reflected under this item line are expected to assist their local counterparts for, respectively, 50+35 days for the FM expert, and 40+35+10 (or if necessary 40+45) days for the OG&D expert.

Item line details	1	2	3	Grand Total
Honoraria (FM)	42,750,000	30,590,000		73,340,000
Lodging-subsistence (FM)	5,625,000	4,025,000		9,650,000
Travel cost (FM)	6,300,000	6,440,000		12,740,000
Honoraria (OG&G)	34,200,000	26,220,000	14,100,000	74,520,000
Lodging-subsistence (OG&G)	4,500,000	3,450,000	1,762,500	9,712,500
Travel cost (OG&G)	6,300,000	6,440,000	6,580,000	19,320,000
TOTAL	99,675,000	77,165,000	22,442,500	199,282,500

Expertise
The local expertise provided for under this item line is hired at need, with the exception of the computer programmer (local expertise for OG&G) charged with the maintenance of Fipro. The

sliding amounts for the latter are due to the progressive perfectioning and customisation of the software, which is expected to be concluded by the end of the period.

Item line details	1	2	3	Grand Total
Local expertise for OG&D	6,750,000	5,175,000	3,525,000	15,450,000
Expertise for Advocacy	0	17,250,000	17,625,000	34,875,000
Legal counsel	11,250,000	11,500,000	11,750,000	34,500,000
TOTAL	18,000,000	33,925,000	32,900,000	84,825,000

Supervision
Many of the supervisory visits under this item line cannot be planned for adequately. The Bureau has entered into a progressive "pull" approach. For this reason the budget has been defined on a lump sum basis. Otherwise the same assumptions as for the Core functions are valid.

Item line details	1	2	3	Grand Total
Supervision	15,750,000	16,100,000	16,450,000	48,300,000

Field activities
The activities provided for under this item line are mainly carried out by persons from the field. The budget intends to provide support on a need to basis for exchange visits and peer reviews. The sum provided is a lump sum.

Item line details	1	2	3	Grand Total
Exchange visits	4,725,000	4,830,000	4,935,000	14,490,000
Peer review (performance)	4,725,000	4,830,000	4,935,000	14,490,000
Peer review (CG&D)	4,500,000	4,600,000	4,700,000	13,800,000
TOTAL	13,950,000	14,260,000	14,570,000	42,780,000

Policy and technical workshops
Each year two policy/technical workshops take place for Hospital Management Team members and for Diocesan Co-ordinators, respectively. The budget is based of historical records. Each Hospital workshop cost on average 16 M UgSh, and each DHC workshops cost on average about 9 M UgSh.

Item line details	1	2	3	Grand Total
Policy/techn. work.p (HMT)	31,500,000	32,200,000	32,900,000	96,600,000
Policy/techn. work.p (DHC)	18,000,000	18,400,000	18,800,000	55,200,000
TOTAL	49,500,000	50,600,000	51,700,000	151,800,000

Thematic workshops, seminars and meetings
Thematic workshops, in general terms, are events concerning a variable number of persons on specific topics. These are better detailed in the descriptive part of the Plan. Most of the amounts indicated are either based on historical data or as lump-sum.

Item line details	1	2	3	Grand Total
Central consultation	1,575,000	1,610,000	1,645,000	4,830,000
FM Thematic workshops	36,000,000	33,350,000	21,150,000	90,500,000
OG&D thematic workshops	11,250,000	5,750,000	5,875,000	22,875,000
Training on Peer review	9,000,000	9,200,000	0	18,200,000
TOTAL	57,825,000	49,910,000	28,670,000	136,405,000

Regional training initiatives
Regional initiatives are seminars held at regional level for Board Members, to introduce them to the functions of the Boards. Amounts have been fixed on a lump-sum basis, being impossible at the moment to obtain information on discrete cost and attendance.

Item line details	1	2	3	Grand Total
Regional seminars (OG&D)	13,500,000	13,800,000	28,200,000	55,500,000

PCS Secretariat and standing committee's operations
The cost reflected under this item line refers to the cost of pursuing the professional accreditation (including subscription to OPCE Association) for CPE trainees and to the direct cost of the standing committee (meeting, transport refunds, meals etc...).

Item line details	1	2	3	Grand Total
PCS enhancement	6,750,000	6,900,000	7,050,000	20,700,000
Ordinary running committee	3,375,000	3,450,000	3,525,000	10,350,000
TOTAL	10,125,000	10,350,000	10,575,000	31,050,000

Fora
This item is a lump-sum provision for the organisation of annual for a of advocacy and/or specific issues' consideration. Also in this case the amount indicated is a provision. It is also difficult at planning stage to determine the exact target and number of persons attending.

Item line details	1	2	3	Grand Total
Fora for Religious Leaders	22,500,000	23,000,000	23,500,000	69,000,000
Fora for Congregations	9,000,000	9,200,000	9,400,000	27,600,000
TOTAL	31,500,000	32,200,000	32,900,000	96,600,000

Support to diocesan initiatives
This fairly large ticket includes different types of activities. The common denominator is the intention to support financially diocesan activities, on a shared basis. The largest component is the support to the running of the Diocesan Health Co-ordination of selected in need of a kick start or recovering from a problematic past. Each DHO is expected to be supported at levels of ab. 20 M per year each.

Item line details	1	2	3	Grand Total
Diocesan sens. on PPPH	10,800,000	12,880,000	11,280,000	34,960,000
Diocesan training support	10,800,000	12,880,000	11,280,000	34,960,000
Interfaith events support	6,750,000	8,050,000	7,050,000	21,850,000
Support to selected DHOs	81,000,000	82,800,000	84,600,000	248,400,000
TOTAL	109,350,000	116,610,000	114,210,000	340,170,000

16.3.3 C ICT.

Total forecast excluding share of overheads **UgSh 523,584,146** **€ 228,565**
Share of running cost and depreciation **UgSh 73,830,000** **€ 31,100**
Budget share 7%

The expenditure for the Information Communication Technology activities reflects the cost of employment for the professional positions of the Data Analyst and System Administrator, the cost of the long term TA (deployed by AVSI) and the hired consultants maintaining the functionality of the system. In addition it includes the operational cost of the system (strictly the provider fees). The queue of the ICT project addresses the provision of ICT equipment to HC4 and Health Training Schools. All the cost is financed by Projects (IICD and AVSI – M&P) and by a partial cost recovery scheme. Training activities for HMIS and ICT are reflected in the Cost Centre Capacity Building – Training.

Employment
Two professional staff re needed to secure the continued function of the ICT component of the Plan: a data analyst and a system administrator. The data analyst will progressively take over the tasks carried out by the TA. Both are full time employed positions.

Item line details	1	2	3	Grand Total
Personnel – Data Analysis	16,338,000	17,154,900	18,012,645	51,505,545
Personnel - ICT SA	19,108,200	20,063,610	21,066,791	60,238,601
TOTAL	35,446,200	37,218,510	39,079,436	111,744,146

Technical assistance
The TA provided by AVSI will continue until the end of the current ICT Projects and become part time TA in the second and third year of the Plan. The amounts reflected are partly covered by the project input and partly are work in kind value.

Item line details	1	2	3	Grand Total
TA ICDM	81,000,000	55,200,000	56,400,000	192,600,000

Expertise
Two types of expertise are hired here: one for the service to the outstations (4 visits per year per station to be progressively tapered as more and more service contracts are decentralised). The other is the website administrator, who will be retained on contractual basis for the entire duration of the plan.

Item line details	1	2	3	Grand Total
Expertise for ICT - periphery	16,200,000	8,280,000	8,460,000	32,940,000
Expertise for ICT - website	6,750,000	6,900,000	7,050,000	20,700,000
TOTAL	16,200,000	8,280,000	8,460,000	32,940,000

ICT System recurrent cost
The subscription to the ISP covers a 24 hrs access to internet not only for the staff of the Bureau and secretariat, but as necessary condition for access to the server by the about 50 (and more by the end of the plan) users at the periphery. Some degree of cost recovery is applied.

Item line details	1	2	3	Grand Total
ICT system running cost	33,750,000	34,500,000	35,250,000	103,500,000

Assets
This item line covers the cost of computers and communication hardware for the HC4 and HTI. It is the only form of assets financed by the plan, totally devoted to the peripheral level.

Item line details	1	2	3	Grand Total
ICT equipment – HC4s	13,500,000	0	0	13,500,000
ICT equipment - HTIs	48,600,000	0	0	48,600,000
TOTAL	62,100,000	0	0	62,100,000

Capacity Building.

16.3.4 D CAPACITY BUILDING – TRAINING.

Total forecast excluding share of overheads UgSh 767,075,000 € 333,750
Share of running cost and depreciation UgSh 114,540,000 € 49,800
Budget share 11%

This cost centre is one of the three specifically addressing Capacity Building. It is kept separate because of the methodology used in capacity building (i.e. provision of training). It has two major

sub-items: the cost of developing training modules not yet available (or not sufficiently customized for the RCC health network), and the actual provision of training (mostly contracted out). Although items of expenditure are fairly specific at budgetary level, it is assumed that a high degree of flexibility should exist for virement of resources within the cost centre. It has not been possible to gather all the necessary information for such diverse type of training and necessary expertise.

Modules development
This item line reflects the costs of contracting the experts and the direct cost of the development of the teaching aids.

Item line details	1	2	3	Grand Total
Modules - adv-neg-leadersh.	16,875,000	0	0	16,875,000
Modules- mental health	13,500,000	0	0	13,500,000
Modules - NFP	0	13,800,000	0	13,800,000
Modules - TOT for HUMC	16,875,000	8,625,000	0	25,500,000
TOTAL	47,250,000	22,425,000	0	69,675,000

Thematic training
As indicated above, estimated per course are still grossly define. Hence a large degree of flexibility within the cost centre is expected in this case.

Item line details	1	2	3	Grand Total
HSM courses	33,750,000	34,500,000	35,250,000	103,500,000
HUMC TOTs	18,000,000	18,400,000	0	36,400,000
ICT related training	11,250,000	5,750,000	5,875,000	22,875,000
PCS CPE workshops	6,750,000	6,900,000	7,050,000	20,700,000
Peer review for performance	4,500,000	4,600,000	4,700,000	13,800,000
Adv.neg.leader.skills H&HC4	0	23,000,000	0	23,000,000
Adv.neg.leader.skills DHC	0	9,200,000	0	9,200,000
Adv.neg.leader.skills Bureau	0	3,450,000	3,525,000	6,975,000
Care oriented - CPE units	60,750,000	93,150,000	95,175,000	249,075,000
Care oriented – Mental H.	0	18,400,000	18,800,000	37,200,000
Care oriented - NFP	0	18,400,000	0	18,400,000
Care oriented – Palliative C.	28,125,000	28,750,000	29,375,000	86,250,000
Care oriented - EmOC	0	6,900,000	7,050,000	13,950,000
SP/conting.plann. - pull	0	4,600,000	4,700,000	9,300,000
SP/conting.plann. - push	9,000,000	9,200,000	0	18,200,000
ICT - use of equipment	11,250,000	3,450,000	3,525,000	18,225,000
ICT - records	3,375,000	3,450,000	3,525,000	10,350,000
TOTAL	186,750,000	292,100,000	218,550,000	697,400,000

16.3.5 E CAPACITY BUILDING – SCHOLARSHIPS.

Total forecast excluding share of overheads **UgSh 1,150,729,463 € 501,175**
Share of running cost and depreciation **UgSh 156,630,000 € 68,100**
Budget share 16%

This cost centre reflects another methodology applied in Capacity Building. This approach also has a very high return of image and credibility for the Bureau in the network. The cost centre is highly amenable to multiple financing (as it has proven in the past). The management of the Fund is labour intensive and the former HR advisor is not mainly employed to manage the fund and the organisation of the various and numerous training activities envisaged in then three capacity building cost centres. The operational cost of the Secretary of the Fund and of the Fund's Management Committee are covered by the share of running cost.

Employment
It reflects the cost of one full time position (although about 30 to 40% of the work of this position will be demanded by the other two capacity building cost centres).

Item line details	1	2	3	Grand Total
Personnel - SF	22,753,200	23,890,860	25,085,403	71,729,463

Scholarship fund
This item line reflects the disbursements of the Budget Plan to the Fund (now having a separate dedicated account). Disbursements of the Fund to beneficiaries will be provided in each annual report along with the assessment of the Fund's performance. Efforts will be made to finance the Fund through a multiplicity of donors.

Item line details	1	2	3	Grand Total
Transfers to Fund	382,500,000	391,000,000	305,500,000	1,079,000,000

16.3.6 F CAPACITY BUILDING - HTI&T.

Total forecast excluding share of overheads **UgSh 736,367,519** **€ 319,870**
Share of running cost and depreciation **UgSh 114,540,000** **€ 49,800**
Budget share 10%

The third Capacity Building cost centre is almost completely new. It reflects the cost of co-ordinating the this of the network and of the joint/inter-denominational work. It includes the cost of the standing committee established in the middle of 2006, the costs of Technical Assistance and a Permanent Secretariat. It also reflects the cost of specific training initiatives, supervision by the committee and Bureau and some degree of innovation (development of alternative training curricula and support of demand for them in the early stages). This cost centre is amenable for funding through a specific project that will be considered if necessary.

Employment
The item line reflects the cost of one permanent professional staff as desk person and secretary of the committee. It is a new figure in the Bureau.

Item line details	1	2	3	Grand Total
Personnel - HTI&T	25,523,400	26,799,570	28,139,549	80,462,519

Technical assistance
Given the novelty of the initiative and the need of inducting the desk person, a provision is made for expert technical assistance (70+45+35 days).

Item line details	1	2	3	Grand Total
TA honoraria - (HTI&T)	55,125,000	36,225,000	30,432,500	121,782,000
TA subsistence- (HTI&T)	7,875,000	5,175,000	4,112,500	17,162,500
TA travel -(HTI&T)	3,150,000	3,220,000	3,290,000	9,660,000
TOTAL	66,150,000	44,620,000	37,835,000	148,605,000

Supervision
The supervision activities envisages are expected to be carried out mainly by the members of the standing committee. Hence the slightly higher cost of 700 € per visit for 15 visits per year.

Item line details	1	2	3	Grand Total
Supervision visits	23,625,000	24,150,000	24,675,000	72,450,000

Modules development
This item line reflects a provision for the contracting of the development of modules of training in complementary disciplines to nursing. It is not clear if the provision is sufficient, but it is possible to address the need on an ad hoc basis.

Item line details	1	2	3	Grand Total
New courses modules development	16,875,000	17,250,000	17,625,000	51,750,000

Thematic training
At least twice a year all the managers of HTI need to undergo Technical Workshops, similar in its objectives to that of Hospitals and DHCs. One of the two is extended to the entire PNFP HTIs. The provision covers also the cost of courses to induce the tutors of schools ready to provide new courses.

Item line details	1	2	3	Grand Total
Tutors prepar. new cours.	11,250,000	11,500,000	11,750,000	34,500,000
HTI TWs and consultations	11,250,000	11,500,000	11,750,000	34,500,000
HTI joint WSs/consultations	18,000,000	18,400,000	18,800,000	55,200,000
TOTAL	40,500,000	41,400,000	42,300,000	124,200,000

HTI&T Secretariat and standing committees' operations
In addition to the share of running costs of this cost centre, it has proven necessary to adequately provide for the relatively higher cost of the committee (whose composition is drawn from all parts of the Country, and whose work schedule is somewhat more intensive given the complexity of the problems to be addressed and the several consultations necessary). The item line also provides for the cost of pursuing the establishment of the joint PNFP HTIs partnership.

Item line details	1	2	3	Grand Total
Core activities HTI&T coord.	33,750,000	34,500,000	35,250,000	103,500,000
PNFP HTI partnership	11,250,000	11,500,000	11,750,000	34,500,000
TOTAL	45,000,000	46,000,000	47,000,000	138,000,000

Support to innovative training
This item line is a direct financial support to schools willing to introduce new courses, in the event that demand should be sustained with subsidies to facilitate access to a training venture with many unknowns. As the modules will not be ready until the second year, this provision is reserved for the later stages of the Plan.

Item line details	1	2	3	Grand Total
Support to HTIs pioneering new courses	0	59,800,000	61,100,000	120,900,000

16.3.7 G RESEARCH, STUDIES AND EXPERTISE.

Total forecast excluding share of overheads **UgSh 383,700,000** **€ 167,250**
Share of running cost and depreciation **UgSh 56,565,000** **€ 24,600**
Budget share 5%

Expertise
There are several studies that the Bureau wishes to pursue, for which expertise needs to be hired. The high degree of uncertainty about the extent of the study and the cost of such expertise means that the figures here below are largely indicative and could be swapped between them and with the next item line, which reflects the direct cost (not expertise related) of the studies.

Item line details	1	2	3	Grand Total
R&S - effects of Scholarship	20,250,000	0	0	20,250,000
R&S - hospital cost analysis	60,750,000	0	0	60,750,000
R&S - MHCP	0	0	21,150,000	21,150,000
R&S - quick and dirty costing	13,500,000	0	0	13,500,000
R&S - Training needs ass.	0	44,850,000	0	44,850,000
R&S - Training sch.s costing	0	36,225,000	0	36,225,000
R&S – poors' access	0	35,250,000	0	35,250,000
TOTAL	94,500,000	116,325,000	21,150,000	231,975,000

Research and studies
See above item line. In addition a provision is made for supporting mini-surveys carried out by diocesan staff.

Item line details	1	2	3	Grand Total
Cost analysis in hospitals	33,750,000	0	0	33,750,000
Drugs' prescr.-pts satisf.surv.	9,000,000	9,200,000	9,400,000	27,600,000
EmOC minisurvey	0	3,450,000	0	3,450,000
HTI training costing	0	9,200,000	0	9,200,000
MHCP survey	0	0	23,500,000	23,500,000
Quick and dirty costing	9,000,000	0	0	9,000,000
Poors' access	0	17,625,000	0	17,625,000
TOTAL	51,750,000	39,475,000	32,900,000	124,125,000

Operational Research
For the last three years the Bureau has been supporting small operational research initiatives with variable degree of success. It is anyway deemed necessary to continue fostering a research attitude by giving a modest support to individual initiatives supported by the various managements.

Item line details	1	2	3	Grand Total
Support to OR	9,000,000	9,200,000	9,400,000	27,600,000

16.3.8 H SPECIAL PROGRAMS.

Total forecast **UgSh 182,000,000** **€ 80,000**
Share of running cost and depreciation **UgSh n.a.** **€ n.a.**
Budget share 3%

This cost centre with a single item line reflects the uncertainty existing at the moment as to the right methodology to follow. This is a simple provision of fund awaiting the identification of the right approach. It is expected that a regional co-ordination cost much more that the amount provided for. Hence this cost centre is amenable to be developed further as stand alone project and/or as partnership.

Item line details	1	2	3	Grand Total
Coordination North. Region	90,000,000	92,000,000	0	182,000,000

16.3.9 Y M&E - ACCOUNTABILITY.

Total forecast **UgSh 138,200,000 € 59,000**

Budget share 2%

For the first time the Bureau has separated the function of accountability and M&E from all the others, establishing it as a cost centre, It includes the cost of the expertise necessary for the Mid Term (or near end term) evaluation and the formulation of the new Operational plan, plus the cost of both processes. It also includes the cost of audit.

Item line details	1	2	3	Grand Total
Payment to auditor	6,750,000	6,900,000	7,050,000	20,700,000
MTR and New Opplan fora	0	0	35,250,000	35,250,000
MTR expertise	0	0	47,000,000	47,000,000
New Opplan expertise	0	0	35,250,000	35,250,000
TOTAL	6,750,000	6,900,000	7,050,000	20,700,000

16.3.10 Z OVERHEADS.

Total forecast **UgSh 821,085,000 € 357,000**

Budget share 12%

Two items constitute the overheads: office running cost and depreciations of assets. Each of these is attributable (virtually) to a cost centre.

Depreciation - share

Total forecast **UgSh 207,000,000 € 90,000**

The Bureau is now in position to purchase its own assets and to finance their replacement. For this reason it feels authorised to charge the cost of their depreciation to the Plan and more specifically (albeit virtually) to each cost centre.

Item line details	1	2	3	Grand Total
Share of Core functions	10,125,000	10,350,000	10,575,000	31,050,000
Share of OG&D	14,850,000	15,180,000	15,510,000	45,540,000
Share of ICT	6,075,000	6,210,000	6,345,000	18,630,000
Share of CB - Training	9,450,000	9,660,000	9,870,000	28,980,000
Share of CB – Schol. Fund	12,825,000	13,110,000	13,395,000	39,330,000
Share of CB - HTI&T	9,450,000	9,660,000	9,870,000	28,980,000
Share of R&S	4,725,000	4,830,000	4,935,000	14,490,000
Share of special programs	0	0	0	0
TOTAL	67,500,000	69,000,000	70,500,000	207,000,000

Running of office – share

Total forecast **UgSh 614,085,000 € 267,000**

The (virtual) apportionment of ordinary running costs – whose totals have been established on historical basis and require further details – has been based on the approximate respective cost-centres' contribution to the total budget, i.e. Core functions 15%, OG&D 22%, ICT 9%, CB – Training 14%, CB - Scholarship Fund 19%, CB - HTI&T 14%, R&S 7%.

Item line details	1	2	3	Grand Total
Share of Core functions	30,375,000	31,050,000	31,725,000	93,150,000
Share of OG&D	44,100,000	45,080,000	46,060,000	135,240,000
Share of ICT	18,000,000	18,400,000	18,800,000	55,200,000
Share of CB - Training	27,900,000	28,520,000	28,520,000	84,940,000
Share of CB – Schol. Fund	38,250,000	39,100,000	39,950,000	117,300,000
Share of CB - HTI&T	27,900,000	28,520,000	29,140,000	85,560,000
Share of R&S	13,950,000	14,260,000	13,865,000	42,075,000
Share of special programs	0	0	0	0
TOTAL	200,475,000	204,930,000	208,060,000	613,465,000

16.3.11 Z CONTINGENCY.

Total forecast **UgSh 213,850,000 € 93,000**
Budget share 3%
Contingency is calculated at approximately 3%.

17 Income Budget

The total income forecast is of € 1,929,100 corresponding to UgSh 4,419,990,000.

17.1. LOCAL INCOME

Total forecast **UgSh 545,940,000 € 237,300**
Income Budget share 13%

AA Local Income carried forward
This income sub-centre reflects the accruals of local income that were unspent in the previous year. At the moment the only balance to be carried forward refers to accruals from the refunds paid by the units receiving ICT services.

Item line details	1	2	3	Grand Total
Recoveries from ICT serv.	13,500,000	0	0	13,500,000

AB Local donors
At the moment these are represented by Joint Medical Store earmarked contribution to capacity building and the contributions from GoU.

Item line details	1	2	3	Grand Total
GoU	13,500,000	13,800,000	14,100,000	41,400,000
JMS	63,000,000	64,400,000	65,800,000	193,200,000
TOTAL	76,500,000	78,200,000	79,900,000	234,600,000

AC Local revenues
This is a mix of revenues related to services the Bureau offers, refunds received and the fees paid by units. It is better specified in the detailed budget.

Item line details	1	2	3	Grand Total
Administr./logistic services	2,250,000	2,300,000	2,350,000	6,900,000
AGM	4,500,000	4,600,000	4,700,000	13,800,000
Health Units Fees	63,000,000	73,600,000	84,600,000	221,200,000
Honoraria/profes. services	1,125,000	1,610,000	2,115,000	4,850,000
ICT recoveries	6,750,000	8,280,000	8,460,000	23,490,000
Incidental	2,250,000	2,300,000	2,350,000	6,900,000
Treasury management yield	6,750,000	6,900,000	7,050,000	20,700,000
TOTAL	86,625,000	99,590,000	111,625,000	297,840,000

17.2. EXTERNAL INCOME

Total forecast **UgSh 3,874,050,000 - € 1,691,800**

Income Budget share xx%

BA External Income Carried Forward

These are the unspent balances on the donors and projects accounts carried forward from previous exercise(s). The sub-centre is further divided per source.

Item line details	1	2	3	Grand Total
AVSI	47,250,000	0	0	47,250,000
TOTAL	47,250,000	0	0	47,250,000

BB External Transfers

These are revenues in monetary terms received in the course of the year. They are further specified per source (i.e. Donor agency).

Item line details	1	2	3	Grand Total
Cordaid	450,000,000	460,000,000	940,000,000	1,850,000,000
IICD	175,050,000	0	0	175,050,000
PSO	900,000,000	805,000,000	0	1,705,000,000
SVFOG	56,250,000	0	0	56,250,000
TOTAL	1,581,300,000	1,265,000,000	940,000,000	3,786,300,000

BB External revenues in kind

This income sub-centre reflects the monetary value of services, goods, work supplied to the Bureau "in kind", and specified by source (donor).

Item line details	1	2	3	Grand Total
Work in kind AVSI	40,500,000			40,500,000

17.3. THE FUNDING GAP

At the moment of the formulation of this proposal there exist a forecast for local resources, commitment from various donors and a series of pledges that, cumulatively, amount to a total of ab. 1.92 M €, in effect about 37% of the envisaged expenditure budget (total gap 1.15 M €). The gap calculated for the first year (i.e. the year for which the most critical decisions are impeding, and therefore urgent), stands at about 0.25 M €. In subsequent years the gap is calculated at about € 0.45 M per year. It is possible to reduce plans and activities, and targets, for year one, while time is taken to formulate additional projects to fund the gap and perhaps extend further the objectives. The decision taken at the Conference of November 2006, was to continue operating on the assumption that the funding gap will be covered year after year and to postpone major budget decisions towards the end of year 1 or at the moment of the mid-term review.

17.4. MANAGEMENT OF THE BUDGET

The budget will be managed in accordance with the approved Financial Management Guidelines that have already been provided to all major donors. In general term the resources, unless specifically earmarked at the origin by the donor, will be managed from a basket. The spending function is regulated by the Financial Management Guidelines and supervised by the Finance and Planning Committee on a quarterly basis.

18 Summary of the Budget by Head Items (centres)

The summary of the Budget per cost centre and income centre is provided here below **in € (Euros).**

Expenditure

Budget Item Group - Centre attribution	2007	2008	2009	Grand Total
A Core functions	117,995	120,199	122,649	360,843
B Organisation Governance and Development	206,721	205,106	175,439	587,266
C ICT	104,554	61,782	62,230	228,565
D Capacity Building - Training	104,000	136,750	93,000	333,750
E Capacity building - Scholarships	180,113	180,387	140,675	501,175
F Capacity Building - HTI&T	96,744	113,052	110,074	319,870
G Research, studies and expertise	69,000	71,250	27,000	167,250
H Special Programs	40,000	40,000	0	80,000
X M&E - Accountability	3,000	3,000	53,000	59,000
Y Overheads	119,100	119,100	118,800	357,000
Z Contingency	31,000	32,000	30,000	93,000
Grand Total Expenditure	**1,072,227**	**1,082,626**	**932,866**	**3,087,719**

Income

Income Budget item line (origin)	2007	2008	2009	Grand Total
LOCAL INCOME				
Recoveries cfw	6,000			6,000
	6,000			**6,000**
GoU	6,000	6,000	6,000	18,000
JMS	28,000	28,000	28,000	84,000
Other				
	34,000	**34,000**	**34,000**	**102,000**
Administrative and logistic services	1,000	1,000	1,000	3,000
AGM	2,000	2,000	2,000	6,000
Health Units Fees	28,000	32,000	36,000	96,000
Honoraria and professional services	500	700	900	2,100
ICT recoveries	3,000	3,600	3,600	10,200
Incidental	1,000	1,000	1,000	3,000
Treasury management yield	3,000	3,000	3,000	9,000
	38,500	**43,300**	**47,500**	**129,300**
Total Local Income	**78,500**	**77,300**	**81,500**	**237,300**

Income Budget item line (origin)	2007	2008	2009	Grand Total
EXTERNAL INCOME				
Carried forward				
AVSI	21,000			21,000
Cordaid				
IICD				
Other				
PSO				
External Transfers	**21,000**			**21,000**
AVSI				
Cordaid	200,000	200,000	400,000	800,000
IICD	77,800			77,800
Other project 1				
Other project 2				
Other project 3				
PSO	400,000	350,000		750,000
SVFOG	25,000			25,000
External Revenues in kind	**702,800**	**550,000**	**400,000**	**1,652,800**
Goods in kind				
Services in kind Cuamm				
Services in kind other				
Work in kind AVSI	18,000			18,000
Work in kind other				
	18,000			**18,000**
Total External Income	**741,800**	**550,000**	**400,000**	**1,691,800**
Grand Total Income	**820,300**	**627,300**	**481,500**	**1,929,100**

Gaps

	2007	2008	2009	Grand Total
INCOME	**820,300**	**627,300**	**481,500**	**1,929,100**
EXPENDITURE	**1,072,227**	**1,082,626**	**932,866**	**3,087,719**
Gap Total	**-251,927**	**-455,326**	**-451,366**	**-1,158,619**

ANNEXES

ANNEX I: Logical Framework

PROJECT PURPOSE	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE	MEANS OF VERIFICATION	ASSUMPTIONS
To enable the RC health service network to increase its contribution to the attainment of the Uganda Health Sector objectives and the Millennium Development Goals in Uganda.	**At national aggregate level:** • Number of OPD new contacts per year in RC HU's • Percentage of total national OPD new contacts contributed by RC HU's • Number of deliveries in RC health facilities per year • Percentage of total deliveries in HU's contributed by RC HU's • Nr of children having received three doses of DPT/Pentavalent vaccine per year • Percentage of total nr of children having received three doses of DPT/Pentavalent vaccine contributed by RC HU's • Nr of persons started on ARV treatment in RC Hospitals • Nr of women who received ARV for prophylaxis (PMTCT) • Nr of new TB cases hospitals • Accessibility in RC Hospitals: median value of standard units of output (SUO) • Accessibility in RC Health centres: median value of standard units of output (SUO) • Equity in RC hospitals: median value of user fees per SUO • Equity in RC Health Centres: median value of user fees per SUO	- 2,173,847 - 9% - 69,127 - 19% - 136,216 - 13% - 5.220 - 2,617 - To establish - 182,255 - 9,658 - 1,243 - 1,209	- Annual HMIS 107 reports of the RC hospitals and HC 4 - Annual HMIS reports of the health centres and Diocesan health Departments - Annual analysis of annual HMIS 107 reports of hospital and health centres by UCMB - Annual report of UCMB - Annual Report of MOH	• the economic environment, does not worsen compared to the assessment in this plan; • the political stability of the country remains as it is; • the security in the north and north east really improves following the outcome of the peace negotiations; • the Sector Wide Approach remains the key strategy for the implementation of the NHP and HSSP II; • the political commitment for the Public-Private Partnership in Health is fully regained and maintained; • the subsidies to the PNFP health facilities are continued at least at the present level; • the DP's of the RC health network support the plan with the required external funding; • the DP's continue open dialogue with UCMB and continue flexible funding arrangements to enhance responsiveness to developments on the ground during implementation • the technical staff can be recruited / retained, at reasonable rates.

STRATEGIC GOALS	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE	MEANS OF VERIFICATION	ASSUMPTIONS
1. The RC Health Service Network has enhanced the Partnership with the Public Health actors, at national and district level, and with other actors in faithfulness to the Mission.	• Percentage of occurred meetings of national Health Policy Advisory Committee and Health Sector Working Group Sector attended • Annual allocation of PHC Conditional Grants to RC hospitals and health centres • Percentage of PHC-CG released to RC hospitals and health centres annually • Nr. of contracts signed between Districts and RC hospitals and HC 4 annually • Nr. of RC hospitals participating in SHIS	- 75% 9.551.028.391 - 75%	- Annual report UCMB - Annual Report MOH - Annual reports of RC hospitals and health centres - Annual analysis of hospital and HC's reports by UCMB - Annual report MOH and MOFPED - Annual report SHIS - Copies of the contract between districts and RC HU's - Copies of contracts between NHIS and RC HU's	**In addition to above external assumptions:** **RC Internal:** • the RC health institutions remain faithful to the Mission and Policy Statement as well as to the new Strategic Plan 2007 – 2011; • the RC authorities and other internal stakeholders actively support their health units in striving towards realisation of the Mission; • the RC leaders enhance their active support to the Bureau's efforts to improve performance. • the relevance, timeliness, and accurateness of the data, obtained from the member institutions, is maintained, when the responsibility for the operation of the ICT technology is handed over to them.

STRATEGIC GOALS	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE	MEANS OF VERIFICATION	ASSUMPTIONS
2. The RC Health Services have improved their sustainability as well as the range and quality of their services in Faithfulness to the Mission.	• Nr. of RC hospitals providing evidence of annual External Audit • Nr. of Diocesan Health Offices providing evidence of use of financial management guidelines • Median value of the staff productivity (SUO per staff) in hospitals • Median value of the staff productivity in health centres • Median recurrent cost per SUO in hospitals • Median recurrent cost per SUO in health centres • Median value of access (total SUO) in hospitals • Median value of access (total SUO) in health centres • Percentage of RC hospitals and HC 4 accredited annually • Percentage of health centres accredited annually • Median value of degree of completeness of UMHCP in HCs III • Nr of hospitals having staff in place for CPE, mental health, and palliative care (all three)	- 17 (62%) - 1,379 - 1,672 - 4,852 - 2,644 - 182,255 - 9658 - 100% - 99.5% - 75% - 4	- Annual reports RC hospitals - Annual external audit reports in RC hospitals - Annual reports of Diocesan health departments - Copies of the diocesan financial management manuals - Annual analysis of hospital / HC 4 annual reports by UCMB - Annual analysis of health centre reports by UCMB - Annual analysis of DHD reports by UCMB - Annual report UCMB - Annual accreditation applications and awards - Three year survey of UMHCP completion - Annual report hospitals - UCMB scholarship funds report - Training reports	**In addition to the above external and RC internal assumptions:** **UCMB Internal** • UCMB can preserve the effective mix of skills of the professionals and support staff and they, in turn, continue to be highly committed and dedicated to the realisation of the aims of this plan; • the UCMB team and the RC member institutions retain the balance between the spiritual and technical, e.g. the Mission continues to inspire them while they strive towards technical excellence; • the UCMB team maintains it willingness and capacity to reflect on - and learn from – its own experiences.

STRATEGIC GOALS	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE	MEANS OF VERIFICATION	ASSUMPTIONS
3. The RC Health Institutions have improved their governance, management, and accountability structures and practices.	• Nr of RC hospital / HC 4 managers having attended a recognised management course • Nr of valid RC hospital / HC 4 charters at end of plan period • Nr of valid DHD constitutions at end of plan period • Percentage of RC hospital / HC 4 management team providing evidence of accountability to their Boards on access, equity, efficiency and quality • Percentage of DHO's providing evidence of accountability to their Boards on access, equity, efficiency and quality • Percentage of RC hospitals and HC 4 using the HMIS form 107 for annual reporting • Percentage of RC health centres using the HMIS form 107 for annual reporting • Percentage of RC hospitals / HC 4 with functional ICT equipment (reply to UCMB email within 5 working days). • Percentage of DHO's/DHD's scoring good / very good, using the assessment tool agreed • Percentage of DHO's with functional ICT equipment (reply to UCMB email within 5 working days).	- - Hosp 24 - HC IV 0 - 16 - 10 (37%) - 7 (36%) - Hosp 80% - HC IV 0 - 70%	- Annual reports of RC hospitals / HC 4 - Annual reports of RC health centres - Annual report Scholarship fund - Copies of RC Hospital Charters on file at UCMB - Copies DHD Constitutions on File ate UCMB - Copies of the hospital and HC 4 reports to Board on file at UCMB - Copies of DHD reports to Board on file at UCMB - Email communication between UCMB and RC hospitals, HC 4, and DHO's. (% of hospitals / HC 4 / DHO's replying to monthly tests of UCMB within 3 working days)	**See above**

STRATEGIC GOALS	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE	MEANS OF VERIFICATION	ASSUMPTIONS
4. The RC Health Service Network has improved the development of its human resources and its contributions towards professional training.	• Nr of scholarships awarded annually • Annual attrition rate among staff having benefited from a UCMB scholarship • Percentage of RC hospitals and HC 4 having the HRD guidelines • Percentage of DHO's having the HRD guidelines • Percentage of reduction in annual (EN+EMW) staff attrition rate in RC hospitals • Percentage of reduction in annual (EN+EMW) staff attrition rate in RC HC's • Percentage of HTI producing an integrated annual report in line with MOES / MOH format • Percentage of RC HTI providing evidence or accountability to their Board • Nr. of PNFP HTI consultation meetings held per year • Nr of HTI using ICT equipment for communication (reply to UCMB email within 5 w days) • Percentage of RC HTI accredited annually • Nr of ECN's graduating from RC HTI annually • Nr of new curricula being implemented by RC HTI • Nr of RC HTI providing evidence of a policy assuring access to poor candidates	- 110 - 29% - 46% - 28 (2005)	- Annual report of the Scholarship fund - Annual staff retention reports from hospitals - Annual reports of RC hospital and HC 4 - Copies of HRD guidelines in the RC hospitals and HC 4 - Copies of HRD guidelines in DHO's - Annual reports of RC HTI - Copies of the RC HTI reports to Boards - Reports of PNFP HTI consultation meetings - Email communication between UCMB and HTI - Accreditation applications and awards - Annual report of MOES and / or UNMC - Annual report of UCMB HTI&T desk - Copies of HTI policies on file at UCMB	**See above**

STRATEGIC GOALS	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE	MEANS OF VERIFICATION	ASSUMPTIONS
5. The RC Health Services have improved their advocacy for the target populations and institutions	• The agenda (list of subjects) for advocacy published annually • Nr of joint advocacy actions pursued with the other Medical Bureaus per year • Nr of RC hospital / HC 4 managers having attended a negotiation and advocacy skills course • Nr of DHC's having attended a negotiation and advocacy skills course • Percentage of DHC's providing evidence of an activity to raise awareness of the RC Mission and Policy in health • A study to improve the accessibility of the poor presently not accessing RC services has been undertaken.		- The advocacy agenda published for the year - Copies of the joint Medical Bureaus' position papers - Reports of the negotiation and advocacy training courses - Annual reports of RC hospitals and HC 4 - Annual reports of DHO's - The report of the study.	See above
6. A. Overarching and Crosscutting objectives	• Specific objectives in operational plan for the period		- Copy of the Operational Plan 2007-2009 - The operational Plan 2010-2012	See above
6. B UCMB core functions are carried out and governance is secured.	• Core functions mentioned in annual work plans • Annual external audit report of complete UCMB financial operations • Revised Terms of Reference for the statutory organs • The new Operational Plan 2010-2012		- The annual work plans of UCMB - Copies of the Annual External Audit reports - Copy of the Terms of Reference for the statutory organs - Copy of the Operational Plan 2010-2012	See above

Operational Plan 2007-2009: Primary Targets

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 1. The RC Health Service Network has enhanced the Partnership with the Public Health actors, at national and district level, and with other actors in faithfulness to the Mission.**				
1.1. Representation of UCMB in - and policy advice to - HPAC and related working groups and fora is ensured.	• Attend 75% of the annual occurred meetings of national HPAC and Health Sector WG.	- 75%	- Percentage of occurred meetings attended per year of HPAC and HS WG	• Minutes of the meetings attended • List of meetings held of MOH • Notes to the files of UCMB
1.2. The revival of Public-Private Partnership in Health Desk at the Ministry of Health and the functioning of the Public-PNFP working group are pursued.	• Information concerning PHC CG allocations is provided by the PPPH Desk annually.		- Formal communications from the PPPH Desk contain information on PHC-CG for the year	• Formal correspondence from PPPH desk
1.3. The Public – Private Partnership Policy for health and the guidelines for the implementation of the P-PNFP partnership are officially approved by the Ministry of Health.	• PPPH Policy and guidelines published.		- Formal publication of the PPP Policy in Health - Formal publication of the PPPH implementation guidelines	• Publications of the cabinet • Publications of MOH
1.4. If the previous objective is achieved: The P-PPH Policy with FB-PNFP health sector is consistently implemented.	• Two regional workshops per year have been implemented for sensitisation / facilitation of implementation.		- Nr of workshops held annually on PPPH	• Reports of the workshops
1.5. Diocesan Health Offices / Co-ordinators have consolidated the integration of Health Units into the District Health System.	• The total % of released PHC CG to Lower Level Units remains above 75% every year of the Plan	Above 75%	- Percentage of allocated PHC-CG's released to all RC Lower Level Units each year	• Annual reports of the LLU's • Annual reports of the DHD's • UCMB analysis at national level • Annual report MOH
1.6. RC HSD Leaders have improved their capacity to implement all the HSD leadership functions (planning, support supervision, monitoring and advocacy).	• One member of the management team of each RC HSD leader unit has attended a targeted / specific training workshop		- Nr of members of management team of each RC HSD leader unit having attended a HSD specific course	• Reports of the training courses held • Annual reports of the HSD leader units

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 1. The RC Health Service Network has enhanced the Partnership with the Public Health actors, at national and district level, and with other actors in faithfulness to the Mission. (continued)**				
1.7. Contractual Approaches (taking developments regarding GI's and the Social Health Insurance into account) are being implemented.	• In each diocese at least one RC HU (but preferably more), has signed a service delivery contract with the district to replace the old Memorandum format.		- Nr of dioceses in which one, or more health units have signed a new contract with the district to replace the old service delivery MOU	• Copies of the contracts on file at UCMB • Copies of contracts on file in the health units.
1.8. GIFMU, HIV/AIDS Focal Point. and UCS are implementing harmonised policies and strategies to enable the RC institutional levels to respond to the challenges of the GI's?	• GIFMU, HIV/AIDS FP and UCMB together present at least one position papers / agreed strategies per year on issues related to effects of GIs on RC HUs.		- Nr of joint position papers / agreed strategies published on issues related to GI's on RC HU's	• Annual report of UCMB • Annual report of GIFMU • Annual report of HIV/AIDS FP • Copies of the publications at national level • Copies of the publications in RC HU's
1.9. RC HUs have been enabled to take part in the Social Health Insurance (SHI) scheme constructively.	• Guidelines are published (before end of FY 2006/7).		- Publication of the guidelines - Nr of HU's	• Copy of the guidelines published • Copies of the guidelines available in RC HU
• **STRATEGIC GOAL 2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION.**				
Financial Management:				
2.1. Cost based (accrual) accounting practices are followed in RC Hospitals	• By the end of the plan 10 hospitals are able to produce reports according to accruals (cost based) accounting concept having implemented recommendations of the manual. (Baseline at mid 2006: only 2/27).	- 20%	- Nr of hospitals producing financial reports according to the accruals accounting concept and cost centres	• Copies of the annual financial reports received by UCMB • Findings during support supervision visits to RC hospitals

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION (CONTUNED)**				
2.2. Hospitals using ABC_Fipro are able to produce relevant reports for monitoring and management decision-making processes.	• At least 5 hospitals are using ABC_Fipro effectively using all the modules and producing reports through ABC_Fipro.	- 40%	- Nr of hospitals producing reports through ABC_Fipro programme	• Copies of the reports available in the RC hospitals • Findings during support supervision visits to RC hospital s
2.3. Fiduciary assurance has been enhanced in RC Hospitals. (the key elements of transparent financial accountability are in place in RC hospital)	• By the end of 2008 10 Hospitals have had a process audit carried out. (Baseline at mid 2006:3/27) • By the end of 2007 27 RC hospitals produce evidence of annual external audit of their accounts carried out	- 11% - 77%	- Nr of RC hospitals producing evidence that a process audit was carried out in the year - Nr of RC hospitals producing evidence of an external audit carried out each year	• Annual analytical reports of RC hospitals sent to UCMB • Process audit reports available in the hospitals • External audit reports available in the hospitals
2.4. Hospitals accessing funds from GIs are able to meet the specific demands of financial accountability of GIs.	• Every year all RC hospitals, accessing funds through GIFMU, are compliant to the respective reporting guidelines.		- Nr of RC hospitals reporting annually in accordance with the respective reporting guidelines	• Annual reports of GIFMU • Annual reports of the hospitals accessing funds through GIFMU • Assessment reports of GI FMU partners
2.5. Cost implications are taken into account when scaling-up, adding new services, or extending the package of services is decided in RC hospitals.	• Five hospitals have costs of at least 3 frequently occurring treatments.		- Nr of RC hospitals reporting costs of three frequently occurring treatments	• Annual reports of RC hospitals

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION (CONTUNED)**				
2.6. Health Unit managements are trained to assess financial sustainability of own unit and to decide upon the scope of the care package offered.	• The training module on the assessment of financial sustainability has been inserted in one of the Hospital technical workshops • The training module on the assessment of financial sustainability has been inserted in one of the DHC's technical workshops		- A developed training module on the assessment of financial sustainability of a health unit - Programme of TWS for hospital managers including the training module on sustainability of HU's - Programme of TWS for DHC's including the training module on sustainability of HU's	• Copy of the training module developed • Reports of the TWS for Hospital managers • Reports of the TWS for DHC's
2.7. The financial management guidelines/manuals are in use in the Diocesan Health Offices.	• 30% (6) Diocesan Health Offices are implementing financial management guidelines for their office.		- Nr of Diocesan Health offices reporting according to the financial management guidelines	• Annual reports of the Diocesan health Departments / offices • Findings during support supervision visits
2.8. The financial management guidelines/manuals are in use in the Diocesan Health Units.	• By the end of 2008 all Dioceses have adopted a financial management manual for LLUs in their Dioceses as indicated by the reports from the monitoring tool		- Nr of diocesan financial management manuals according to the monitoring tool	• Reports from the monitoring tool • Copies of the diocesan financial management manuals • Reports of the training on financial management
Efficient Use of Resources				
2.9. The RC Hospitals are making efficient use of their resources in the given circumstances.	• The observed median values of staff productively (SUO per staff) in RC hospitals for the period is neutral or positive compared to 2005/06		- Annual median value of SUO per staff member in RC hospitals	• Annual comprehensive reports of the hospital • Annual UMCB analysis report of all RC hospital reports

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	**PRIMARY TARGET**	**BASELINE**	**OBJECTIVELY VERIFIABLE INDICATORS**	**MEANS OF VERIFICATION**
• **STRATEGIC GOAL 2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION (CONTUNED)**				
2.10. The LLU's have improved the efficient use of their resources.	• In 75% of the health centres (LLU's) the SUO per staff member is six or above per day	- 61%	- Annual SUO per staff in RC in each RC health centres	• Annual comprehensive reports of LLU's • Annual UMCB analysis report of all RC health centre reports
Access and equity:				
2.11. Improved access to - and equity in – health care for vulnerable groups are actively pursued by RC Hospitals	• The observed trend of median value of access (total SUO) in RC Hospitals for the period is neutral or positive compared to baseline data of 2005/06	- 182,255	- Annual median value of total SUO in RC hospitals	• Annual comprehensive reports of the hospital • Annual UMCB analysis report of all RC hospital reports
2.12. Improved access to - and equity in – health care for vulnerable groups are actively pursued by RC LLUs	• The observed trend of median value of access (total SUO) in RC Health Centres for the period is neutral or positive compared to baseline data of 2005/06	- 9,658	- Annual median values of access in health centres	• Annual comprehensive reports of LLU's • Annual UMCB analysis report of all RC health centre reports
Range and Quality of Services:				
2.13. Quality of care and quality of management parameters are established in the process of accreditation	• Annual addition of at least 1 quality of care and 1 quality of management criterion to the accreditation criteria	- 100% - 224= 99,5%	- Quality of care criteria in annual additions to accreditation criteria - Quality of management criteria in annual additions to accreditation criteria - Percentage of RC hospitals accredited annually - Percentage of health centres accredited annually	• Accreditation criteria published by the HC each year • Annual assessment of RC accreditation applications

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION (CONTUNED)**				
2.14. The capacity to provide Pastoral Care of the Sick in hospitals has been enhanced	• The number of CPE trainees presented for training by hospitals annually exceeds 5. • 27 hospitals have an established chaplaincy (at least 1 member of the team trained in CPE). (Baseline: 16 / 27)	- 16/27 = 59%	- Nr of candidates presented for training annually by the hospitals - Nr of hospitals reporting having a chaplaincy with at least one member trained in CPE annually	• Applications for training received by the PCS Committee annually • Reports of the CPE training courses held in the year • Annual HR establishment report in annual analytical reports of RC hospitals • UCMB annual analysis of Annual reports
2.15. The capacity to provide basic mental health care has been enhanced in RC units	• 50% of the Hospitals have staff trained in provision of mental health services		- Nr of RC hospitals reporting having staff trained in mental health services annually	• Annual HR establishment reports of RC hospitals • Reports of mental health training courses held in the year • Annual UCMB analysis report of all HU annual reports
2.16. The capacity to provide NFP in RC units has been increased.	• Provision of NFP is reported in 27 hospitals • Provision of NFP is reported in 75% of HC3	- 14% - 58%	- Nr of RC hospitals reporting NFP service uptake in annual comprehensive or analytical report - Nr of RC HC 3 reporting NFP service uptake in annual comprehensive report	• Annual comprehensive reports of RC hospitals • Annual comprehensive reports of HC 3 • Annual UCMB analysis report of all HU annual reports
2.17. The capacity to provide palliative care has been increased in RC units	• All 27 hospitals render palliative care services	- 55%	- Nr of RC hospitals reporting palliative care service	• Annual analytical reports of RC hospitals • Annual UCMB analysis report of all HU annual reports
2.18. The degree of complete implementation of the Minimum Health Care Package by RC HU's has increased.	• The median value of the degree of completeness of the package for HC3 has increased to 85%	- 75%	- Median value of the degree of completeness of MHCP in HC 3 in 2009	• Follow up survey of degree of completeness of MHCP in HC 3

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 2. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR SUSTAINABILITY AS WELL AS THE RANGE AND THE QUALITY OF SERVICES IN FAITHFULNESS TO THE MISSION (CONTUNED)**				
2.19. RC HU's comply with Emergency Obstetric Care (EmOC) criteria	• A clear increase of the % of RC HC 3 which satisfy the basic EmOC criteria • All hospitals and HC 4 satisfy the comprehensive EmOC criteria	- 4% - Hosp: 85% - HC 4: 40%	- Percentage of RC LLU's reporting all basic EmOC criteria in place - Percentage of RC hospitals / HC 4 reporting all basic and comprehensive EmOC criteria in place	• Baseline survey 2006/07 • Annual analytical reports RC DHD's • Annual analytical reports RC hospitals and HC 4 • Support supervision reports • Or: annual follow-up surveys
2.20. RC Health Services' Network makes effective use of ICT to improve performance and faithfulness to the mission	• Visits of users to the UCMB website increase in time	- +/- 2000	- Nr of visits of RC HU's to UCMB website per year	• UCMB Website quarterly and annual reports • A survey among UCMB ICT users (2008)
• **STRATEGIC GOAL 3. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES**				
3.1. The advocacy, negotiation and leadership skills of RC Hospitals/HC4 managers have been strengthened.	• At least one manager of each hospital / HC 4 has attended the advocacy-negotiation-leadership skills course (preferably the leader of the management team)		- Nr of hospital managers / HC 4 having attended the advocacy – negotiation – leadership skills course per year - Nr of RC hospitals / HC 4 reporting that manager(s) attended the advocacy, negotiation, leadership course per year	• Applications to attend the advocacy – negotiation – leadership skills received each year • Reports of each advocacy – negotiation – leadership skills course held
3.2. The advocacy, negotiation and leadership skills of DHCs have been improved.	• All DHCs have attended the advocacy-negotiation-leadership skills course (preferably the leader of the DHO team		- Nr of Diocesan Health Coordinators having attended the advocacy – negotiation – leadership skills course per year - Nr Dioceses reporting that DHO staff attended the course per year	• Applications to attend the advocacy – negotiation – leadership skills received each year • Reports of each advocacy – negotiation – leadership skills course held

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 3. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES (CONTINUED)**				
3.3. The high compliance of RC HU's with labour legislation is upheld	• All Manuals of Employment of Hospitals have been assessed as aligned with the new legislation requirements.	- 8 (29%	- Nr of Manuals of Employment of RC hospitals assessed / reported as aligned with the new legislation requirements	• Copies of the Manuals of Employments presented to UCMB • The assessment report of UCMB of each Manual of Employment • The Uganda new labour legislation
3.4. Good corporate governance has been firmly established in the RC Health network.	• At least 13 Hospital Boards (50%) give evidence of assessment of their hospital management teams • At least 9 Diocesan Boards (50%) give evidence of assessment of their Health co-ordination office		- Nr of RC hospitals Boards providing evidence of annual assessment of management team each year - Nr of Diocesan Health Boards providing evidence of annual assessment of Health coordination office staff	• Annual analytical reports of RC hospitals • Accreditation reports of RC hospitals to UCMB • Annual analytical reports of DHD's • Findings support supervision visits
3.5. Accountability of Hospital Managements to Boards vis-à-vis performance/faithfulness to the Mission (access, equity, efficiency and quality) is established.	• 100% of Hospitals managements show evidence of the accountability they provided to Board	- 10 (37%)	- Nr of RC hospital management teams providing evidence that they report to their Board on the key RC Mission indicators (access / equity / efficiency / quality) each year	• Copies of the reports to RC hospital Boards received by UCMB each year • Annual analytical reports of RC hospitals

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 3. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES (CONTINUED)**				
3.6. Adequate internal and external accountability of RC hospitals is ensured.	• 100% of the Hospitals report using the HMIS 107 HU Annual Comprehensive Report form • 100% of the Hospitals report on 3 PEAP / HSSP II indicators		- Nr of RC hospitals reporting on HMIS 107 form annually - Nr of RC hospitals reporting on 3 PEAP / HSSP II indicators in annual analytical report each year	• Annual comprehensive reports of RC hospitals • Copy of the HMIS 107 form • Annual analytical reports of RC hospitals • Copy of the PEAP / HSSP II and RC indicators
3.7. Professional management of the RC Hospitals is enhanced.	• In 80% of the hospitals (22/27) the three core managers (Medical, Administrative, and Nursing Director) have attended recommended management course	- 8	- Nr of RC hospitals reporting that three core managers attended a recommended management course	• Annual analytical reports of RC hospitals • Annual reports of UMU HSM courses • Annual report of UCMB Scholarship fund
3.8. RC hospital have been enabled to develop / implement plans that can guide emergency and / or development decisions.	• 70% of the RC hospitals have a contingency plan to assure continuity of essential services in case of HR or financial crisis situations	- 10 (37%)	- Nr of RC hospitals having submitted a contingency plan	• Copies of the RC hospital contingency plans on file at UCMB
3.9. RC hospitals have been enabled to improve their organisational structures / performance.	• All hospitals have undertaken one organisational assessment, using the self-assessment tool		- Nr of RC hospitals having carried out an organisational self assessment using the tool developed by UCMB	• Copy of the self assessment tool developed by UCMB • Reports of the self assessment carried out by the hospitals sent to UCMB • Or report of self assessment included in the Hospital Annual report of the year the assessment was carried out.

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 3. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES (CONTINUED)**				
3.10. The RC Health Centres Four (HSD) are governed and managed as professionally as hospitals.	• At least one manager of each HC 4 has attended a recommended management course		- Nr of managers of RC HC 4 having attended a recommended management course	• Annual analytical reports of RC HC 4 • Annual reports of UMU HSM courses • Annual report of UCMB Scholarship fund
3.11. The management of ICT is sustained by the RC Hospitals.	• 100% (27/27) of the hospitals have adopted an internal information an communication policy • 90% (24/27) of the hospitals make effective use of e-mail in Hospitals (measured by response to monthly tests by UCMB i.e. reply within 3 days)		- Nr of RC hospitals sending in a valid information and communication policy - Average nr of hospitals responding within three days to monthly test message from UCMB	• Copies of the RC hospital Information and communication policies on file at UCMB • Results of the validation assessment of the presented Information and communication policies • Annual Report of the monthly tests of email responses
3.12. Effective Diocesan Coordination of Health Centres is established in the majority of the dioceses.	• 70% percent of the DHO's/DHD's (13/19) score good to very good, using the assessment tool agreed		- Nr. Of DHO's / DHD' scoring good to very good each year according to the assessment tool developed	• Copy of the assessment tool approved by the HC • The results of the annual assessment of the performance of the DHO's / DHD's using the assessment tool • The annual reports of the DHD's
3.13. Accountability of Diocesan Health Offices to Diocesan Health Boards vis-à-vis performance/faithfulness of own LLUs to the Mission (access, equity, efficiency and quality) is established.	• 70% of DHO (13/19) show evidence of the accountability they provided to their Boards.	- 7 (36%)	- Nr of Diocesan Coordinators providing evidence that they report to their DHB on the HC's performance towards 4 key RC Mission indicators (access / equity / efficiency / quality) each year	• Copies of the reports sent to the DHB's received by UCMB each year

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 3. THE RC HEALTH INSTITUTIONS HAVE IMPROVED THEIR GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY STRUCTURES AND PRACTICES (CONTINUED)**				
3.14. Adequate internal and external accountability of diocesan health network is ensured.	• 60% (140 / 230) of the HU's report using the HMIS 107 HU Annual Report • 70% (13/19) of the DHO's report on three PEAP / HSSP II indicators		- Nr of HU's using the HMIS 107 for the annual comprehensive report to UCMB - Nr of DHO annual analytical reports containing information regarding the LLU performance towards 3 PEAP / HSSP II indicators	• Annual comprehensive reports received by UCMB by HU's • Copy of the HMIS 107 form • Annual analytical reports of DHD's received by UCMB • Copy of the HSSP II indicators
3.15. The management of ICT is sustained by the Diocesan Health Offices.	• 100% (19/19) of the DHO's have taken up the cost of management of e-mail services • 80% (15/19) of the DHO's use the email effectively	- 66% - 70%	- Average nr of DHO's responding within three days to monthly test message from UCMB	• Replies to emails received by UCMB • Annual Report of the monthly tests of email responses
3.16. The management capacity of the HUMC's of RC LLU's has been enhanced.	• In 70% (160/230) of the RC LLU's at least two members of the HUMC have been trained.	- 85 = 37%	- Nr of HUMC members trained per year - Nr of HUMC's represented per training course	• Annual HUMC training reports per diocese received by UCMB • Annual analytical reports of DHD's received by UCMB
• **STRATEGIC GOAL 4. THE RC HEALTH SERVICE NETWORK HAS IMPROVED THE DEVELOPMENT OF ITS HUMAN RESOURCES AND ITS CONTRIBUTIONS TOWARDS PROFESSIONAL TRAINING.**				
4.1. The sustainability and effectiveness of the Scholarship Fund and other scholarship investments have been assured (see also 6.7.).	• The study on the effect of the scholarship fund on retention of staff has been undertaken in 2007		- The study report has been published in 2007	• Copy of the study report

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 4. THE RC HEALTH SERVICE NETWORK HAS IMPROVED THE DEVELOPMENT OF ITS HUMAN RESOURCES AND ITS CONTRIBUTIONS TOWARDS PROFESSIONAL TRAINING (CONTINUED)**				
4.2. The capacity of RC hospital managers and diocesan coordinators to plan for human resource development has been enhanced	• Guidelines for the elaboration of HR development plans available		- The guidelines have been published - The guidelines have been disseminated to RC hospital and DHO's	• Copy of the guidelines • List of institutions to which the guidelines have been distributed
4.3. The RC Health Training Institutions (HTI's) are effectively co-ordinated and assisted by UCMB	• The HTI&T Coordinator attends 90% of the occurred meetings concerning HTI		- Number of occurred meetings attended	• Minutes of the meetings attended • Invitations to meetings • Notes to the files of UCMB
4.4. Inter-denominational collaboration with other HTIs has been pursued	• At least one annual consultation, with all PNFP Health Training Institutions, has been held together with UPMB and UMMB		- Nr of the annual joint consultations held in the year - The number of other HTI attending the joint annual consultation	• Copy of the report of the joint consultation(s) held in the year • List of participating institutions of that year's consultation
4.5. Fiduciary assurance has been enhanced in RC HTI's.(the key elements of transparent financial accountability are in place in RC HTI)	• Each of the 12 schools produces an integrated report in line with MOH/MOES guidelines / formats		- Nr of RC HTI publishing an integrated report according to the MOH / MOES guideline / format each year	• Annual integrated reports of HTI's received by UCMB • Copy of the MOH / MOES guidelines / formats
4.6. The organisational unity between each RC hospital and HTI has been maintained	• 50% of the HTIs produce evidence of the accountability presented to the Board		- Nr of accountability reports presented to RC Hospital Boards by HTI / Hospital management each year	• Copy of the accountability report s to RC Hospital Boards by HTI / Hospital management received by UCMB
4.7. The use of ICT technology has been established in RC HTI's	• Each school has a staff trained in the use of ICT equipment • 80% (10/12) of the HTI use the email effectively		- Nr of HTI having a staff trained in use of ICT equipment - Nr of staff members per RC HTI having attended an ICT training course - Average nr of HTI responding within 3 days to monthly test message from UCMB	• Reports of ICT training course organised by UCMB • Lists of participants in ICT training course • Annual Report of the monthly tests of email responses

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 4. THE RC HEALTH SERVICE NETWORK HAS IMPROVED THE DEVELOPMENT OF ITS HUMAN RESOURCES AND ITS CONTRIBUTIONS TOWARDS PROFESSIONAL TRAINING (CONTINUED) .**				
4.8. The RC HTIs have improved the quality of training and management	• 80% of RC HTIs have trained one of the Tutors in management • An accreditation approach for HTI has been developed and published • At the first round of accreditation in 2008/09 at least 70% of the RC HTI are accredited	- 5	- Nr of tutors trained in management per RC HTI - The accreditation approach published - Nr of RC HTI accredited each year	• Reports of the management training courses organised for tutors • Or: list of tutors enabled to attend a management course • List of RC HTI accredited by the HC each year
4.9. The RC HTI's are training Enrolled Comprehensive Nurses in correspondence to the national strategic plan for HR development.	• The number of ECN's graduating annually from RC HTI corresponds to the national planning ((or if not known yet by July 2008: the total nr of graduates reaches 480 by the end of 2009)	- 28 (2005)	- Nr of ECN students graduating annually from RC HTI's	• Annual national ECN examination results published by MOES – UNMEB • Annual reports of RC HTI
4.10. The RC HTI's have broadened the range of training programmes for health workers	• Two new curricula are being implemented by RC HTI.		- Nr of new curricula being provide in RC HTI	• Copies of the new curricula approved by RC HTI and HC • Annual reports of RC HTI having accepted to implement the approved curricula
4.11. The RC HTI's have improved their sustainability while remaining accessible for candidates from the rural areas	• All RC HTI's receive recurrent cost subsidy from one, or more, partners (excluding MOH PHC-CG)	- 3 / 11 = 27% from Danida	- Nr of RC HTI reporting recurrent cost subsidies in their annual integrated reports - Nr of partners reported providing these subsidies	• Annual integrated reports of RC HTI • Annual report of UCMB HTI&T desk • Annual reports of HTI development partners

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 5. THE RC HEALTH SERVICES HAVE IMPROVED THEIR ADVOCACY FOR THE TARGET POPULATIONS AND INSTITUTIONS**				
5.1. A focused advocacy agenda has been developed and implemented.	• One agenda / list of subjects is documented and shared with hospital and diocesan coordinators.		- An agenda for advocacy is published each year by UCMB - The agenda has been disseminated to all RC Hospitals and DHC's	• Copy of the year's advocacy agenda • The advocacy agenda distribution list per year
5.2. Strategic partnerships and alliances have been enhanced.	• If developments in external environment call for it: Joint advocacy action(s) is pursued, together with the other Bureaus		- Nr of advocacy actions undertaken in the year together with UPMB and UMMB	• Copy of the position papers published by the three Bureaux • Signatures to the position papers published • Minutes of the meetings where the joint position was presented • Annual report of UCMB
5.3. The UCMB team has maintained a conciliatory advocacy approach, also under pressure.	• Before mid 2008 at least two UCMB staff / advisors have attended advocacy and negotiations coaching sessions, or a training course on advocacy and negotiations		- Nr of UCMB staff / advisors having attended advocacy and negotiations coaching sessions / training course per year	• Reports of advocacy and negotiation coaching sessions • Reports of advocacy and negotiation training courses • Annual report of UCMB
5.4. Advocacy and negotiation (and leadership skills) of RC HU managers have been improved.	• At least one manager of each hospital / HC 4 has attended the advocacy and negotiation skills course • All diocesan health co-ordinators have attended the advocacy and negotiation skills course.		- Nr of managers of RC hospital / HC 4 having attended the advocacy – negotiation – leadership skills course per unit / per year - Nr of DHC's having attended the advocacy – negotiation – leadership skills course per year	• Applications to attend the advocacy – negotiation – leadership skills received each year • Reports of each advocacy – negotiation – leadership skills course held

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 5. THE RC HEALTH SERVICES HAVE IMPROVED THEIR ADVOCACY FOR THE TARGET POPULATIONS AND INSTITUTIONS (CONTINUED).**				
5.5. The RC Mission Statement and Health Policy priorities are owned by the UEC.	• The Health Commission expressed agreement with RC Mission and Policy with priorities for the period 2007-2011		- The Health Commission published a circular addressed to all Diocesan Health Boards and RC Hospital Boards stating its approval with the RC Mission and Policy priorities	• Copy of the circular sent out by the UEC • Minutes of the UEC plenary during which the RC Mission and Policy priorities for 2007-2011 were discussed
5.6. The awareness of the RC Mission Statement and Health Policy priorities has increased among catholic actors at local level.	• 70% of the DHCs show evidence of an activity to raise awareness for the RC Mission and Policy Priorities in their diocese		- Nr of DHC's / DHB's reporting having carried out an activity to raise awareness for the RC Mission and Policy priorities in the diocese per year	• Annual analytical reports of the DHD's received by UCMB
5.7. A study has been undertaken to determine which poor population groups are presently not accessing the RC health services and which feasible strategies exist to increase their access.	• The report of the study is available in all hospitals and Diocesan Health Offices		- The study report has been published in 2008/09.	• Copy of the report of the study.
• **STRATEGIC GOAL 6. OVERARCHING AND CROSSCUTTING OBJECTIVES**				
6.1. A suitable format for enhanced UCMB Coordination and Support for the RC health institutions in conflict-ridden dioceses, of Gulu, Lira, Moroto, and Kotido, is operational.	• The four Diocesan Health Offices in the conflict-ridden diocese are functioning well according to the UCMB assessment tool.		- Nr of DHO's of these four dioceses scoring good / to very good according to the UCMB assessment tool per year	• Copy of the assessment tool approved by the HC • The results of the annual assessment of the performance of the DHO's / DHD's using the assessment tool • The annual reports of the DHD's

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 6. OVERARCHING AND CROSSCUTTING OBJECTIVES (CONTINUED)**				
6.2. Congregations in Health have been assisted in re-defining/re-focusing their own mission in the healing ministry	• Formulated Memoranda of Understanding between Diocese and congregation point at a clear understanding of the Managing Agency role		- Nr of Memoranda of Understanding between diocese and congregation defining the role of the congregation in line with the actual posts taken up	• Copies of the MOU's received by UCMB
6.3. Options for own legal status for large RC health institutions are identified.	• UCS interdepartmental legal committee or equivalent is operational		- Terms of reference for the UCS interdepartmental committee, or equivalent, have been approved by the UEC - The committee meets regularly	• Copy of the Terms of Reference approved • Minutes of the meeting of the Committee
6.4. Strong bonds of collaboration with UMU department of health sciences have been established.	• Annual publication of one jointly agreed/identified study/research agenda by UMU department of health sciences and UCMB		- The joint research / study agenda published by UMU DHS and UCMB for the year	• Copy of the research / study agenda published for the year
6.5. Innovations in health care delivery by - and management of - RC hospital and LLU's have been pursued	• Annually one article on innovations in health care delivery and / or management has been published in the Bulletin		- Nr of articles on innovation is health care / management published in the Bulletin each year	• Copies of the Bulletin editions in the year

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 5. THE RC HEALTH SERVICES HAVE IMPROVED THEIR ADVOCACY FOR THE TARGET POPULATIONS AND INSTITUTIONS : CORE FUNCTION UCMB**				
6.6. Core functions of UCMB are carried out	• All core functions are reflected by the annual work plans		The mention of the following functions in the annual work plan of UMCB: - Employment established personnel - Running of office - Ordinary supervision / advisory visits to dioceses and hospitals (see also 3.4.) - Organisation of Technical and policy Workshops for HM's plus HC4, DHC's, HTI's (see also 2.13 and 4.3.) - Publication of the news letter (Bulletin), twice a year - Data collection, analysis and provision of feed back; - Dissemination of national policies and guidelines - Information exchange between the RCC health services and external partners - Ad hoc support to peripheral level - Safety of physical assets is guaranteed - Provisions for unforeseen events	• The annual work plan of UCMB • The annual report of UCMB

STRATEGIC GOALS / SPECIFIC OBJECTIVE OPERATIONAL PLAN	PRIMARY TARGET	BASELINE	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION
• **STRATEGIC GOAL 5. THE RC HEALTH SERVICES HAVE IMPROVED THEIR ADVOCACY FOR THE TARGET POPULATIONS AND INSTITUTIONS : CORE FUNCTION UCMB (CONTINUED)**				
6.7. Governance of UCMB is secured (See Section 20)	• Membership of the Health Commission has been renewed at its expiry • Membership in the JMS statutory organs have been renewed as necessary • The report of the Mid-term Review of the Operational plan is available by the end of the second year (2008) of the plan • The Operational Plan 2010-12 is approved before the end of 2009		- The formal appointment of new Health Commission members - The statutory organs of JMS to which UCMB is formally appointed as member - The publication of the mid-term review report in 2008 - Publication of the Operational Plan 2010-2012	• The list of members of the Health Commission • Copies of the appointment letters of the members of the Health Commission • The minutes of the Health Commission • Letters of appointment to its statutory organs received from JMS • Minutes of the meeting of JMS statutory organs • The published mid-term report • The published Operational Plan 2010-2012

ANNEX II: Budget for the Operational Plan 2007 – 2009

Currency: Euros

Cost Centre	Exp. Budget item group	2007	2008	2009	Grand Total
A Core functions	A Employment cost	81,095	83,299	85,749	250,143
	D Health Commission functions	16,500	16,500	16,500	49,500
	E Supervision	10,000	10,000	10,000	30,000
	F Support to peripheral level	5,000	5,000	5,000	15,000
	G Bulletin	5,400	5,400	5,400	16,200
A Core functions Total		**117,995**	**120,199**	**122,649**	**360,843**
B Organisation Governance and Development	A Employment cost	20,421	24,706	25,389	70,516
	B Technical assistance	44,300	33,550	9,550	87,400
	C Expertise	8,000	14,750	14,000	36,750
	E Supervision	7,000	7,000	7,000	21,000
	H Field activities	6,200	6,200	6,200	18,600
	I Policy and technical workshops	22,000	22,000	22,000	66,000
	J Thematic workshops, seminars and meetings	25,700	21,700	12,200	59,600
	K Regional training initiatives	6,000	6,000	12,000	24,000
	L PCS Secretariat and standing committee's operations	4,500	4,500	4,500	13,500
	M Fora	14,000	14,000	14,000	42,000
	N Support to diocesan initiatives	48,600	50,700	48,600	147,900
B Organisation Governance and Development Total		**206,721**	**205,106**	**175,439**	**587,266**
C ICT	A Employment cost	15,754	16,182	16,630	48,565
	B Technical assistance	36,000	24,000	24,000	84,000
	C Expertise	10,200	6,600	6,600	23,400
	O ICT System recurrent cost	15,000	15,000	15,000	45,000
	P Assets	27,600	0	0	27,600
C ICT Total		**104,554**	**61,782**	**62,230**	**228,565**
D Capacity Building - Training	Q Modules development	21,000	9,750	0	30,750
	R Thematic training	83,000	127,000	93,000	303,000
D Capacity Building - Training Total		**104,000**	**136,750**	**93,000**	**333,750**
E Capacity building - Scholarships	A Employment cost	10,113	10,387	10,675	31,175
	S Scholarship fund	170,000	170,000	130,000	470,000
E Capacity building - Scholarships Total		**180,113**	**180,387**	**140,675**	**501,175**

Cost Centre	Exp. Budget item group	2007	2008	2009	Grand Total
F Capacity Building - HTI&T	A Employment cost	11,344	11,652	11,974	34,970
	B Technical assistance	29,400	19,400	16,100	64,900
	E Supervision	10,500	10,500	10,500	31,500
	Q Modules development	7,500	7,500	7,500	22,500
	R Thematic training	18,000	18,000	18,000	54,000
	T HTI&T Secretariat and standing committees' operations	20,000	20,000	20,000	60,000
	U Support to innovative training	0	26,000	26,000	52,000
F Capacity Building - HTI&T Total		**96,744**	**113,052**	**110,074**	**319,870**
G Research, studies and expertise	C Expertise	42,000	50,250	9,000	101,250
	V Research and studies	23,000	17,000	14,000	54,000
	W Operational Research	4,000	4,000	4,000	12,000
G Research, studies and expertise Total		**69,000**	**71,250**	**27,000**	**167,250**
H Special Programs	X Special Programs	40,000	40,000	0	80,000
H Special Programs Total		**40,000**	**40,000**	**0**	**80,000**
X M&E - Accountability	Y Accountability	3,000	3,000	53,000	59,000
X M&E - Accountability Total		**3,000**	**3,000**	**53,000**	**59,000**
Y Overheads	Z Cost of assets - share	30,000	30,000	30,000	90,000
	ZZ Running of office - share	89,100	89,100	88,800	267,000
Y Overheads Total		**119,100**	**119,100**	**118,800**	**357,000**
Z Contingency	Contingency	31,000	32,000	30,000	93,000
Z Contingency Total		**31,000**	**32,000**	**30,000**	**93,000**
Grand Total		**1,072,227**	**1,082,626**	**932,866**	**3,087,719**

ANNEX III: Budget Framework in Relation to Plan's Objectives 2007 – 2009

Cost Centre	Exp. Budget item group	Objective reference
A Core functions	A Employment cost	6.6.
	D Health Commission functions	6.7.
	E Supervision	6.6.
	F Support to peripheral level	6.6.
	G Bulletin	6.6.
B Organisation Governance and Development	A Employment cost	2.14.
		2.2.
		3.4.
	B Technical assistance	2.2.
		3.4.
	C Expertise	2.2.
		5.1.
		6.3.
	E Supervision	3.4.
	H Field activities	3.4.
		3.8.
		3.9.
	I Policy and technical workshops	2.13.
	J Thematic workshops, seminars and meetings	1.9.
		2.1.
		2.2.
		2.3.
		2.7.
		3.4.
		3.6.
	K Regional training initiatives	3.4.
	L PCS Secretariat and standing committee's operations	2.14.
	M Fora	5.5.
		6.2.
	N Support to diocesan initiatives	1.4.
		1.5.
		2.8.
		3.12.
C ICT	A Employment cost	2.20.
	B Technical assistance	2.20.
	C Expertise	2.20.
	O ICT System recurrent cost	2.20.
	P Assets	3.10.
		4.7.

Cost Centre	Exp. Budget item group	Objective reference
D Capacity Building - Training	Q Modules development	2.15.
		2.16.
		3.1.
		3.16.
	R Thematic training	2.14.
		2.15.
		2.16.
		2.17.
		2.19.
		3.1.
		3.10.
		3.16.
		3.2.
		3.7.
		3.8.
		3.9.
		4.7.
		5.3.
E Capacity building - Scholarships	A Employment cost	4.1.
	S Scholarship fund	4.1.
F Capacity Building - HTI&T	A Employment cost	4.3.
	B Technical assistance	4.3.
	E Supervision	4.5.
	Q Modules development	4.10.
	R Thematic training	4.10.
		4.3.
		4.4.
	T HTI&T Secretariat and standing committees' operations	4.3.
		4.4.
	U Support to innovative training	4.10.
G Research, studies and expertise	C Expertise	1.9.
		2.18.
		2.5.
		4.1.
		4.11.
		4.2.
	V Research and studies	1.9.
		2.13.
		2.18.
		2.19.
		2.5.
		4.11.
	W Operational Research	6.5.
H Special Programs	X Special Programs	6.1.
X M&E - Accountability	Y Accountability	6.7.
Y Overheads	Z Cost of assets - share	6.6.
	ZZ Running of office - share	4.1.
		4.3.
		6.1.
		6.6.
Z Contingency	Contingency	6.6.

ANNEX IV: Overview of The Key Indicators for Monitoring, Evaluation, and Accounting during the Operational Plan 2007 – 2009.

Indicators for Monitoring and Evaluation: Strategic Plan 2007 – 2011

Person responsible for data	Nr.	SG Nr shared	Op Nr Shared	Goal / Objective nr.	Level of indicator	Indicator	Baseline 2006	Result 2007	Result 2008	Result 2009
						At national aggregate level:				
ICDMA	1			Purpose	OP	Number of OPD new contacts per year in RC HU's	2,173,847			
ICDMA	2			Purpose	OP	Number of deliveries in RC health facilities per year	69,127			
ICDMA	3			Purpose	OP	Nr of children having received three doses of DPT/Pentavalent vaccine per year in RC HU's	136,216			
ICDMA	4			Purpose	OP	Nr of persons started on ARV treatment in RC Health Hospitals	5,220			
ICDMA	5			Purpose	OP	Nr of women who received ARV for prophylaxis (PMTCT) in Hospitals	2,617			
ICDMA	6			Purpose	OP	Nr of new TB cases in Hospitals	NA			
ICDMA	7	22	24	Purpose	OC	Accessibility in RC Hospitals: median value of standard units of output (SUO)	182,255			
ICDMA	8	23	25	Purpose	OC	Accessibility in RC Health centres: median of standard units of output (SUO)	9,658			
ICDMA	9			Purpose	OC	Equity in RC hospitals: median value of user fees per SUO in Hospital	1,243			
ICDMA	10			Purpose	OC	Equity in RC health centres: median value of user fees per SUO in Health Centres	1,209			

Person responsible for data	Nr.	SG Nr shared	Op Nr Shared	Goal / Objective nr.	Level of indicator	Indicator	Baseline 2006	Result 2007	Result 2008	Result 2009
ES	11		1	**SG 1**	OP	Percentage of occurred meetings of national Health Policy Advisory Committee and Health Sector Working Group Sector attended		75%	75%	75%
ICDMA	12			SG 1	OP	Annual allocation of PHC Conditional Grants to RC hospitals and health centres	9,551,028,391	At least maintained at 06/07 level	At least maintained at 06/07 level	At least maintained at 06/07 level
ICDMA	13		6	SG 1	OP	Percentage of allocated PHC-CG released to RC hospitals and health centres annually	Above 75%	Above 75%	Above 75%	Above 75%
AES	14		8	SG 1	OP	Nr of dioceses in which one, or more, RC health units have signed a service delivery contract with district	0	0	9	19
AES	15			SG 1	OP	Nr. of RC hospitals participating in SHIS	0	0	5	15
				SG 2		**Sustainability**				
FMA	16		14	SG 2	OP	Nr. of RC hospital providing evidence of annual External Audit	17	22	27	27
FMA	17		20	SG 2	OP	Nr of Diocesan Health offices reporting according to the financial management guidelines	0	1	3	6
ICDMA	18			SG 2	OC	Median value of the staff productivity (SUO per staff) in hospitals	1,379	neutral	5% increase	5% increase
ICDMA	19			SG 2	OC	Median value of the staff productivity (SUO per staff) in health centres	1,672	neutral	5% increase	5% increase
ICDMA	20			SG 2	OC	Median recurrent cost per SUO in hospitals	4,852	neutral to 10% increase on previous year following inflation rate	neutral to 10% increase on previous year following inflation rate	neutral to 10% increase on previous year following inflation rate

Person responsible for data	Nr.	SG Nr shared	Op Nr Shared	Goal / Objective nr.	Level of indicator	Indicator	Baseline 2006	Result 2007	Result 2008	Result 2009
ICDMA	21			SG 2	OC	Median recurrent cost per SUO in health centres	2,644	neutral to 10% increase on previous year following inflation rate	neutral to 10% increase on previous year following inflation rate	neutral to 10% increase on previous year following inflation rate
ICDMA	22	7	24	SG 2	OC	Median value of access (total SUO) in hospitals	182,255	increase of 3%	increase of 3%	increase of 3%
ICDMA	23	8	25	SG 2	OC	Median value of access (total SUO) in health centres	9,658	increase of 3%	increase of 3%	increase of 3%
				SG 2		**Range of services**				
ICDMA	24		36	SG 2	OC	Median value of degree of completeness of UMHCP in RC Health Centres III	75%	NA	NA	85%
ES	25			SG 2	OC	Nr of hospitals having staff in place for CPE, mental health, and palliative care (all three).	4	8	12	14
				SG 2		**Quality of services**				
ES	26		28	SG 2	OC	Percentage of RC hospitals accredited annually	100% - 27 / 27	100%	100%	100%
ES	27		29	SG 2	OC	Percentage of health centres accredited annually	99% - (224 / 228)	99%	100%	100%
HRA	28		49	**SG 3**	P	Nr of RC hospitals reporting that three core managers attended a recommended management course	8	14	20	22
ODA	29			SG 3	OP	Nr of valid RC hospitals charters at the end of the period	24	24	27	27

Person responsible for data	Nr.	SG Nr shared	Op Nr Shared	Goal / Objective nr.	Level of indicator	Indicator	Baseline 2006	Result 2007	Result 2008	Result 2009
ODA	30			SG 3	OP	Nr of valid DHD constitutions at the end of the period	16	19	19	19
ES/ODA	31		46	SG 3	OC	Nr RC hospital management teams providing evidence of accountability to their Boards on access, equity, efficiency and quality	10 (=37%)	18	27	27
ES/ODA	32		55	SG 3	OC	Nr of RC diocesan health offices providing evidence of accountability to their Boards on access, equity, efficiency and quality	7 (36%)	9	12	13
ICDMA	33		47	SG 3	OP	Nr of RC hospitals using the HMIS form 107 for annual reporting	NA	12	27	27
ICDMA	34		56	SG 3	OP	Nr of RC health centres using the HMIS form 107 for annual reporting	NA	>80	>110	>140
ICDMA	35			SG 3	OP	Annual average percentage of effective use of e-mail (% of hospitals replying to monthly tests of UCMB within 3 working days)	80%	>80%	>85%	>90%
ODA	36		54	SG 3	OC	Nr of DHO's scoring good, to very good, each year, according to the assessment tool developed.	NA	6	10	13
ICDMA	37		58	SG 3	OP	Annual average percentage of effective use of e-mail (% of DHCs replying to monthly tests of UCMB within 3 working days)	70%	>70%	>75%	>80%
HRA	38			**SG 4**	OP	Nr of scholarships awarded annually	110	> 110	> 120	>120
HRA/AES	39			SG 4	OC	Attrition rate among staff having benefited from a UCMB scholarship	NA	Baseline through survey	NA	Less than baseline 2007

Person responsible for data	Nr.	SG Nr shared	Op Nr Shared	Goal / Objective nr.	Level of indicator	Indicator	Baseline 2006	Result 2007	Result 2008	Result 2009
HRA	40			SG 4	OP	Nr of RC hospitals having the HRD guidelines	NA	na	10	24
HRA	41			SG4	OP	Nr of DHO's having the HRD guidelines	NA	na	9	17
HRA/AES	42			SG 4	OC	Percentage reduction in annual staff attrition rate in RC hospitals (EN+EMW)	29%	neutral	reduced by 10%	reduced by 25%
HRA/AES	43			SG 4	OC	Percentage reduction in annual staff attrition rate in RC HC's (EN+EMW)	46%	neutral	reduced by 6%	reduced by 15%
HTIC	44		66	SG 4	OP	Nr of HTI producing an integrated annual report in line with MOES / MOH format	0	5	10	12
ES/HTIC	45		67	SG 4	OP	Nr of RC HTI providing evidence or accountability to their Board	NA	5	10	12
HTIC	46		64	SG 4	OP	Nr. of PNFP HTI consultation meetings held per year	NA	1	1	1
ICDMA	47			SG 4	OP	Annual average percentage of effective use of e-mail (% of HTIs replying to monthly tests of UCMB within 3 working days)	NA	>50%	>70%	>80%
ES/ODA	48		72	SG 4	OC	Nr of RC HTI accredited annually (after 2008)	NA	na	6	12
HTIC/ICDMA	49		73	SG 4	OP	Nr of ECN's graduating from RC HTI annually	28	80	150	480

Person responsible for data	Nr.	SG Nr shared	Op Nr Shared	Goal / Objective nr.	Level of indicator	Indicator	Baseline 2006	Result 2007	Result 2008	Result 2009
HTIC	50		74	SG 4	OC	Nr of new curricula being implemented by RC HTI	NA	NA	1	1
HTIC	51			SG 4	OP	Nr of RC HTI providing evidence of a policy assuring access to poor candidates	NA	NA	6	12
ES	52		77	**SG 5**	OP	Nr of documented advocacy actions undertaken by of UCMB per year	NA	1	1	1
ODA	53		78	SG 5	OP	Nr of hospitals having undertaken a documented advocacy action each year	NA	1	1	1
ODA	54		79	SG 5	OP	Nr dioceses having undertaken a documented advocacy each year	NA	1	1	1
ES	55		80	SG 5	OP	Nr of joint advocacy actions pursued with the other Medical Bureaus per year	NA	1 (if required)	1 (if required)	1 (if required)
ES	56		86 - 91	**SG 6**	P	Average score of progress of the five cross cutting / overarching objectives	NA	75%	80%	85%
ES	57		92	SG 6	P	Average degree of implementation of the core activities of UCMB	NA	80%	85%	85%
ES	58		94	SG 6	P	Annual external audit report of complete UCMB financial operations	Annual report	Annual report	Annual report	Annual report
ES	59		97	SG 6	OP	The new Operational Plan 2010-2012				Approved Nov 2009

ANNEX V: Purpose, aim and mottos used.

Summary of the RCC Health Services' Mission Statement

In Faithfulness to the Mission of Christ, we provide professional and sustainable holistic health services, through partnership, to enable the population to live their life to the full.

Aim of the Strategic Plan 2001-6

To contribute to the improvement of the health status of the Ugandan population by improving access to health care as well as the quality of services.

Goal of the Operational Plan 2004-6

To improve the functioning of the RC health services through improved support from the diocesan health offices and UCMB.

Motto of the Plan 2004-6

Investing in Faithfulness to the Mission.

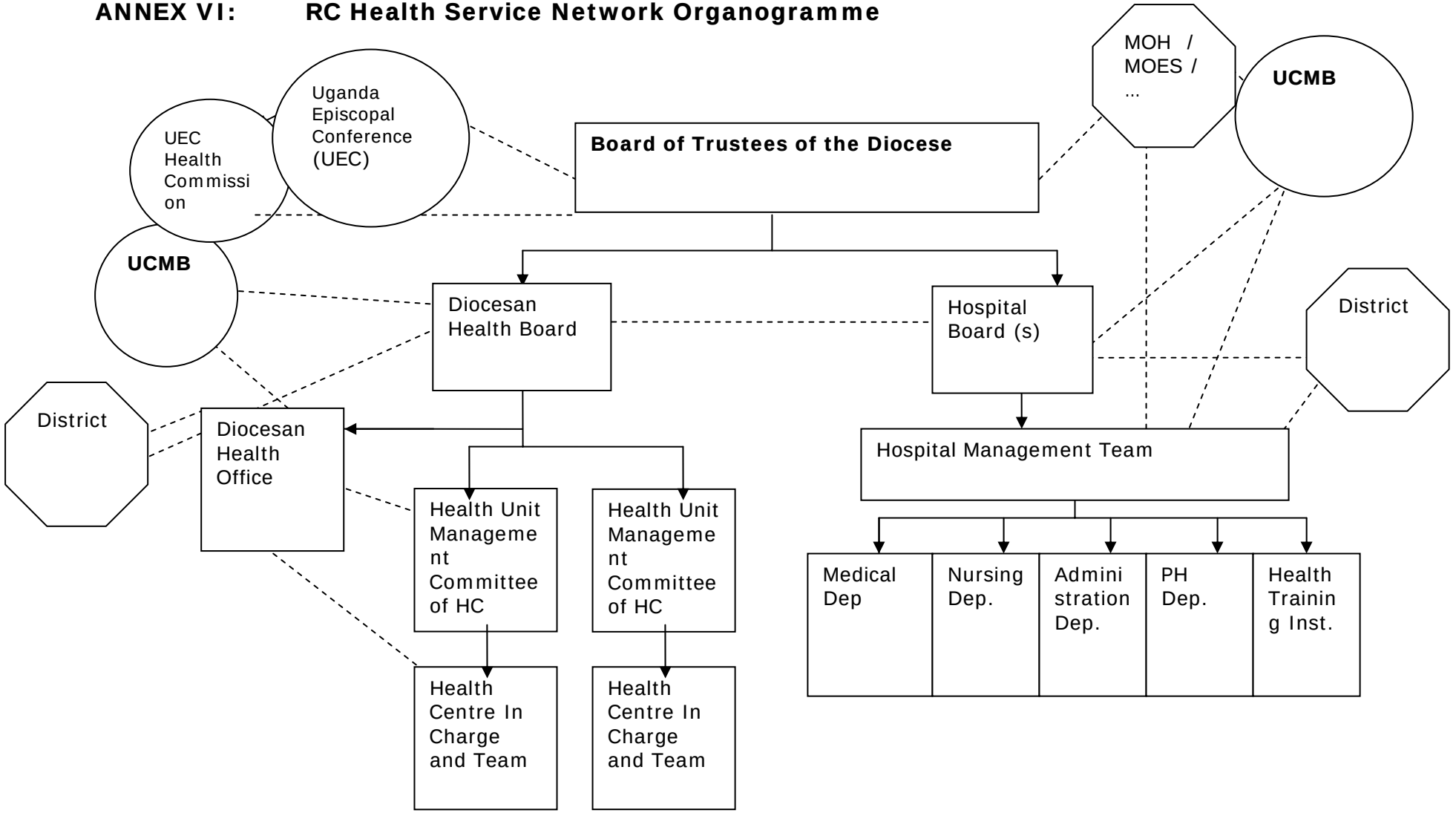
Aim of the Strategic Plan 2007-11

To enable the RC health service network to increase its contribution to the attainment of the Uganda Health Sector objectives and the Millennium Development Goals in Uganda.

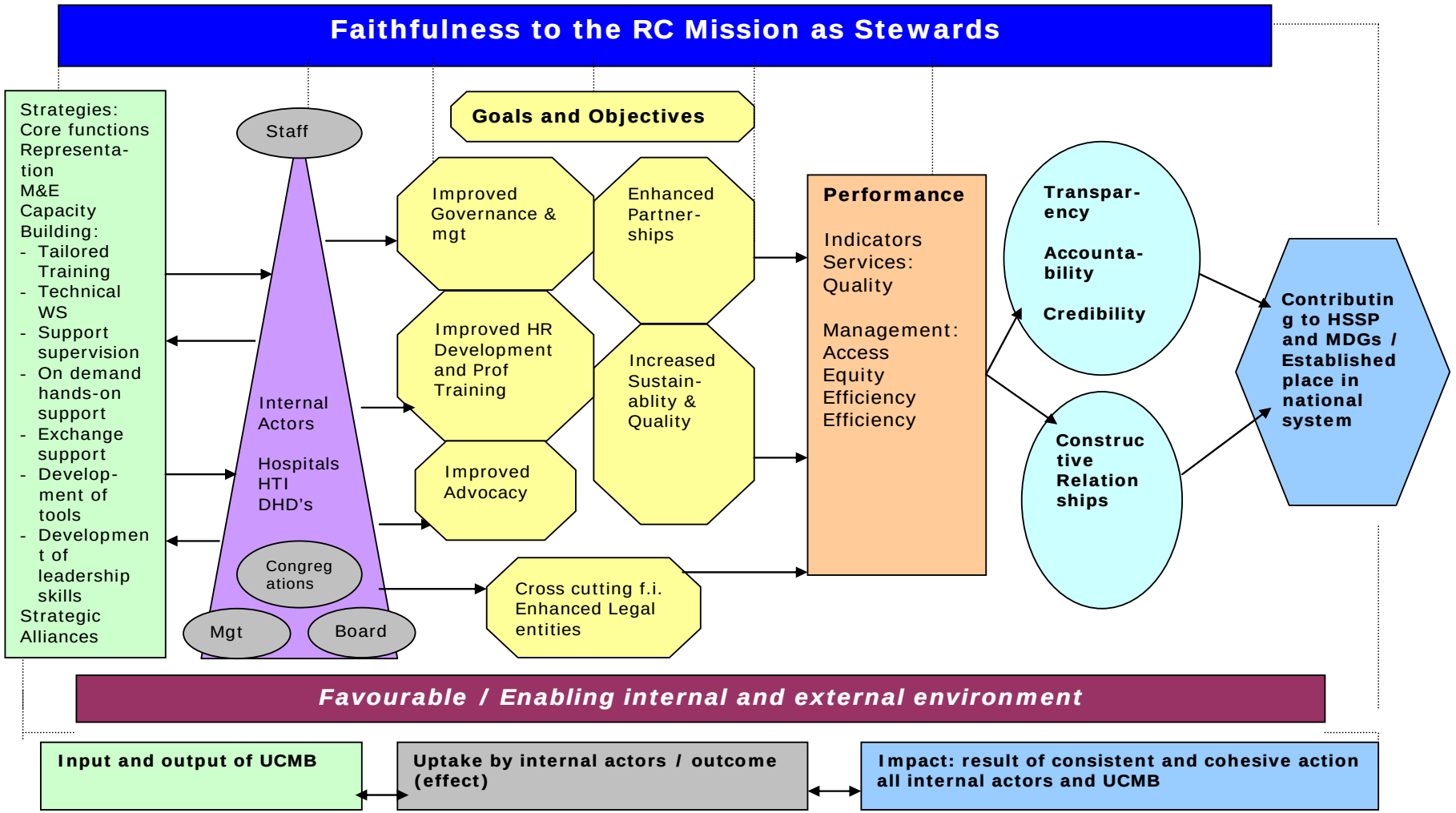
Motto of the Plan 2007-9

Enabling All for Faithfulness to the Mission

ANNEX VI: RC Health Service Network Organogramme



ANNEX VII: RC Health Service Strategic Plan 2007 – 2011 and Operational Plan 2007 – 2009 Flowchart



ANNEX VIII Resource Documents

UCMB

1. Mission and Policy of the Catholic Health Service in Uganda, text approved by the Bishops Conference in Uganda, June 1999.
2. Investing in Faithfulness to the Mission, Strategic Plan 2001 – 2005 and Operational Plan 2004 – 2006, Uganda Episcopal Conference / Uganda Medical Bureau, February 2004.
3. UCMB Operational Plan 2004 – 2006 Review, Ria van Hoewijk (IC Consult, the Netherlands) and George Paryio (Makarere University, Uganda), June 2006.
4. Annual Reports UCMB 2004, 2005, and 2006.
5. The Future of Nurse Training in support of the Mission of the Private Not for Profit Health Care Sector in Uganda, Final Report to the UEC Health Commission of the Task Force, May 2005.

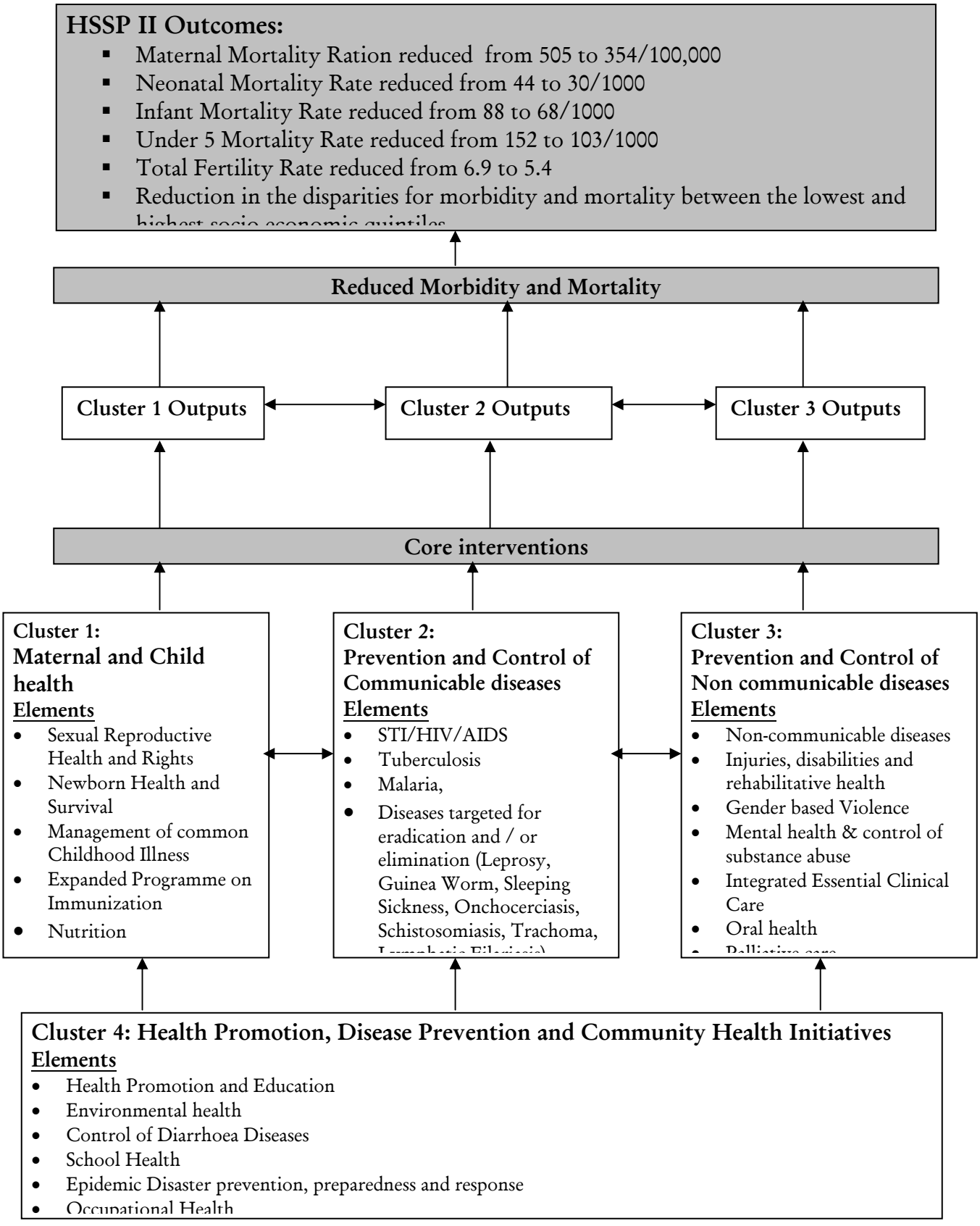
Ministry of Health and Government

6. Uganda Bureau of Statistics 2002
7. Poverty Eradication Action Plan 2001-2003 and Uganda National Household Survey 2003.
8. Poverty Status Report 2000
9. Poverty Eradication Action Plan 2001-2003 and 2004-2007
10. Uganda National Household Surveys 1999/00 and 2002/03.
11. National Health Policy 1999
12. Health Sector Strategic Plan II 2005/06 – 2009/10
13. Uganda National HIV/AIDS Sero - Behavioral survey 2004/05, MOH March 2006.
14. Draft National Human Resource Development Strategic Plan October 2006, MOH and EU-DHRH project.

Others

15. Budget ceiling and Health in Uganda, Dr. J. Odaga and Dr. P. Lochoro, WEMOS and Caritas Internationalis, January 2006

ANNEX IX: HSSP II Framework for the Delivery of the Minimum Health Care Package

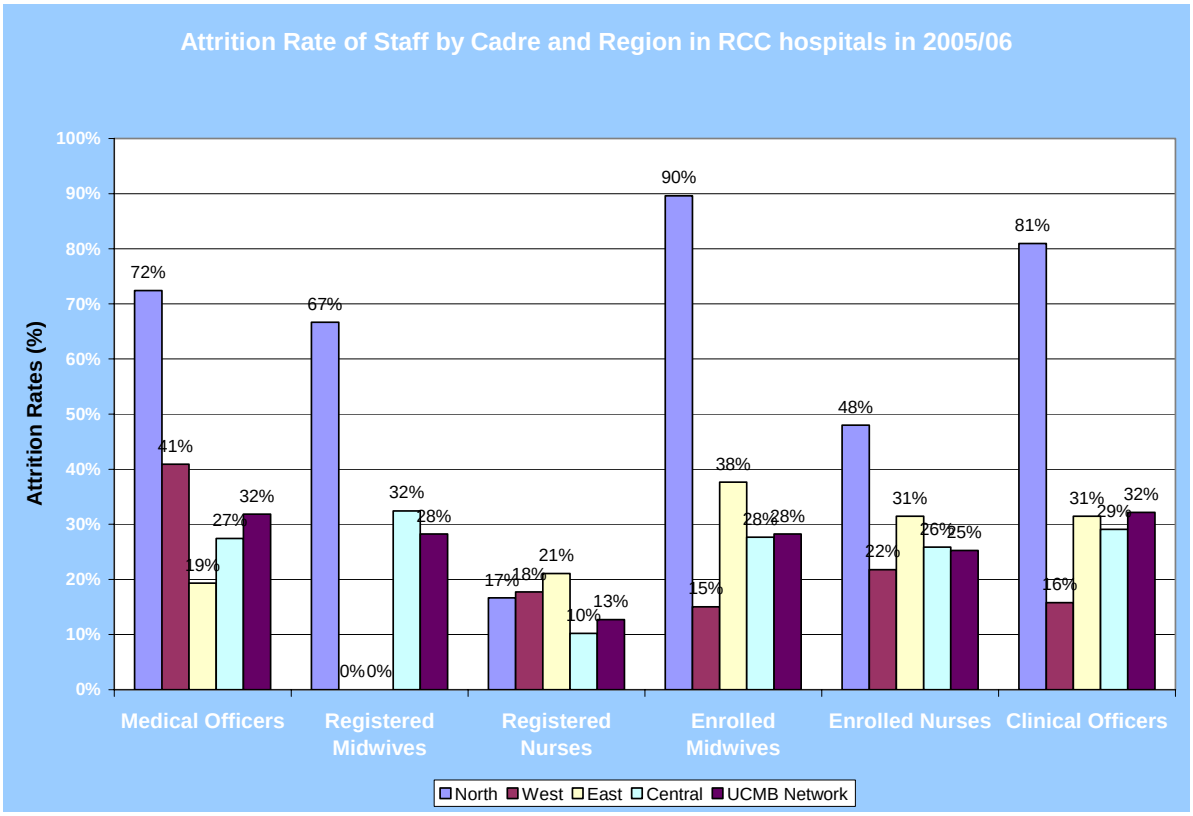


ANNEX X: Staff Attrition Rates

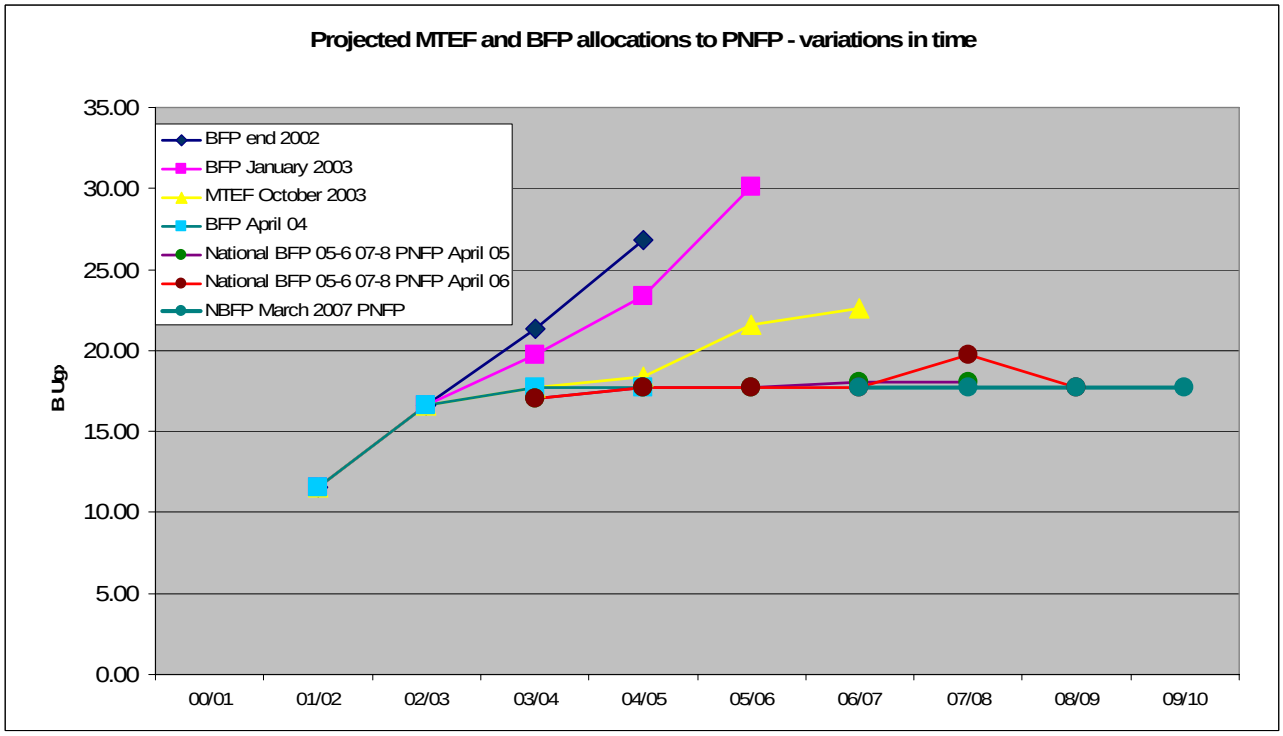
ATTRITION RATES OF SELECTED CADRES IN UCMB HOSPITALS			
	2003/04	2004/05	2005/06
Medical Officers	28%	21%	30%
Clinical Officers	22%	21%	36%
Enrolled Nurses	16%	17%	26%
Enrolled Midwives	15%	10%	34%
Registered Midwives	9%	11%	27%
Registered Nurses	5%	14%	11%
Cumulative EN+EMW			**29%**

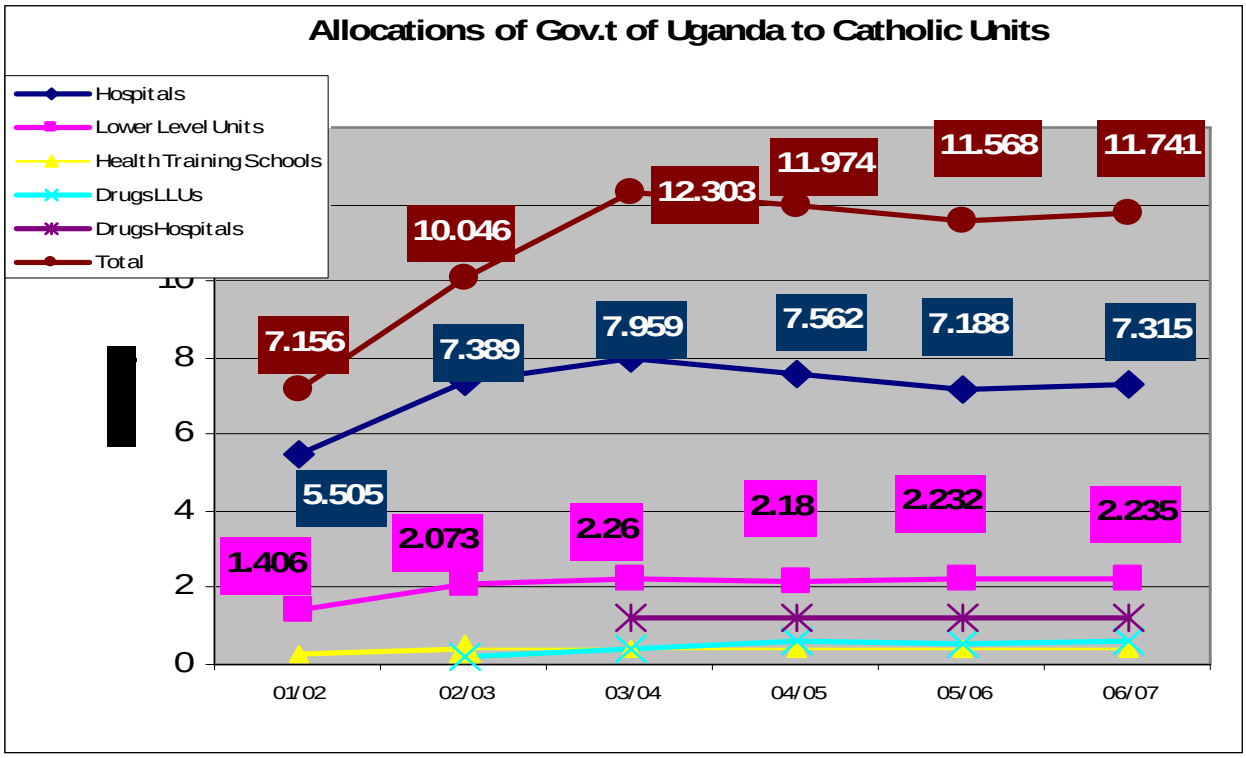
ATTRITION RATES OF SELECTED CADRES IN LLUs			
	2003/04	2004/05	2005/06
Clinical Officers			30%
Enrolled Nurses			45%
Enrolled Midwives			46%
Cumulative EN+EMW			**46%**

ANNEX XI: Staff Attrition Rates in RCC Hospitals per Region - 2005/6

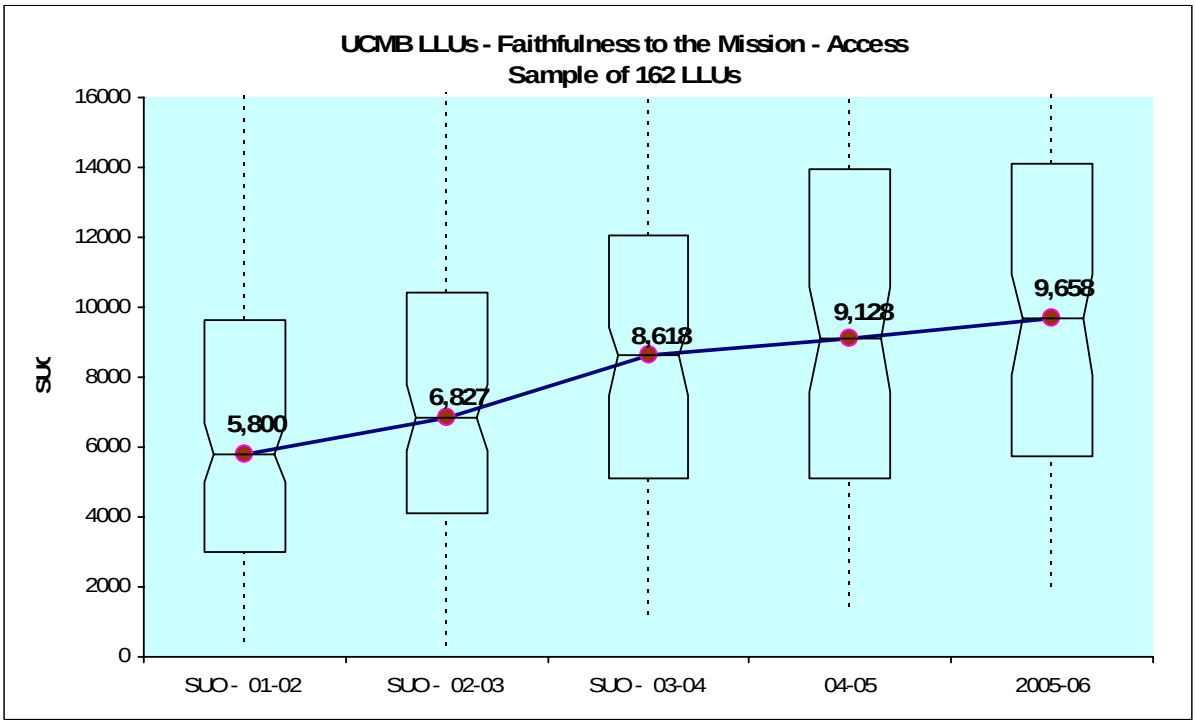


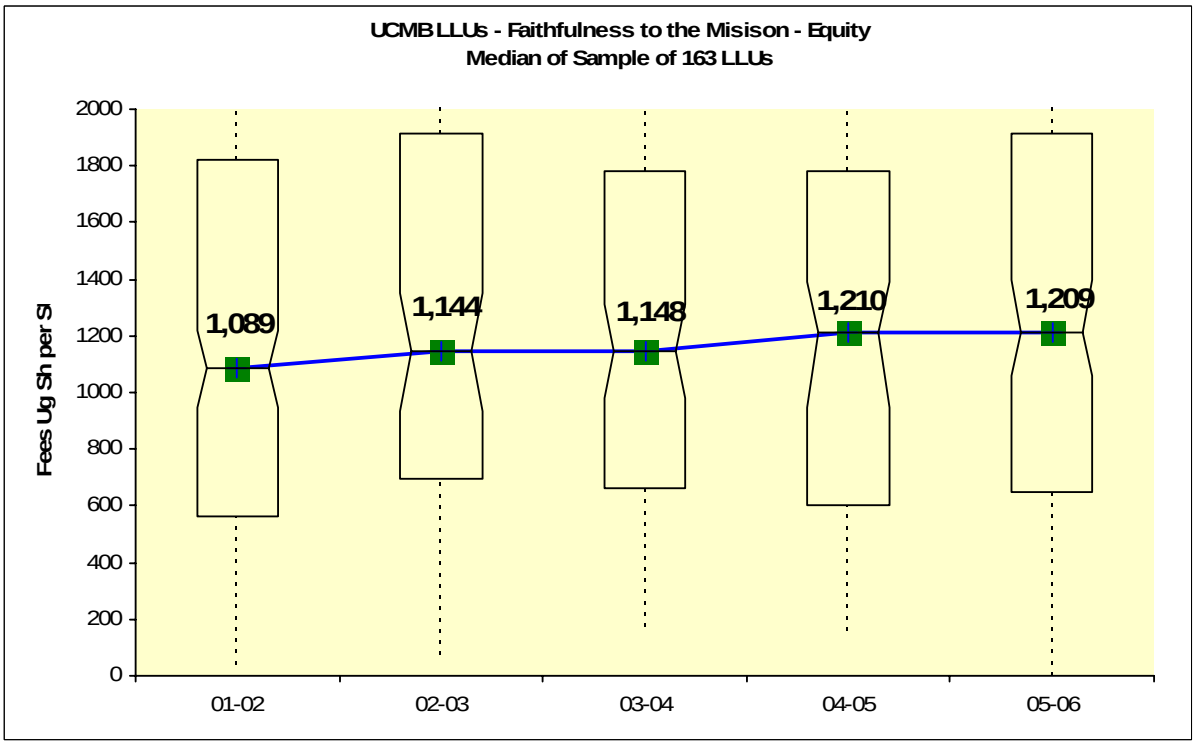
ANNEX XII: Evolution of PHC-CG to PNFP Health Sector

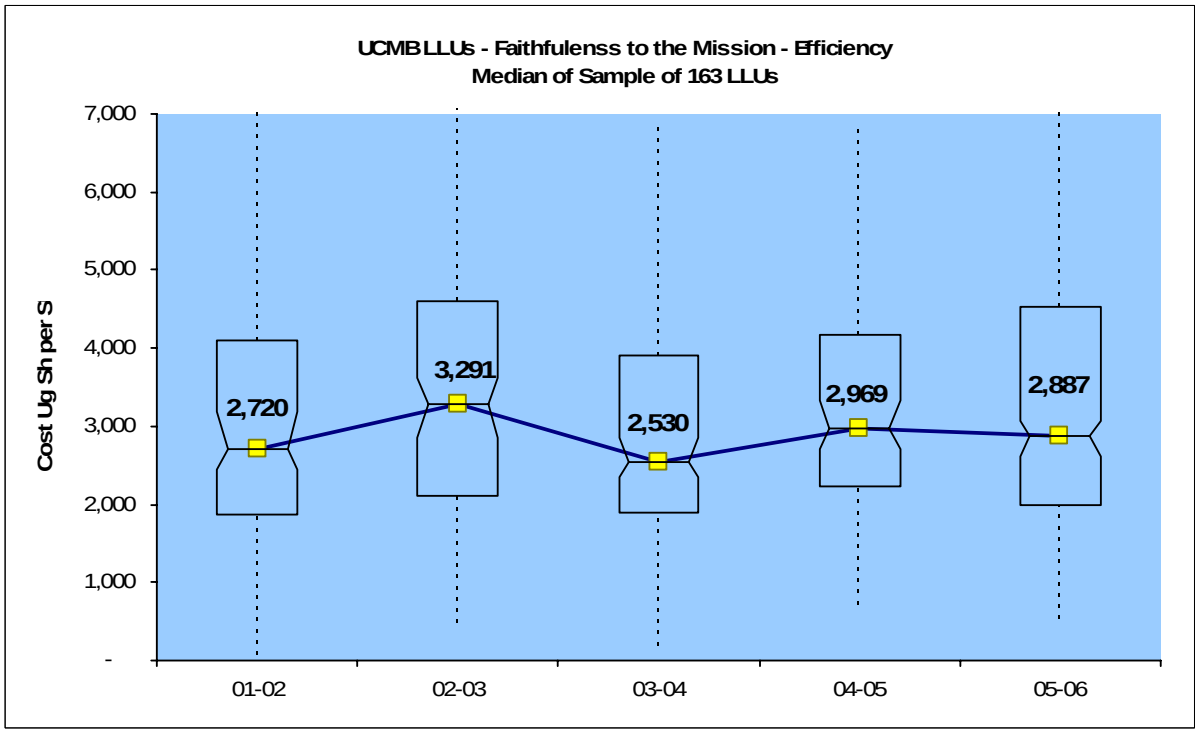

Projected MTEF and BFP allocations to PNFP - variations in time
B Ugx
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
BFP end 2002
BFP January 2003
MTEF October 2003
BFP April 04
National BFP 05-6 07-8 PNFP April 05
National BFP 05-6 07-8 PNFP April 06
NBFP March 2007 PNFP
00/01
01/02
02/03
03/04
04/05
05/06
06/07
07/08
08/09
09/10

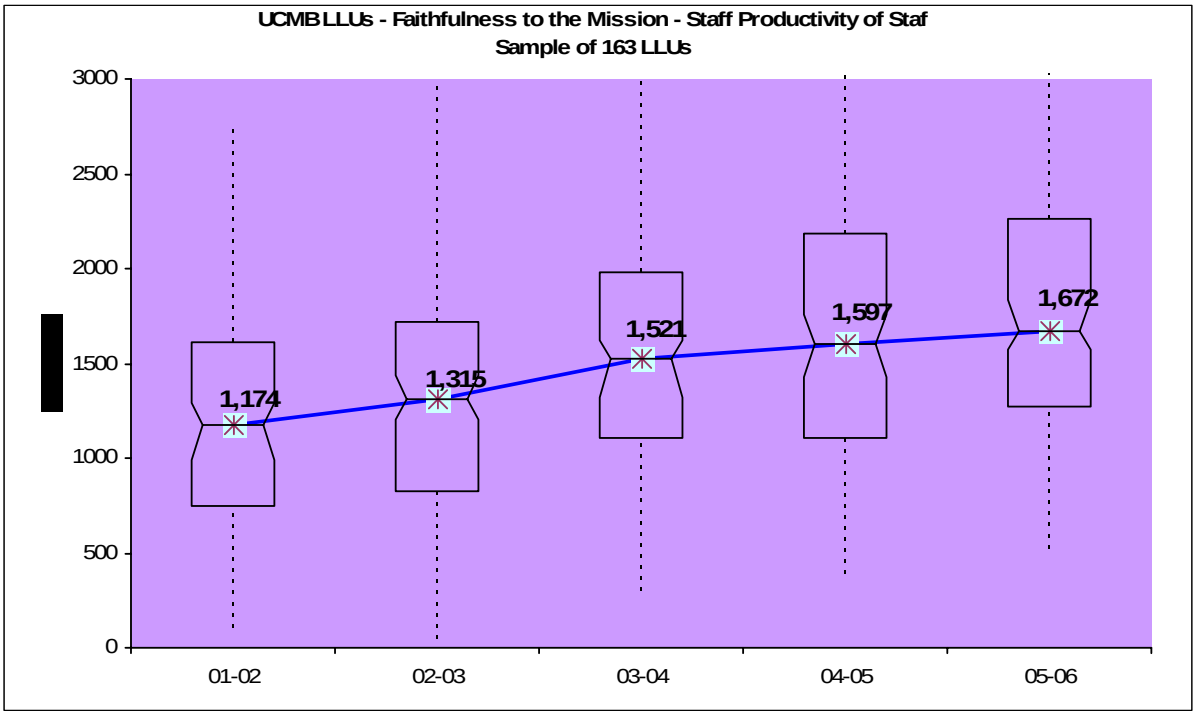

Allocations of Gov.t of Uganda to Catholic Units
Hospitals
Lower Level Units
Health Training Schools
DrugsLLUs
DrugsHospitals
Total
10.046
12.303
11.974
11.568
11.741
7.156
7.389
7.959
7.562
7.188
7.315
5.505
1.406
2.073
2.26
2.18
2.232
2.235
8
6
4
2
0
01/02
02/03
03/04
04/05
05/06
06/07

ANNEX XIII: Evolution of the Four Key Indicators in Lower Level Health Units

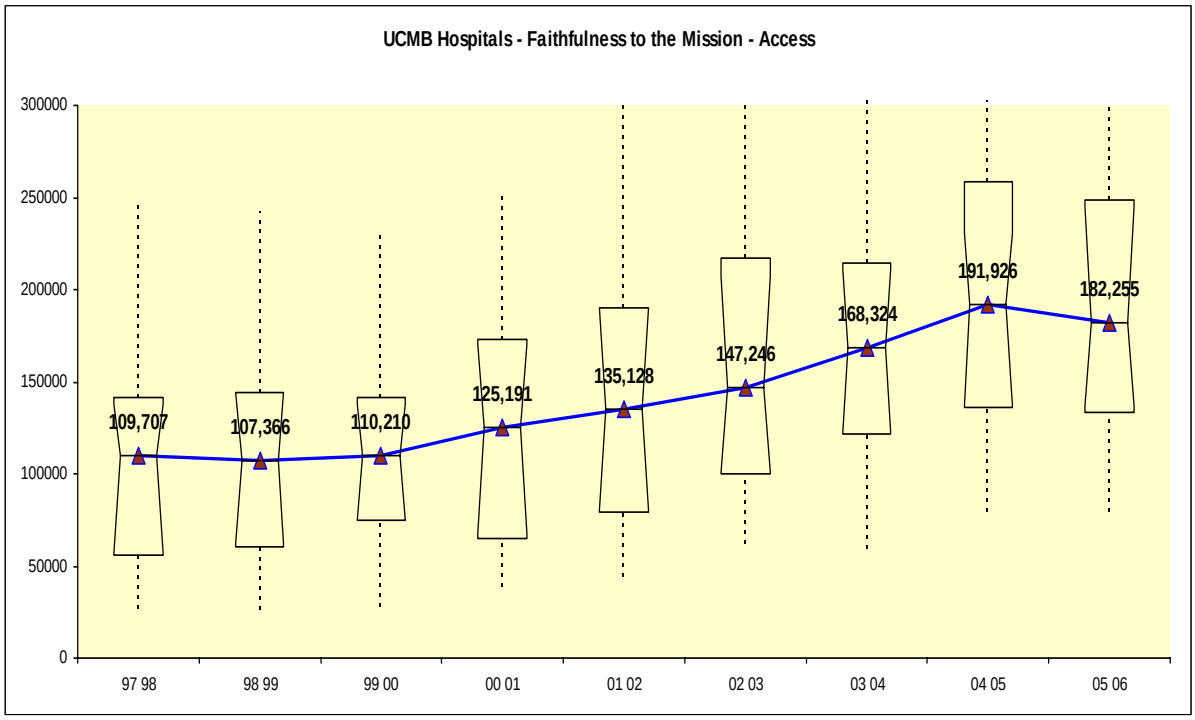


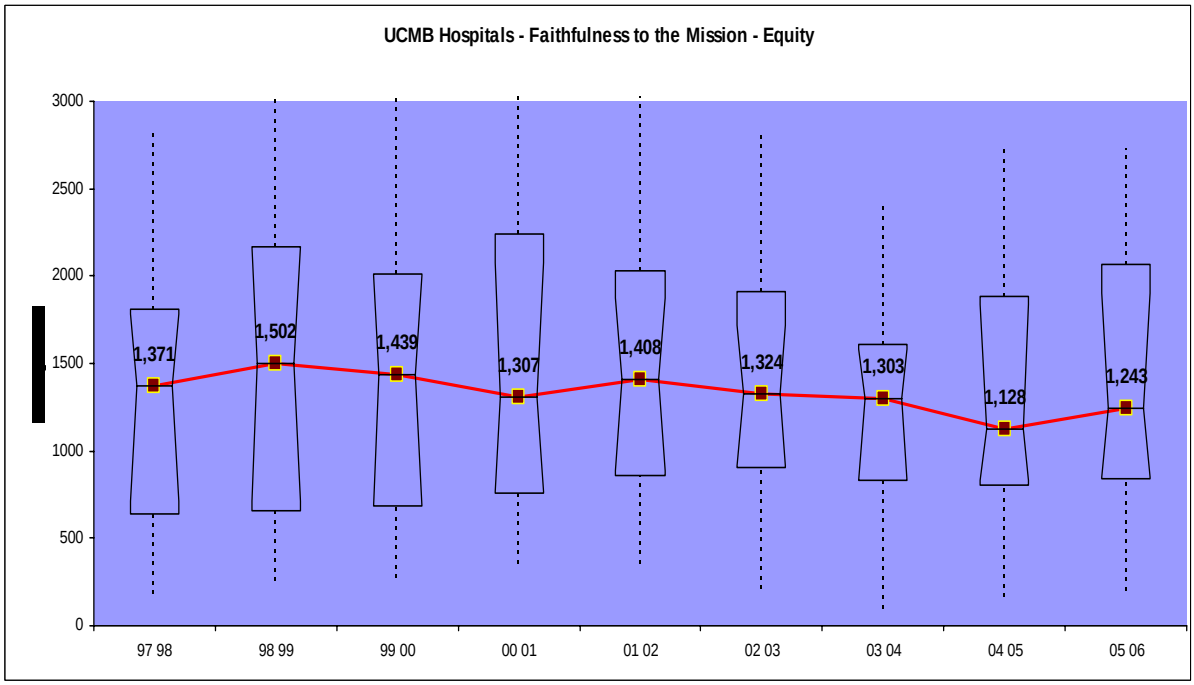


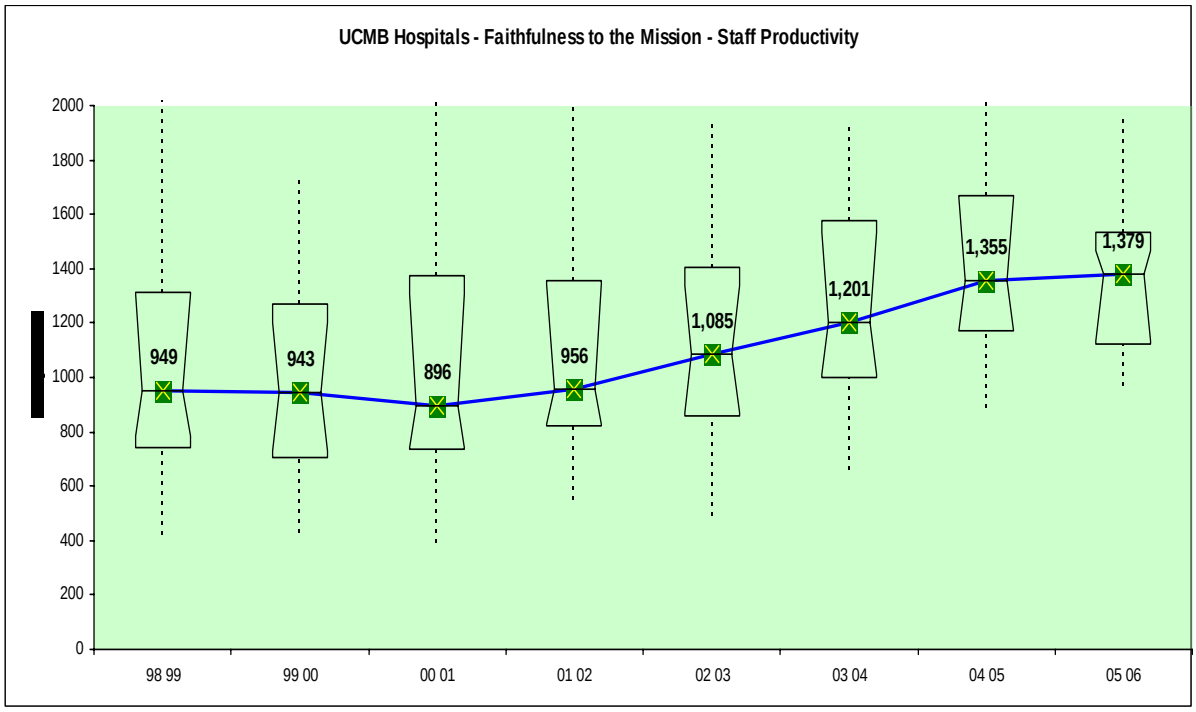

UCMB LLUs - Faithfulenss to the Mission - Efficiency
Median of Sample of 163 LLUs
Cost Ug Sh per S
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
2,720
3,291
2,530
2,969
2,887
01-02
02-03
03-04
04-05
05-06

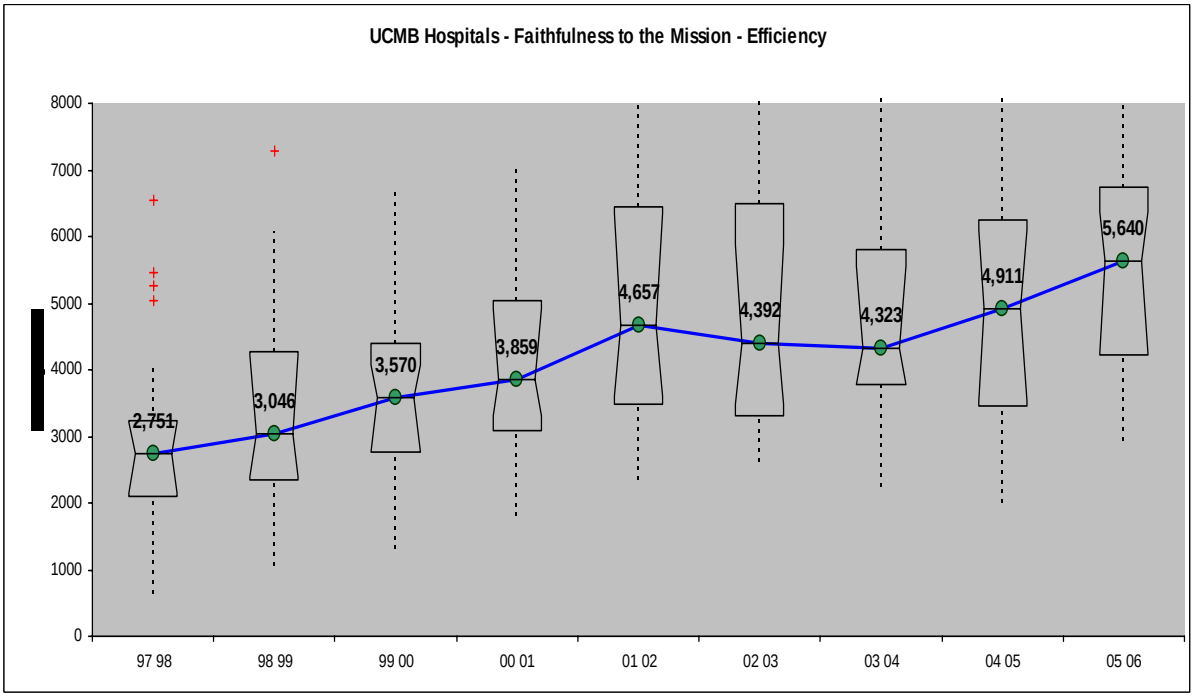

UCMB LLUs - Faithfulness to the Mission - Staff Productivity of Staf
Sample of 163 LLUs
3000
2500
2000
1500
1000
500
0
1,174
1,315
1,521
1,597
1,672
01-02
02-03
03-04
04-05
05-06

ANNEX XIV: Evolution Four Key Indicators in Hospitals






UCMB Hospitals - Faithfulness to the Mission - Staff Productivity
2000
1800
1600
1400
1200
1000
800
600
400
200
0
949
943
896
956
1,085
1,201
1,355
1,379
98 99
99 00
00 01
01 02
02 03
03 04
04 05
05 06


UCMB Hospitals - Faithfulness to the Mission - Efficiency
8000
7000
6000
5000
4000
3000
2000
1000
0
2,751
3,046
3,570
3,859
4,657
4,392
4,323
4,911
5,640
97 98
98 99
99 00
00 01
01 02
02 03
03 04
04 05
05 06