CATHOLIC HEALTH NETWORK IN UGANDA

ENABLING ALL FOR FAITHFULNESS TO THE MISSION

Abbreviated Version

THE STRATEGIC PLAN 2007 – 2011

OPERATIONAL PLAN 2007 – 2009

FOR UCMB

DRAFT FOR CONSULTATION CONFERENCE

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INTRODUCTION

Towards the end of the last century the RC health service network became aware that they 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.
In this light a review of the functioning of the Uganda Catholic Medical Bureau (UCMB), the technical arm of the Uganda Episcopal Conference, was undertaken in 1996. The conclusion pointed at the high need for technical guidance, of the RC institutions, to respond to the internal and external challenges. To this effect the Health Commission decided that the services and the organizational structure of the Bureau were to be restructured. Its main roles were to be: technical advisor to the RC health institutions, coordination, and representation at national level. A further assessment of the development needs of the institutions, compared to the RCC Mission in health, was then undertaken. This resulted first in a renewal of the RC Mission in Health Statement and the addition of a Policy Statement to guide the RC network to realize the healing ministry more effectively. The Bishops Conference approved this document in 1999.

The first Strategic Plan for the period 2001 – 2005 was then developed, based on the policies set out. The Strategic Goals determined were:

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.

This plan, together with its translation in operational terms for the first three years, was agreed upon during the first consultation conference of November 2001. Both plans were then approved by the Health Commission and the RC development partners. The latter allocated the budget for the first operational plan. In 2003 the first Operational Plan was evaluated and the second operational plan developed for 2004 – 2006. A second consultation conference was held during which all stakeholders arrived at a consensus on the objectives to be achieved to attain the strategic goals. Again the Health Commission approved the plan and the Development Partners assured the necessary resources.

Now a new Strategic Plan has been elaborated for the years 2007 – 2011, together with an Operational Plan for 2007 – 2009. This document presents the Summary of these two plans. It is to be the key document for the conference that aims to complete this plan with the inputs of all RC health service stakeholders and thus build consensus for the implementation.
This proposed second Strategic Plan and its first Operational Plan have been built on an external and internal assessment of the achievements realized, and constraints met, during the implementation of first strategic plan. Both reviews also examined the external environment to determine the opportunities and challenges for the new period. Based on this information the new plans were developed in dialogue with a Focus Group, consisting of representatives of all the internal stakeholder groups. The group reviewed the information against their own experiences, presented their priorities, and provided feedback, theirs and of their constituencies, on the draft proposals. In addition, the UCMB team has contributed extensively by developing the plans for their section as well as improvements for the methods of work.
A word of sincere thanks goes to both groups.

1. PROFILE OF THE CATHOLIC HEALTH SERVICE NETWORK IN UGANDA

The RC health service network was started by the Missionaries soon after their arrival in Uganda, towards the end of the 19th century. A considerable number of the RC hospitals and health centres have celebrated their centenary. Presently the RC network is the largest group of PNFP health facilities in Uganda. In table 1 the number and level of care of the 261 institutions is presented.

Table 1:

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 and Source 2. MOH Health Facility Inventory 2004.

To give an indication of their contribution in the health services provided in the last years:

Table 2

Total for Fiscal Year	OPD	IP	ANC	Deliveries	Immuni-sations	DPT3	Total population
2002/03	2,198,771	288,443	270,565	48,208	1,229,043	261,400	24,748,977
2003/04	2,191,554	369,864	274,032	48,982	1,250,476	277,507	25,590,442
2004/05	2,147,286	434,047	298,572	61,622	1,417,204	137,403	26,460,517
2005/06	2,173,847	443,057	261,385	69,127	1,535,198	136,216	27,244,426

Source: annual reports of the RC health institutions per year.

In 2005/06 the PNFP sub-sector provided OPD visits: 17%; Deliveries 35%; DPT3: 29%. The RC units' share of the national output were respectively 9%; 18%, and 13%. In the past two years the PNFP sector they received 7.35% of the Government share of the health budget. The RC share represented 4%.

The Organizational Structure

In line with the organizational structure of the RC church the health institutions belong to the diocese. There are 19 dioceses and each has a number of health facilities varying from 2 HC's to 24, from 0 hospitals to 4). The Board of Trustees is the highest authority for all diocesan institutions as it forms the sole legal entity.
The national coordination bodies of the RC church, like the Bishops Conference, the Health Commission of the Conference, and UCMB, all have advisory roles towards the diocesan authorities and institutions. Annex III presents an organogram of the RC health services.

<u>Hospitals</u>
The hospitals are governed by a Board of Governors (BOG), appointed by the Board of Trustees. Daily management is entrusted to the management team (HMT). The

hospitals operate fairly independently and relate, in most cases directly to UCMB. Eighteen RC hospital have been appointed the public responsibility of leading a Health Sub-district HSD).

Health Training Institutions

These have all been started by the hospital to which they belong. They are nearly all governed by the BOG of the hospital and daily management is secured by the HMT. The Principal Tutor should then be a member of the HMT. The main categories of staff trained are: enrolled nurse and midwives, enrolled comprehensive nurses, registered nurse and midwives, laboratory assistants and technicians. Together with the other church owned schools the PNFP network caters for at least 60% of the nurse training capacity in the country.

Diocesan Health Departments

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

Health Centres of Lower Level Units

These centres are the primary care units. Each HC, or LLU, has a Health Unit Management Committee (HUMC) composed of representatives of the locally direct concerned stakeholders. The HUMC ensures overall management and the implementation of the diocesan policies. Daily management is entrusted to the In Charge Nurse or Clinical Officer.

Diocesan Health Board

The Health Board of the Diocese (DHB) is appointed by the Board of Trustees and has the responsibility to set the policies for - and assure adherence by - the health centres and non-institutional health programmes. The Board is composed of the representatives of the main stakeholders concerned with the diocesan health services.
As hospital are complex organizations they do not fall under the DHB. However, hospital BOG and HMT do align policies and provide technical expertise through membership of the DHB.

Diocesan Health Coordinator and Office

The diocesan health office (DHO) is to be the technical executive arm and secretary of the DHB. The main functions of the coordinator (DHC) are to coordinate and support the health centres (HUMC's, In Charges, and team) in implementing the diocesan and national policies and improving their performance. This includes enabling them to improve their cooperation with Public health authorities and other actors in the district and HSD. Since 2003 the function of diocesan HIV/AIDS focal point is being added to a number of DHO's. The main aim is to initiate and coordinate a diocesan multi-sectoral response to HIV/AIDS, and gradually other Global health initiatives (Malaria and TB).

The Health Commission and the Uganda Medical Bureau

The Health Commission, with its statutory committees, is the health policy advisory and supervision board of the Uganda Episcopal Conference. It is composed of representatives of the internal stakeholders and institutional partners of the RC Health Services. The policies are set in dialogue with all affiliated health institutions during the Annual General Assembly (AGA of AGM).
The UCMB is the technical – executive arm of the Health Commission, or health office of the Catholic Church. In line with the organizational structure of the RCC, where the diocese is the autonomous entity, the UCMB does not have a hierarchical authority over the hospitals and diocesan health offices. Its core functions are coordination, providing services and technical / managerial advice, liaising with national / international health actors, and advocacy.

Its role in providing medical / clinical technical advice has been limited to avoid duplications with the many nationally coordinated programmes (HIV/AIDS / Maternal and Child Health / IMCI / ACP / ...) When needed pertinent subjects related to these programmes are addressed in the technical workshops.

Institutional Partners

Religious Congregations

The congregations are very important partners to the RC health services. Religious personnel are present in 120 units (+/- 50% of the health units - including hospitals). About one third (81) of the units are managed by members of religious congregations and a number of units are owned by them. Members of religious Congregations form around 6.1% of the 5,958 employees of Catholic Health Units.

Joint Medical Stores

JMS is jointly owned by the Catholic and Protestant Churches. It was set up in 1979 to ensure the provision of medicines and medical supplies to their health units. JMS is currently the largest procurement agency and supplier in the country next to the National Medical Stores. It serves the PNFP units, NGO's, and increasingly the public and private for profit sector. JMS also implements governmental essential drug and supplies programmes that aim to support the PNFP health sector.

Uganda Martyr's University

Uganda Martyr's University, Faculty of Health Sciences (UMU-HS) provides a range of health service management courses that are essential to the RC health services efforts to improve management of institutions. The Faculty has an important training and a research capacity. The UCMB has been instrumental, in the past, in establishing the Health Service Management courses.

2. THE RC MISSION AND POLICY STATEMENT 2000 - 2005

The Mission of the RCC Health Services was renewed, by the Uganda Episcopal Conference (UEC), in 1999 and was summarised in the first Strategic Plan as[1]:

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:

- respect for the dignity of the human person and the sacredness of life
- person centred approach and subsidiarity
- justice, universality and equality
- professionalism.

The 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 operated, 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;

[1] 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.

- 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.

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.

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 was summarised as:

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

3. COUNTRY CONTEXT

Uganda is landlocked country in East Africa. The estimated population number is 28.2 million with an average growth rate of 3.4%. During the past decade the country has realised considerable improvements in the economy with an annual economic growth rate of +/- 6%. Inflation fell from 150% per year to an annual average of 4.5%. The percentage of the population living below the poverty line initially declined from 52% in 1992 to 35% in 2000, but it has since risen again to 38% (2003). Of the poor 96% live in the rural areas.

The northern region is by far the worst off in all aspects, due to the ongoing civil war, waged by the Lord's Resistance Army (LRA). Since July 2006 serious peace negotiations between LRA and the Government are on the way. It is hoped that this time peace may become a reality for this region.

3.1. THE UGANDA DEVELOPMENT PLAN

The government initiated the development of the Poverty Eradication Action Plans (PEAP) as comprehensive development frameworks, in 1999. The first full-fledged PEAP (also known as poverty reduction strategy) ran from 2001 to 2003. The second plan runs to 2009. The results so far, reported by UNDP, are: a rise in the life expectancy from 43 to 45,7 years; an increase in literacy rate to 67.7%; and a rise in the Human Development index from 0.449 to 0.488.

In the 2004/09 PEAP, the main goals of the PEAP were retained but the objectives refined to reaffirm commitment to the Millennium Development Goals (MDG'S), address regional disparities, and consolidate the Human Development achievements. However, the government does specify in the plan that "the relative speed at which any particular target (of the MDGs) is approached will reflect the particular constraints and trade-offs that the country faces".

The now five pillars of the Poverty Eradication Plan are: 1) economic management; 2) enhancing production, competitiveness & income; 3) security, conflict resolution and disaster management; 4) good governance; 5) human development. The last pillar covers the social sectors of health and education. The main cross cutting objectives

include mainstreaming the response to HIV/AIDS, mainstreaming attention for gender issues, and promoting cost-effectiveness through out-put oriented programming.

Among the strategies to improve governance, decentralisation policy takes the highest prominence. The aim of government is to gradually devolve budgetary powers to the districts (now 76). Already a further devolution is being considered to county and sub-county level.

Development Challenges

- *Macro economic constraints*: to curtail fiscal deficits government spending has been capped by setting ceilings for sectoral budgets. Specifically spending on social sectors has been limited. This policy figures among the main reasons why the budget for health is not growing, despite the many global initiatives targeting improved health outcomes.
- *Energy crisis*: reduction of water levels in Lake Victoria has led to a gradual decline in electricity production. This is, coupled with the huge international rise in oil prices, causing a decline of the economy. The 2006/07 national budget shows that all sectors are doubly affected: the costs of normal operations are increased and contributions for the investment in new power sources are demanded.

3.2. THE HEALTH STATUS OF THE UGANDAN POPULATION

The PEAP document recognises the concern for health the population: "*Health 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.

The overall health status of the Ugandan population has not yet benefited from the economic growth. The key indicators used in the Second Health Sector Strategic Plan (2005-2009) shows the following trends towards the PEAP and MDG targets:

Table 2

Indicator	1990	2000	Target 2005	Results 2005[2]	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%
HIV/AIDS prevalence (ANC HIV prevalence)	30%	6.2%		Overall [3]6.4% (7.5% females and 5% male)	1.7%

[2] Findings of 2005 Demographic and Health Survey (UDHS) expected soon.
[3] National Sero-prevalence and Behavioural study, 2004-05, MOH 2006.

The first Health Sector Strategic Plan brought considerable improvements in the national health services. However, communicable diseases continue to be the leading causes of morbidity and mortality. 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. Similarly, the Under 5 mortality rate for the lowest quintile is twice as high as that for the highest quintile.

3.3. The National Health Policy and Health Sector Strategic Plan

The National Health Policy dates from 1999. 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 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 output targets are (base year 2003/04):

Table 3

Nr.	**Indicator**[4]	**Target 2009**
1.	Total (GoU and PNFP) per capita OPD utilization	from 0.72 to 1.0
2.	Percentage of children <1yr receiving 3 doses of DPT/Pentavalent vaccine according to schedule by district	from 87% to 93%
3.	Percentage of deliveries taking place in a health facility (GoU and NGO)	from 24.4% to 50%
4.	Proportion of approved posts (HSSP I norms) that are filled by trained health personnel	from 68% to 90%
5	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%
6.	Couple Years of Protection	from 223,686 to 494,908
7.	Reduce the Case Fatality Ratio among malaria inpatients aged less than 5 years	from 4% to 2%
8.	Proportion of TB cases that are cured raised from	62% to 85%

[4] The indicators 1 to 3 are directly linked to the first three PEAP / MDG's targets.

The main coordination and implementation strategy remains the Sector Wide Approach. In addition a number of strategies have been developed, or are to be developed during the plan period, to address the constraints of the HSSP I. These include: increase the focus on health outcomes; reviewing the Minimum Health Care Package (MHCP) to improve effectiveness; affirmative action to improve equity especially for the vulnerable groups and the north; and operationalising of the HSD's.

The Partnership with the Private Not for Profit Sector

The Public – Private Partnerships for Health (P-PPH) are given specific attention in HHSP II. The scope has been widened to bring all the main private actors (including the traditional healers) on board. This has been one of the reasons why the policy for P-PPH was not yet presented for approval by cabinet, since 2004.
During the last two years the relationship between the government and the PNFP sector came under pressure due to the rise in salaries of government health workers coupled with considerable recruitment drives while no compensation was given to the PNFP to increase salaries.
However, the HSSP II clearly builds on effective P-PPH implementation. It particularly recognises the PNFP facilities as integral part of the health system.

Challenges of the Health Sector

- *Human Resources for Health*:

Compared to the HSSP I staffing norms, the Public and PNFP sector currently have a gap of 4000 health workers, on a total of +/- 28.000. This does not take into account the needs for HSSP II, or the national and international calls to scale up services for better outcomes. The above mentioned salary difference between PNFP and public health workers caused a huge increase in staff attrition / staff turn-over in PNFP facilities affecting quality of services. It also caused a significant increase in cost and loss of efficiency. A new Human Resource policy has just been adopted and will form the basis for a Strategic Plan for HR development in the country. It is hoped that this plan will also provide the required guidance for the number and categories of staff that should be trained for the country.

- *The Budget for Health*:

The budget for health has been reduced for the present financial year to an amount of 7.7 USD per capita (compared to the costs of the full MHCP, excluding ARV's, of 28 USD). The reduction is motivated as necessary response to the energy crisis. The mid- to long-term budget framework papers of government indicate that the budget for health will only start rising again slightly from 2008/09. Up to then the budget for the PNFP sector remains at the same level. For 2006/07 this stands at 4.7% of the total health budget of 375.38 B USHS, or 7.37% of the Government share of the budget 240.42 B USHS. The HSSP II document clearly states that if the budget is not increased significantly the PEAP and MDG targets cannot be met.

- *The Sector Wide Approach and the Global Health Initiatives:*

Implementation of this systematic approach to develop the national health system, as a whole, started in 1998/99. In 2004, just as results became evident, new international health policies and funding arrangements emerged. These Global Health Initiatives each target one or more specific diseases, or health problems, and each has its own funding sources and mechanisms. As the coordination mechanisms are separate, and the government does not always have control over the use of the funds, the SWAp is becoming less effective. In addition, as the budgets for these programmes rarely cover the health system requirements to implement them, there is a growing competition for scarce resources like Human Resources. Crowding out of basic services

may soon become a reality. This danger is aggravated by the macro-economic ceiling on the health budget.

- *Social Health Insurance Scheme*

Following the electoral manifesto of the President the government launched the plan for the Social Health Insurance Scheme in July 2006. The aim is to gradually introduce the health insurance countrywide, starting with salaried workers. The scheme is to become operational by July 2007. As all details still need to be developed it is not possible to overview the implications.

- *New International Development Assistance Approaches:*

The World Bank and Ugandan Government have agreed a new strategy to assure that development assistance is well targeted, coordinated, and used. Under this Uganda Joint Assistance Strategy (UJAS) international funds for development will be pooled at government budget level and managed by the Ministry of Finance Planning and Economic Development. The influence of the individual sectors and their Development Partners will be reduced. For the PNFP health sector this means that international advocacy for their participation may disappear and that their own advocacy efforts will need to target the government and Ministry of Finance.
At the same time the opposite move is noted as some development partners, wanting more certainty of value for money, are returning to project mode funding. The national health financial outturn of 2005/06 shows that the resource envelop for health increased from the forecast of 508 to 737 Billion USHS. Of these, over two thirds were spent through projects. This is a reversal of the expected SWAP trend.

4. REVIEW OF THE RC STRATEGIC PLAN 2001 - 2005

For the sake of brevity, this review will concentrate on the conclusions reached regarding the Second Operational Plan and the Strategic Plan as these are essential to understanding the proposals in the new Strategic and Operational Plan.

The RC Mission and Policy priorities meant that the aim of the Strategic Plan for the period 2001 – 2005 was determined as:
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.
The Strategic Goals set as to realise this purpose were:

I. A recognised place in the national health system for the RCC Health Services (this goal was reformulated in 2003 as: The RC health institutions occupy a place in the national health system that is befitting to the needs of the population and their Mission in Health);
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.

The purpose of the first Operational Plan (2001 – 2003) was: *To improve the functioning of the RC health services through improved support from the diocesan health offices and UCMB.*
For each goal the plan stipulated a number of specific objectives with their activities. Respecting the mandate of UCMB in the church organisation, the key strategies for implementation were capacity building, monitoring and feed back, representing the RC

institutions at national level and assuring information flow, and advocating for the RC health services.
The implementation of this Operational Plan was externally evaluated at the end of 2002 and internally reviewed at the end of 2003, before the second Operational Plan was formulated. The recommendations of the consultants and the findings of the internal assessment, did not lead to considerable changes in the strategic goals or the purpose of the Operational Plan for the years 2004 – 2006.
However, the theme of for this second period was "*Investing in Faithfulness to the Mission*" This was necessary as the conclusions urged for a considerable scaling up of efforts to ensure that the strategic goals could be achieved.

One recommendation of the external review team of 2002 did have a significant impact. This concerned the need to set more specific targets and develop indicators (including outcome / impact indicators) to monitor these. Thus the second operational plan counted 47 objectives, 71 targets, and 112 indicators. This meant that M&E of the plan itself started to demand considerable additional activities and time. On the other hand though, the UCMB's search for valid outcome indicators led to the development of indicators that could allow all RC actors to monitor outcomes that corresponded to the aims enshrined in RC Mission. Thus the four key Mission indicators were developed: Access, Equity, Efficiency, and Quality[5] .

4.1. PROGRESS TOWARDS THE STRATEGIC GOALS OF 2001 – 2005

The implementation of Operational Plan of 2004 – 2006, and, in fact, of the Strategic Plan 2001 – 2005, was reviewed by a team of external consultants in April / May 2006[6]. Apart from determining the results, the Terms of Reference included the request to assess the implications and propose possible responses to dilemma's that UCMB recognised as emerging. These were: *how to pursue further integration into the health system while retaining operational autonomy; how to enhance quality and sustainability while remaining faithful to the Mission; and how to combine vertical programmes with the systemic development approach*. In addition, the team was asked to critically review issues related to the approach and working methods used by UCMB and how the advocacy efforts could be made more effective.

The general conclusions of the external consultants were that the RC health services should be applauded for their achievements, which are undisputable, both according to the perception of the actors interviewed and as can be concluded from objective documentation of progress. In line with the five strategic objectives, they summarised their main conclusions regarding the key achievements, as well as the key issues that remain on the agenda, as follows:

I. The RCC Health Services occupy a place in the National Health System that is befitting to the needs of the population and their mission

This strategic objective has largely been achieved. The place of the RC health services in the National Health System is well recognised and appreciated at the national level.

[5] 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 as results of patient satisfaction and drug prescription behavior could be factored into an index of quality. Results are soon expected.
[6] 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).

In general Government, Development Partners, and to some extent local authorities (mainly districts) take, the involvement of the RCC health sub-sector, and the importance of continuing to provide government and donor subsidies to the PNFP, as an established fact. It is evident that the UCMB and the affiliated health units are integral parts of the national health system and opting out is not a feasible option. However, UCMB and the affiliated facilities can play an active role while protecting, to a large degree, autonomy under the current policy framework. An issue that remains is to strengthen the inter linkages with partners at the operational health sub-district and district levels.

II. Improved Quality and Sustainability in Faithfulness to the Mission Statement

To a large extent the review noted that the RC health services have made a conscious effort to maintain quality of care while maintaining efficiency, and keeping fees charged to patients stable. This means that the fees were actually lowered in real terms (taking inflation into account). The pro-poor focus remains evident in the documents reviewed as well as from interactions with all UCMB staff and staff in the affiliated hospitals and diocesan health offices visited. While the UCMB and affiliates have made a strong case that there is a basic cost of providing services of a defined quality, it remains unclear as to whether this message is getting across to the other stakeholders and if so, how the shortfall in meeting the package of care will be met. The alternative is to provide care with less qualified staff. The team noted encouraging signs that the issue of human resources is being addressed through a supplemental budget and it will be important to follow this through[7].

III. Increased Dynamic and Transparent Management

There has been significant progress in achieving performance targets. The availability of timely and accurate information on activities and targets achieved, as well as use of financial and human resources are clearly done in a transparent and accountable way to the main stakeholders and funding sources (donors and government). Areas to be strengthened include continued emphasis on cost-consciousness, including clear plans for scaling down in the event of reduced funding (already started by at least one hospital), as well as completing the transition to accrual based accounting. In addition, involvement of groups representing users of the facilities could be strengthened so as to lend additional credence and weight to the efforts to lobby government and donors for continued and even increased funding.

IV. Improved cohesive internal organisation and external organisational arrangements

The UCMB has clearly been at the forefront of efforts in the RC health services to strengthen internal organizational arrangements and structures, as well as external relations. Structures such as health facility management boards/committees and diocesan health boards and offices have been put in place where they did not exist or strengthened. Policies and procedures have been streamlined with documentation of expected standards and an accreditation system put in place. Although not having a direct implementation or supervisory mandate over the hospitals and LLUs, the facilitating and/or catalytic role of UCMB was crucial in this. It is evident that some facilities and DHOs remain relatively weak and will need additional support. The relations with central government and local authorities still need careful attention and balancing to keep an active role in the national health system while maintaining autonomy and faithfulness to the mission. In this regard, relations with the government through the PPPH desk of the MOH and other levels e.g., HPAC should be maintained and strengthened. Efforts to revive the functionality of the PPPH desk at

[7] Unfortunately this expectation did not materialize.

the MOH will benefit from the passing of the new PPPH policy, and UCMB could lend its weight to this. The prior agreement for districts to appoint focal persons to liaise with PNFP still needs to be taken up again.

V. Improved advocacy

The notable success under this strategic objective was the acceptance, by the government and the Uganda Nurses and Midwifes Council, to lower the entry criteria for candidates entering the Enrolled Comprehensive Nurse training programme[8]. There has been a perception by the PNFP of lack of commitment to the partnership on the part of government. The review team concludes that this is probably not the case and that other overriding constraints in the national economy seem to be more prominent. The UCMB needs to continue a constructive engagement in a win-win scenario, showing that in fact the UCMB preferential option for the poor, and the government's own commitment to increasing access to quality care to all its citizens, are in fact overlapping and complementary.

4.2. APPROPRIATENESS OF STRATEGIES

Again in the words of the consultants: in general the capacity building, lobbying and advocacy strategies are appropriate taking into account the mandate of the UCMB and the context. However, an overemphasis on rational strategies (convincing others through facts and figures) is noticed, possibly diminishing the role of the more political and emotional dimensions of change processes.

They particularly complimented the UCMB on the accreditation process it invented. This process enhanced the understanding of the importance of adhering to quality criteria and it has given the RC institutions a head start, as accreditation will sooner or later be part of the health quality assurance mechanisms.

4.3. CRITICAL SUCCESS FACTORS AND RISKS

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.

[8] This is the opinion of the Consultants. The UCMB team is less certain that their efforts were the determinant factor. Many partners contributed to this discussion. In addition, the final implementation of the new criteria is not yet secured as the UNMC still has reservations. The UCMB team recognized the gradual growth of the PNFP Conditional Grants in the first year and their continuation during the latter years as the key successes under this goal.

5. CONCLUSIONS AND LESSONS TOWARDS THE FUTURE

This summary of the issues that need to be addressed in the new Strategic and Operational plan is based on the conclusions and recommendations of external review team as well as on the internal review by the Focus Group and the UCMB team.

5.1. THE KEY CHALLENGE: HOW TO IMPROVE EQUITY

The biggest challenge for the coming years, according to all, is "How to improve Equity?" Or, put in other words: "How to remain faithful to the preferential option for the poor as enshrined in the Mission?" This has everything to do with the scarcity of resources and the rapid rise in cost of health service delivery. A two-pronged approach has to be pursued with vigour: A) Improving efficiency and B) Making optimal use of the available opportunities. The latter refer to the Global Health Initiatives and Social Health Insurance Schemes. As all RC actors are convinced that the system development / strengthening approach must continue the challenge will be to assure that these funds contribute both to results for these programmes as to continuation of basic services (e.g. funds can be used for programme and system costs).

5.2. CHALLENGES WITHIN THE INTERNAL ENVIRONMENT

5.2.1. Embedding the Mission and Policy

The RC Mission and Policy Statement in Health is part and parcel of the entire Mission of the Policy of the RC Church. Adherence to – and support for- the Health statements still need significant strengthening at all levels of the church. In the health institutions the instruments (constitutions and manuals) that aim to integrate the mission in all operations are yet to be internalised, or rooted.

5.2.2. Enabling the RC Institutions to take the Lead Role in their Development

During the past years, though UCMB's main aim was to build capacity in the RC health institutions, it has been very much in the driving seat. Though understandable from the perspective of the situation in 2000/01, and its national vantage point, it has resulted in a certain level of dependency on the side of the other actors. To extend and embed the local capacity it is now time to turn the roles around. The implementers (in the largest sense governors, managers, and diocesan coordinators) need to start telling UCMB what they need to address their problems. Put in other words: moving from push to pull. This thrust towards enabling the implementers to drive their own process of change is also called for by the decentralisation policy, as more and more the districts will determine their priorities and budgets.

5.2.3. Accelerating the Improvement of Management Systems and Capacities

The assessments indicated that the uptake of new tools, guidelines and training content is not always complete and / or not yet fully internalised. As the new funding mechanisms will result in new strains on the management systems, and may even require revision of the systems, the need to accelerate improvements in management is great. The high turn-over in human resources magnifies the need to build and internalise systems and practices to assure corporate governance and fiduciary assurance.

5.2.4. Translating Knowledge into Practice

UCMB has mostly concentrated on development and transfer of technical knowledge in its capacity building effort. But in an environment where few persons gain knowledge and are then asked to enable others to change, technical know-how is often not enough. The consultants rightly recommended that UCMB invest more in developing

the additional skills required to lead change (leadership, training of trainers, negotiation, and advocacy). The latter are also needed to improve recognition and strengthen cooperation at district level.

5.2.5. Transferring the UCMB role in Training

UCMB has developed and implemented many new / tailored training courses to equip the present RC managers and health workers for new methods (HMIS / ICT / Financial Management / ….). However, this cannot be a structural role of UCMB. The need to enhance and embed strong and transparent management and governance systems and practices means that the new generation of managers should obtain these skills during their professional or post graduate training. The courses developed therefore need to be integrated into programmes of institutions that provide the original professional training. The same applies to the courses that are proposed under 2.4. For this structural cooperation with other institutions needs to be developed. The preferred partner would be UMU Faculty of Health Sciences.

5.*2.6. Enhancing the Capacities 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. Due to the efforts of UCMB the managers have improved their abilities and tools but this has not yet been matched by improvement at the level of the Governors. To enhance corporate governance, the skills and tools of the governors now require more attention.
In an adjusted form this also applies to Health Unit Management Committees, as the function of this body is, to some extent, comparable to the board of a hospital. To date, efforts to access training for the members of the HUMC's did not succeed well for a number of reasons. In the coming years both the actual training, as the development of the capacity to ensure continuous training at diocesan level, requires attention.

5.2.7. Enhancing the Diocesan Health Coordination

Progress in the four key Mission indicators has been least in the health centres (LLU's). Two factors seem to be determinant here: weak leadership from the diocesan health board and insufficient technical guidance from the diocesan health coordination office. In turn these have a lot to do with weak support from the diocesan authorities, including seeking funding for this service. On the other hand the need for effective diocesan coordination is increasing as the decentralisation of the budgetary powers to the districts accelerates. Fostering support from diocesan authorities and external development partners will have to go hand in hand with capacity building. The latter will have to include new solutions for the organisational position of the DHO and new forms of cooperation with the diocesan hospitals.

5.2.8. Innovating and enhancing the roles of the Congregations

Efforts to enable the Congregations to develop and strengthen their roles in - and contributions to - the RC health services have not yet succeeded. As all internal partners are convinced that the congregations are essential actors in realising the RC Mission in health, new efforts must be sought to reach this overarching objective.

5.2.9. Improving Holistic Care

Extending the range of holistic care components is the area where the least results could be booked in the past years. Clinical Pastoral Care and palliative care training have taken of well. But no progress was booked in mental health and social work, and the capacity to provide Natural Family Planning services has actually reduced. In part these objectives were hampered by lack of training opportunities. For the other part the hospitals and dioceses gave the development of these services low priority. New /

adjusted training programmes need to be sought to assure that the RC institutions can provide the full range of holistic care. These should be coupled with the development of the internal training capacity to assure that these programmes can be continued.

5.2.10. Enabling the RC health institutions in the North and Karamoja to benefit fully from the new opportunities

Significant financial resources are becoming available to improve the health and living conditions of the population of the war-torn and insecure areas. The dioceses Gulu and Lira (North) and Kotido and Moroto (Karamoja) count a total of 5 hospitals, 3 training institutions, 33 HC's and 4 coordination offices. These units form an essential part of the health system in these regions as they are often the sole providers in the most rural and insecure areas. They have continued to provide services against all odds. The push to scale up services will offer new opportunities to improve services and enhance the faithfulness to the Mission. However, there will also be considerable threats, as the focus will be on specific diseases / health problems, and the planned interventions will be short-term and project type with rigid funding and spending mechanisms. Particularly their longer term sustainability can be at stake if the scaling up does not pay due attention to the need to continue basic services or to the existing absorption capacity. These threats are cause for grave concern, not in the least because 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. Thus a form of close and intensified support from UCMB would be warranted to enable these institutions to benefit fully from the new opportunities in the interest of their target populations. To make the support successful and enduring it has to respect the principle of subsidiarity and match with what the main actors deem necessary and feasible. Therefore the approach has to be developed on their request and together with them.
In all case it should also include closer cooperation with other Catholic / PNFP organisations like AVSI and CUAMM.

5.2.11. Human Resource Development and Increasing the Contributions of the Health Training Schools

International recognition that Human Resources are key to improving health outcomes is now assured. The shortage and high turn-over of human resources run through all the problems of the health institutions. To date no clear inroads to address these problems in the RC sector have been identified. The reasons lie in the complexity of the problem itself and the strong interdependencies with other partners in the system. A clear example is the exodus from the PNFP sector to the government sector due to the salary in crease in the latter. Another example is the increasingly large loss of highly trained and qualified staff from both the Public and PNFP sectors to NGO's and programmes active in Global Health Initiatives and vertical programmes.
In addition, the majority of the solutions available have significant long-term cost implications. As resources for the system elements of health care delivery are so constrained in the RC sector, a raise of income to cover additional costs can only come from user fees. The annual reports of 2005/06 clearly indicate that, to be able to retain staff, following the salary increase in government, the RC units had to increase salaries by increasing fees. The result is a loss of efficiency but more importantly a loss in equity.
As the chapter on the national health budget indicates, no increase in funding for PNFP health facilities is yet insight. The national strategic plan for HR development is still being developed. This means that the RC partners and UCMB can only oversee the short term. The priorities that the RC sub-sector can address in the short–term are: improving HR management and retention as well as improving the quality of staff. The

latter has to include the new generation of health workers trained in the RC health training institutions.
With respect to quality and retention of staff the scholarship fund of UCMB has proved of great value. For the schools: the work of the Health Commission's Task Force has shown that the schools need support to improve the range and quality of training and to assure that they can take up their rightful role in the national training network and.

To be able to respond to new opportunities to increase the number of health workers and their motivation through better payment, the RC network will have to have capacity at national level to follow developments closely and advocate effectively for the inclusion of the RC health workers in all the new plans.

5.2.12. The need for better defined Legal Arrangements

The RC health institutions are not legal entities as such. The dioceses are the only recognised legal entities (juridical person). Earlier efforts to find solutions to protect diocese against possible liabilities of hospitals, within the civil and canon law, did not yield clear solutions. Contractual arrangements, between the RC institutions and funding agencies, are back on the agenda in the context of the Global Health Initiatives and the Social Health Insurance Scheme. This means that the need to establish better defined legal arrangements takes on a new urgency. As also government units will require a legal status, the openings in civil law can be expected. In depth research will be needed to establish the options in canon law that can preserve the "ecclesial" nature of the RC institutions and the policy control of the Ordinary, while granting the necessary scope for autonomous decision-making.

5.3. ONGOING AND EMERGING EXTERNAL CHALLENGES

5.3.1. The Public – Private Partnership for Health

The development of the Public-Private Partnership in Health (P-PPH), in particular the partnership with the PNFP has stalled. The reasons are related to the delay in the adoption of the P-PPH Policy, national budget constraints, inconsistent actions from 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 certainly 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 the dialogue has to be continued and PP Partnership reinvigorated at each level. They also agree that new approaches must be developed to enhance advocacy and lobbying skills and 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. The Bureau, together with the colleague Medical Bureaux, should in particular advocate, for the adoption of the P-PPH Policy with its implementation guidelines, the revival of the P-PPH Desk within the Ministry of Health, and the installation of the PNFP coordination committees at district level.

5.3.2. Cooperation within the Private Not for Profit sub-sector

During the past years Uganda Protestant Medical Bureau (UPMB), Uganda Muslim Medical Bureau (UMMB) and UCMB have worked closely together in all matters concerning the P-PPH and national developments.
There is an increasing call from donors that all Faith-Based health organisations should form a Christian Health Association, comparable to the surrounding countries. Such an organisation can enhance coordination, improve efficacy of advocacy efforts, and

facilitate the access to external funding. Where the Medical Bureaux may see the need and advantages, this is not yet the case for church leaders and implementers[9]. In addition, the present legislation is not conducive for the recognition of new church organisations. While remaining attentive for new opportunities, the best way forward is to strengthen the existing cooperation.
At district level, the cooperation within the PNFP sector still needs to be developed and supported as all PNFP units need to be able to be a visible interlocutor in front of the district authorities (see PNFP coordination committees).

5.3.3. System Strengthening versus Re-verticalisation

The new Global Health Initiatives have in common that they target specific diseases, or health problems, and use the tender -project mode with a high short-term result orientation, e.g. they are in fact vertical programmes. The last three years have shown that these funds have, and will continue to have, considerable consequences for health services, in particular in the PNFP sector. This is because, as the national health budget is not growing, these funds are, for the foreseeable future, the main sources for additional funding. On the other hand it is rapidly becoming apparent that the funding provided by the Global Health programmes only cover the variable costs directly related to the targeted services. The RC institutions are not able to cover the ensuing fixed and indirect costs (human resources, amenities, maintenance, etc.…) from other sources without reducing other services. If they are not enabled to collect and present the evidence and develop common standpoints / solutions, the future looks bleak for comprehensive basic care and for system development.
All the RC actors agree that the main orientation of the RC health network and UCMB should remain that of strengthening the institutions and the system as a whole. To achieve the latter, a two-pronged approach is needed to face the challenges of the Global Health Initiatives. The first is a close cooperation between UCMB, the UEC 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.
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 for comprehensive service delivery.

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

As all the details of the Social Health Insurance Scheme are yet to be developed it is difficult to predict what this new funding mechanism will entail for the RC and PNFP health providers. There is no doubt that the principles underlying health insurance correspond to the RC Mission. The concerns have everything to do with the high expectations and the speed with which the government wishes to implement the scheme, while the population with a stable income is limited and the considerable reorganisation of the administrative systems require time.
For now two things are certain. Firstly the employment cost will increase as the employee and employer are obliged to contribute. Secondly the units will have to become able to cost services in detail and account comparably. The present user fees can easily be mistaken for costs while they are far from it as government and other subsidies are used to keep the fees as low as possible. The latter financial management problem also applies, to a lesser extent, to the Community Health Insurance schemes in which a number of RC hospitals and LLU's participate.

[9] The opposition, of some church leaders / owners against the installation of the interdenominational organisation for the Health Training Institutions was a clear sign of this.

Potentially the SHS could change the funding mechanism for RC health services completely if the government decides to replace the subsidy allocations in favour of this funding mechanism. In rural areas this may then threaten access to the poor as the number of salaried workers here are probably too low to assure an adequate income for the health units.

5.3.5. 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. In the light of all the new developments mentioned above, existing alliances need to be enhanced and new alliances sought and developed in the interest of the of the RC health services. Among the new alliances, the IRCU will need to figure prominently, as it is increasingly becoming the "gateway" to the Global Initiative agencies. For the north UCMB, AVSI, and CUAMM might consider a closer cooperation to move from emergency assistance to individual RC units to assuring that the new funds contribute to improving comprehensive service delivery and strengthening the units for longer term sustainability.
At district level the need for stronger alliances and cooperation with other actors is rapidly growing. Diocesan coordinators and hospital managers need to be enabled to become more pro-active in this. For a number of partners cooperation at this level can be enhanced through more intensive coordination at national level. This applies UEC HIV/AIDS Focal Point and Catholic Relief Services (CRS). CRS is the lead agency for of a consortium of American NGO's involved in scaling up HIV/AIDS and other Global Health Initiatives. It is also the official aid agency of the US Bishops Conference.

5.4. OVERALL CONCLUSION: STRENGTHEN THE SYSTEMIC APPROACH

The external and internal reviewers all concluded that the internal and external challenges indicate that the systems approach taken by the RC health network and UCMB should continue and be strengthened. Internally the changes and improvements have to become firmly embedded, or rooted.
In the words of the consultants (page 38 of the report): "Vertical programmes and projects are currently and will remain a reality for the foreseeable future. The level of funding going through vertical programmes/projects and its consequences on the rest of the system cannot be ignored by UCMB and affiliated facilities. This means UCMB needs to develop capacity to support facilities to selectively engage in some vertically funded programmes/projects while not losing sight of the overriding imperative to develop, strengthen, and maintain functional systems. UCMB will need to continue its role of providing support to develop and strengthen the system as a whole as well as provide technical advice on how hospitals can participate in projects while maintaining a systems orientation. In order not to lose the momentum with hospitals and diocesan health offices, it will be important for UCMB to maintain a dedicated officer to help in sourcing and following up projects as is currently the case under GIFMU".
The main implication is that UCMB, which already has acquired a high professional profile, will need to maintain this for the medium term to allow the innovations that have been introduced to take firm root. This will allow for additional learning and experience in institutional strengthening.
The current Executive Secretary is well positioned to transition into a behind-the-scenes supportive role. This role could take the form of high level analysis of policies and their implications for UCMB and its affiliated facilities. He could offer general strategic guidance and liaise with the Church authorities to ensure adherence to the mission and protection of autonomy while functioning as an integral part of the national health system.

6. OVERVIEW OF THE RC HEALTH NETWORK STRATEGIC PLAN FOR 2007 - 2011

For this summary, this section concentrates on the chapters that determine the long term view and directions. Chapters that also apply to the operational plan will be presented there.

THE VISION OF THE RCC HEALTH SERVICES

A healthy and reconciled life for all individuals, their families, and their communities.

6.1. THE RC MISSION IN HEALTH 2007 - 2011

All Focus Group members and the external evaluators agree that the Mission and Vision Statement do not require re-formulation at this point[10]. The formulation of the main tenets and core values befit the present time-spirit in Uganda and are recognisable at each level. The Focus Group members did propose the following summary, or motto, to enable all to memorise the essential message more easily.

In Faithfulness to the Mission of Christ,
we provide professional and sustainable
holistic health services,
though partnership,
to enable the population to live their life to the full.

6.2. POLICY STATEMENT 2007 - 2011[11]

Considering all internal and external challenges the RC policy Statement remains valid (see Section B of RC Mission and Policy Statement).
It is proposed that the Strategic Goals for the coming five years will form section D of the revised Mission and Policy Document.

The RC Policy Priorities
However, the policy priorities (section C) have been revised to focus the efforts on the key areas that all internal actors need to address.

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.

[10] Kindly be referred to the full text of the RC Mission and Policy Statement, as approved by the Uganda Episcopal Conference in 1999.
[11] From here all the chapters that follow are subject to approval by all stakeholders during the Consultation Conference, of November 13-15, 2006. .

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.

The Mission of the Health Commission, of the UEC, and of UCMB, for the new Strategic Plan and Operational Plan period remains, in line with the organizational structure of the RC Church, as well as the guiding principle of subsidiarity:

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

6.3. THE PURPOSE OF THE STRATEGIC PLAN

The purpose for this Strategic Plan has been set first of all in answer to RC Mission assignment to improve health of the population, particularly of the less advantaged and the vulnerable. This goal fully corresponds with the aims and objectives reflected in the Health Sector Strategic Plan of the Uganda Government. In turn this plan corresponds with the Millennium Development Plan International Development Partners. Secondly the Mission and the RC Policy call for cooperation with others to enhance effectiveness. Therefore the purpose 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.

6.4. RATIONAL FOR THE NEW STRATEGIC PLAN

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 that is developing itself 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 extending 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 health, and health funding, policies emerge make it difficult to predict what will need to be realised in the coming five years. These basic strategic directions should provide the essential yardsticks against which new policies and plans can be weighed. On the other hand they allow for the necessary flexibility to tailor the Operational objectives and the annual activity plans to the short-term needs and required responses.

For the internal environment, the continuation of the strategic goals aims at ensuring that the improvements in management and performance can effectively root in all RC institutions. The need for firm embedding is greatly increased by the present challenges and compounded pressures of rising costs, re-verticalisation tendencies, and new funding mechanisms.
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.

6.5. THE STRATEGIC GOALS

As indicated the Strategic Goals are largely comparable to those of the Strategic Plan 2001 – 2005. The changes will be explained were applicable below. Each of the strategic goals addresses a component of the development of the institutions. However, as there is a degree of overlap as well as a level of interdependency between these components there are also inevitably overlaps and interdependencies between the goals. In some cases the choice to locate an area of work under one goal is arbitrary to avoid duplication.
In annex IV the flow chart of the Strategic Plan is presented.

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 remains that the RC institutions become 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 stems from the dual responsibilities towards the catchment population: being effective in service delivery and being able to access their share of the national health budget. The underlying aim is to ensure social and institutional sustainability.
The formulation of this goal has been adjusted as the basic recognition has been achieved but now the relationships have to be strengthened to become effective and durable. The main areas of work 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 include new levels of cooperation with UEC-GIFMU and the UEC-HIV/AIDS Focal Point and other actors.

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. It should be noted that sustainability is viewed here mainly from the financial aspect. Goals one and three address the other aspects of sustainability. These two areas considered together because they are inter-dependent, as developments in one directly impact on the other. More importantly, they need to be considered together because they have very strong influence on accessibility and equity. Accessibility and equity are key Mission assignments but they are also the most threatened by the present circumstances. Therefore improving, or at least maintaining, performance in these two areas has to guide all the choices to be made.
The objectives and actions that are to contribute to financial sustainability first of all aim at improving efficiency and assuring access to - and use of - new funding mechanisms (Global Initiatives and Social Health Insurance). These will have to build on actions that enable the managers to enhance financial management and accountability (fiduciary assurance) and, where required, adjusting service packages to match local needs and assure viability of units.
Areas of work to improve the range of services are related to increasing the degree of completion of the Minimum Health Care Package and completing the range of holistic care. It has to be noted that the present financial constraints may form an obstacle to improvements in range of services as these do have cost implications.

Quality of care and quality of management are demanded by the Mission and thus have to be pursued continuously. The accreditation system will be further developed for this purpose.

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. This goal combines the former goal 3 "increased dynamic and transparent management" and goal 4 "improved cohesive internal organisation and external organisation arrangements". The management systems and organisational arrangements have, to a greater extent, been put in place during the past years. The aim is now to equip the key actors, in hospitals and at diocesan level, who are to assure that the institutions perform optimally and answer transparently to the population and their partners in health. The main themes are Stewardship and Corporate Governance.
The objectives and actions will focus on building and enhancing governance and management capabilities as well as developing instruments that facilitate and support effective implementation. In addition, to facilitate institutional change by these actors, the technical know-how needs to be completed with the necessary "softer" skills to lead and induce change in others (leadership, training of trainers, advocacy and negotiation). 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.
To improve support to - and performance of - the health centres, the diocesan support for the health departments needs to be strengthened and the organisational embedding improved, or renewed.
To ensure that future generations of managers are well equipped for their work, the institutional embedding of the training programmes aiming at developing new skills and practices is essential. To this effect structural cooperation with training institutions also falls under this goal.

4. The RC Health Service Network has improved the development of its human resources and its contributions towards professional training.

It is evident from all internal experiences and the international attention that the development of the key resource in health care, Human Resources, needs intensified attention. To this effect this strategic goal has been added for the next five years. The end point for this goal should be that the RC health institutions have a staff establishment that is well qualified and motivated and that befits the service and management needs in quantity.
However, the present financial constraints, uncertainties regarding PNFP subventions, and national HR development plans entail that the possibilities to improve monetary motivation and to increase the quantity of staff in the RC institutions are very limited. Therefore the focus has to be on improving quality and moral motivation of staff.
The scholarship fund has proven to be an important means to improve quality of staff and improve retention. It has to be continued and enhanced, while the uptake by dioceses and hospitals is improved as well. In addition, developing the capacity of managers to plan for - and implement - HR development plans needs to be developed.

The health training institutions are essential to improving the range and quality of human resources. The work of the Health Commission's Task Force on the future of the Nurse Training Schools proved the important role the PNFP Health Training Schools have for the own sector as well as for the country (f.i. 60-70% of the nurse training

capacity, the RC alone counts 41%). It also put in evidence the potential to increase the contributions of the schools[12]. To this effect professional capacity is required to assist them in their development and to strengthen their position in the country health worker training network. Unfortunately the plan to form an interdenominational organisation for this purpose could not be realised. As the Health Commission recognised the high need it assigned these tasks to the Bureau and installed a Standing Committee and desk for this purpose. Key objectives will be: improving management and governance of the schools, improving the quality of the training, and developing and implementing new programmes to respond the changing / new service needs, and enhance the cooperation between all PNFP schools. The highest priority has to go to assuring representation / negotiation at national level. This will enable the schools to find a way through the present confusion at national level and participate in the development and implementation of the strategic plan for HRD.
This same capacity will also enable UCMB and the schools to respond to new opportunities to improve HR availability and quality, as soon as they present themselves.

5. The RC Health Services have improved their advocacy for the target populations and institutions.

The goal to improve advocacy is also carried forward as it has proven to contribute considerably to enabling the RC institutions to continue pursuing their mission. It is at the same time a goal and a strategy as it supports the realisation of the preceding goals. In the present context, of financial constraints and increasing re-verticalisation, the need to defend the interests of the poor and the RC institutions is even higher as before.
In the past period UCMB lead the advocacy efforts at national level. The devolution of powers to the districts, and beyond, mean that increasingly the peripheral actors have to be able to take up the advocacy role. For this purpose, particularly the hospital managers and the diocesan coordinators should be enabled to develop their advocacy and negotiation skills.
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.
In terms of methods the experiences of the last year have shown that a reliance on technical information and arguments is less effective when the political pressures are high. The training of all RC actors should therefore include methods that enable them to focus on conciliation of the interests of the opposing partners and the development of constructive proposals and relationships.

6. Overarching and Crosscutting objectives

This goal has been added as from the Operational Plan 2004 – 2006, as it proven to be of assistance to ensure that the core functions of UCMB and overarching issues remain in focus. In addition it creates space to cater for emerging issues, which do not easily fit directly within one of the generic goals and / or cut across all.
The continuing overarching subject to be kept on the agenda concerns innovations in care and management. For the cross cutting priorities for the first three years are presented in the Operational Plan 2007 - 2009.

[12] 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.

The core functions of UCMB are those that emanate directly from the Mission of the Health Commission and UCMB, and they have to be continued whatever the extent of the support plan. These 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. To this effect it also has to ensure that the governance of UCMB by the health Commission and the efficient running of the office.

The Main Actors, Implementing Strategies, and Planning, Monitoring and Evaluation of the Strategic Plan

For the sake of this summary these chapters are not presented here. As they are effectively the same for the operational plan they are presented there.

7. The Overview of the RC Health Network Operational Plan 2007 – 2009

In this chapter the Operational Plan for the year 2007 – 2009 is summarized. The logical framework presented in annex V provides a detailed overview of the objectives and primary targets per strategic goal.

7.1. The purpose of the Operational Plan 2007 – 2009

The purpose of the Strategic Plan 2007 – 2011 is also purpose of 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. Instead in the coming years the initiative has to return to the actual implementers and to this purpose UCMB should concentrate fully on "enabling" these actors.

7.2. Rationale of the Operational Plan

To achieve the goal of the Strategic Plan 2007 – 2011, the first Operational Plan foresees a similar level of technical and financial investments as the previous Operational Plan period. Based on the rational for the Strategic Plan, the reasons are:

- Though the Strategic Goals of 2001 – 2005 and the Operational objectives of 2004 – 2006 were, to a large extent, achieved, the assessment indicates the need to set the targets higher to enable the RC Health Institutions to respond to the call of the RC Mission;
- 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 while answering to the overriding imperative to develop, strengthen and maintain functional systems;
- 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;

- 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 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.
- Lastly, but far from least, all the present changes in the national environment (see chapter country context and lessons for the future), indicate that UCMB has to 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 essential to sustaining the services and the institutions.

It is to be noted that again for this Operational Plan period the Focus Group and the UCMB team have not opted to add the medical / clinical focus. The reasons firstly lie in the high priority that needs to be given to strengthening governance and managerial aspects of the RC institutions and the RC system as a whole. Secondly there are so many national specialised programmes, the number is only increasing in the wake of the "vertical" Global Health Programmes, that duplication would be inevitable. As before when necessary to improve quality and or output relevant topics are put on the agenda of the technical workshops for hospitals managers and diocesan coordinators.

7.3. THE OBJECTIVES PER STRATEGIC GOAL

For this Operational Plan UCMB opted to formulate the objectives in more general terms and specify, per objective, a set of primary and secondary targets. The first indicate the pertinence towards achieving the objective and / or to indicate what can be controlled by UCMB. The secondary targets depend more on the peripheral level, or are sub-targets for work plans. All targets are formulated in measurable terms resulting indicators for monitoring and evaluation at operational and annual planning / implementation level. The first reason for this choice is to ensure that maximum flexibility is maintained to answer to the needs of the peripheral units and changes in the environment. The second reason is to focus monitoring and evaluation efforts while retaining maximum time for implementation. As indicated in the chapter on the strategic goals some overlaps and interdependencies mean that some choices are arbitrary. In addition, some objectives of the previous period reappear here, either because they have proven effective towards the goal or they still need to be achieved.

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.**

For this strategic area nine objectives and nine primary targets have been set. The first concerns the core function of the UCMB to ensure the representation of the RC health services in the national fora. The activities related to this objective are also essential, though, to monitor and assess new developments and ensure a timely response. In importance towards achieving the goal this objective is closely followed, by three objectives that aim at ensuring the Public-Private Partnership Policy is adopted and implemented and the P-PPH desk in the Ministry is revived in support of implementation.
The next two objectives aim at enhancing the partnerships at peripheral level: enabling the diocesan coordinators to consolidate the integration of the health centres into the district health system, and improving the capacity of RC HSD leaders to implement all the HSD leadership functions.

The last three objectives are related to assuring access to new funds like the Global Health Initiatives and the Social Health Insurance Scheme, while protecting the autonomy of the RC units and the ability to provide comprehensive basis services.

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

As in the present circumstances, this strategic area is so crucial for the future sustainability of the RC health institutions it does take the lion share of attention and budget for organisational governance and development. Twenty objectives and twenty three primary targets have been set to address all priorities. They are subdivided according to main components of the goal: financial management, efficient use of resources, access and equity, range and quality of services.
For financial management the first objective for hospitals concern the installation and use of the cost-based accrual system for improved monitoring and management decision making. This will include, for hospitals that opt for it, the correct use of the accrual based accounting computer programme (ABC_Fipro). The next set of objectives address: enhancing fiduciary assurance; assuring correct accountability for Global Health funds; improving availability and use of information on costs of services in decisions making regarding service packages and contracts with Social Health Insurance organisation; and training in assessment of financial sustainability of hospitals. At diocesan health office level, the key objective is improving financial management in diocesan health offices and in the health centres by adopting and implementing a financial management for each level.
It goes without saying that the above objectives will greatly enhance the abilities to use resource efficiently. But as efficiency is a Mission assignment, deliberate objectives have been included for hospitals and health centres to keep it in focus. In the same line the objectives to improve access and equity, at both levels, have been maintained. Though, for these two sets of objectives, the intended result is improvement, circumstances may dictate that maintaining the present level is what can be realistically achieved. If the economic situation worsens, or the PHC grants do not follow at least inflation rates, damage control might have to become the objective.

With respect to the range and quality of care the first objective aims at the further development of the accreditation process. Next follow two objectives to extend and improve the capacities of the health units to provide pastoral care of the sick and mental health care services (extending holistic care package). Three objectives concern extending the capacities to provide basic services: natural family planning, completing the Minimal Health Care Package (MHCP), and Emergency Obstetric Care (EmOC). Where in the past some of these objectives could not be achieved because of a lack of available training programmes, these will be now developed, or commissioned. To ensure that the training then continues the training of trainers in Health Training Institutions is included.

The last objective is to support all the above objectives: assuring that hospital teams and diocesan health coordinators use Information and Communication Technology (ICT) to improve performance and faithfulness to the RC Mission.

3. The RC Health Institutions have improved their governance, management, and accountability structures and practices.

This goal forms, together with goal two, the mainstay of strengthening the systems of institutions and the network as a whole. As indicated, the main themes are

stewardship and corporate governance. To assure that the main aspects are improved a total of sixteen objectives and eighteen primary targets have been identified.
First objective is to enable the key actors to implement organisational changes and to advocate for their target populations at district level by strengthening their skills in leadership, advocacy, and negotiations. As the style of management is often cited as one of the reasons for HR attrition, the accent will be on more democratic and participatory leadership. For correct HR management and compliance to labour law the Manuals of Employment need to be aligned the new aligned to the new law.
The next objective concerns establishing corporate governance in the entire RC network. Here it is important to mention that, next to actual training and technical advice, new methods of capacity building are planned. These aim at developing inter-institutional support to reverse the initiative to the peripheral (self assessment tools and peer review and support).
The two following objectives aim at assuring accountability of managers, and coordinators, and health centre teams towards their governors and external partners. The progress towards the four key on RC Mission indicators (access, equity, efficiency and quality) will take prominence in this. An essential ability, all actors require for this, is the ability to analyse and use information for transparent accounting and effective decision-making. Building on the good experiences gained, the activities include further improvement of the information systems and enhancement of these capacities. In view of placing responsibilities where they belong, this period will see the handing over of the responsibility for the management and use of Information and Communication Technology (IC policy and equipment) to the hospitals and diocesan health offices.
It should be noted that courses developed under the above mentioned objectives are to be integrated in the programmes of other institutions (preferably UMU).
Then three objectives target improving professional management in hospitals, enabling them to improve their organisational structures and performance, and enhance planning for emergency and / or longer-term developments.
As it has become clear that HC's IV need to be managed at a level comparable to hospitals, they will be assisted to improve their professional capacities in management and governance.
To improve the performance of health centres (LLU's), and enhance their integration in the district, an important objective with considerable range of activities and targets aims at strengthening the diocesan health coordination. The activities range from advocating for stronger diocesan coordination, at the level of the ordinary, to establishing more effective organisational structures. In addition, to enable underdeveloped diocesan offices to access external support, financial support to improve performance first is included. To the same effect training of Health Unit Management Committees is planned for.

4. The RC Health Service Network has improved the development of its human resources and its contributions towards professional training.

This new strategic goal aims at improving the availability and quality of staff in the RC health institutions. While pursuing the search for opportunities to improve the quantity of workers and their monetary benefits, the main thrust for this operational period is on improving the quality and moral motivation. Human Resource Management (HRM) is captured under the previous two goals, within all the objectives targeting improved management and governance. Human Resource Development (HRD), or career development, inline with the needs of the health unit is aimed at through two objectives and two primary targets. To improve the contributions of the RC schools, and enhance their position in the national training network, a total of nine objectives and ten primary targets have been developed for this purpose.

With respect to human resources development, the scholarship fund is to be continued and its use improved. A study into its effects on longer term retention of staff is to provide guidance on how the effectiveness can be improved. The second objective for this area concerns enhancing the capacity of the hospital managers and diocesan coordinators to plan for human resource development. As it is a complicated issue external expertise is foreseen to assist in developing tools for HRD planning.

For the schools, the first objective concerns installing effective coordination of – and assistance to - the schools by assuring that the newly appointed Standing Committee for Health Training Institutions and Training (HTI&T) as well as the UCMB desk become fully operational. The latter includes effective representation in national fora. The second objective aims at pursuing the interdenominational collaboration among all PNFP HTI's.
These two objectives are followed by three objectives that are to improve governance and management of the schools: enhancing their fiduciary assurance by putting in place all that is required for transparent financial and activity accountability; assuring that the organisational unity with the hospital is maintained / strengthened; and establishing the use of ICT in the schools. Then important attention is given to improving the quality of training and management in the schools. The two next objectives aiming at broadening the range of training programmes: assuring that the RC schools train Enrolled Comprehensive Nurses in line with the national HRD plan; and the RC HTI are implementing at least two new curricula to train cadres needed by the health units.
The last, but far from least, objective concerns improving the sustainability of the RC HTI while remaining accessible for candidates from rural areas.

5. The RC Health Services have improved their advocacy for the target populations and institutions.

To reach this goal six objectives and seven primary targets have been identified. In number they are certainly less than for the other goals, but their importance cannot be stressed enough, as effective advocacy will greatly enable all to achieve the other intended results.
The first objective is about developing and implementing a focused agenda for advocacy at national and peripheral level. The latter will given on more importance as decision making regarding budgets for health are increasingly the remit of the districts.
The second objective concerns the important area of strengthening existing and developing new alliances in view of combining efforts to respond adequately to the external challenges. These two objectives are to be facilitated by improving the skills of UCMB team members as well as hospital managers and coordinators in advocacy and negotiation. The content of the training and efforts will concentrate on constructive and conciliatory methods to ensure that each party gains (creating win-win situations).
The last two objectives aim at increasing awareness and ownership for the RC Mission and Policy Statement in Health among the wider RC network. This proved necessary to ensure that all contribute to their realisation.

6. Overarching and Crosscutting objectives

Under this heading one special objective and four cross cutting priorities for the coming three years are developed. In addition it covers the overarching objectives that aim at ensuring the continuity of UCMB's core functions.
The special objective concerns the conflict ridden dioceses of Gulu, Lira, Moroto, and Kotido. To enable the diocesan offices and institutions to respond adequately to the

new opportunities, a suitable format for enhanced coordination and support from UCMB is to be developed and made operational together with them.
The first crosscutting priority is to assist the congregations in redefining / re-focusing the Mission in the healing ministry. The aim is to enable them, as important contributors to the RC health services, to take up roles that befit their charism and capacity as well as the needs of the network to answer to the RC Mission.
The second priority addresses the need to identify options for own legal status for the larger RC institutions to enable them to enter into contracts with external partners like Districts, Global Fund agencies and SHIS. The legal options need to ensure that the belonging to the diocese is preserved while the diocese is protected against potential liabilities.
The third priority wishes to establish strong bonds of collaboration between UCMB and Uganda Martyr's Faculty of Health Sciences. This is directly related to the need to embed the training activities of UCMB into existing training programmes so that future generations of health workers and managers will be well equipped from the outset. In addition, the cooperation can enable both parties to develop better understanding of the health system problems and their possible solutions by joining hands for research.
The last cross cutting objective is carried forward from previous plans and aims to ensure that innovations in health care delivery by – and management of - RC health units continue to be pursued.

7.4. THE ACTORS IN THE OPERATIONAL PLAN

The key actors in the implementation of this plan are reviewed here.

The Health Commission and UCMB
The Health Commission and UCMB will lead and manage the implementation of the Strategic and Operational Plan. For UCMB the above objectives entail that its extended function is continued. The capacity it will require for this is described below.
In line with the Mission of the Health Commission, UCMB's main role remains, however, policy and technical advisor, facilitator, and coach to the actual decision makers and implementers.

Peripheral Implementers
These are the RC hospitals, health training institutions, and diocesan health departments. Within each of these institutions the owners, governors, and managers / coordinators represent the key actors in ensuring that the institutions can realise the RC Mission. They are therefore the actual implementers of all the improvements planned in the Operational Plan.
The need to accelerate the enhancement of the system 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, including the Health Unit Management teams, will be targeted specifically to enhance their capacities to enact their responsibilities to guide, supervise, and assess the performance of management team members / coordinators and assure transparent accountability.

Institutional Partners
The institutional partners consist of a considerable range of actors that belong to the wider RC network. Each has a specific role to play towards the realisation of the RC Mission in health and the enhancement of the RC heath network for this purpose.
The Church Leaders are asked to support the RC Mission implementation more strongly. The congregations play an active role in the majority of the institutions and will benefit from the special objective aiming at assisting them in redefining their contributions.

To assure that the RC health institutions can access and use the Global Health Funds optimally closer collaboration with the colleague UEC departments HIV/AIDs Focal Point and the Global Initiatives Fund Management Unit (GIFMU) will be pursued. Joint Medical Stores will continue to ensure that its RC constituents benefit from its services and it will contribute to the scholarship fund. The cooperation between and UMU Faculty of Health Sciences and the RC network / UCMB is to be enhanced to ensure embedding of training programmes and tailor research activities.

External Partners
This category of RC health network partners is of great importance to the success of this Operational Plan. Their contributions varied but one thing is evident the relationships have grown and matured. Though this group is already considerable it certainly has to be widened further. This is necessary first to build alliances that can assist the RC network in responding to the present developments in the health sector. Secondly this is necessary to reduce the level of dependency of UCMB and the RC network on the present development partners.
Cordaid is the main development partners and has pledged to continue its support. The method of funding, overall budget support, combined with a continuous open dialogue and the willingness to think with, instead of for, UMCB, meant that the relationship has grown strong. Both partners hope to enhance their relationship further.
AVSI and CUAMM are longstanding partners of the RC health network as well as UCMB. The cooperation is expected to continue during this Operational Plan and, if possible, increased to facilitate joint support for the northern dioceses.
Lastly the Institute for Communication and Development (IICD) has become a valuable partner in the areas of ICT and Continuous Medical Education. Their support for these areas has been approved until the end of 2007.

7.5. IMPLEMENTATION STRATEGIES FOR THE OPERATIONAL PLAN

A range of strategies will be used to implement the Strategic and Operational Plan. The choice is determined by the role of UCMB: enabling the periphery to take up their responsibility and become initiators of their own development. This is not different from the past period and thus the strategies that have proven valid are continued and complemented, or adjusted, with new insights. As in the past UCMB will continue to adjust or renew these if the progress demands it.

Capacity Building
The main assignment of UCMB in its extended role is Building Capacity. 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.

Following lessons from the past period, technical support to individual institutions will be underpinned by specific agreements to foster stronger commitments. To facilitate

contextualised and integrated management support the UCMB team intends to visit units more frequently as team and develop the support jointly.

Monitoring, Evaluation, and Feedback
This approach will continue to form the most important support strategy. Experience has shown that, real time information exchange, data analysis, and feedback on performance, have important positive effects at peripheral level. They motivate managers and diocesan coordinators to strive towards improving their performance. The approach will be extended to two new groups the Health Training Institutions and the HC IV. 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 other key objectives, the activities include the development of distant learning approaches and materials. These will be made accessible through the website.
In addition, the Bureau will continue to use the information and analysis results to adjust and improve the content of its support and capacity building services as well as for advocacy efforts at national level.

Accreditation
The accreditation system has proven of great value to ensure that essential improvements are implemented. Thus the strategy will be further developed to support the attainment of the operational objectives. Annually criteria will be added to improve the quality of care, quality of management and "bring changes home", e.g. to institutionalise them. Following the positive experiences with the accreditation system for health units, a similar accreditation system will be developed for the HTI. In addition, a specific accreditation process will be developed to accredit organisations operating within the Mission in health but 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.

Advocacy and Negotiation
During this operational plan the advocacy goal and objectives (see strategic goal 5.) are crucial as so much is at stake. This underscores the reason to also consider advocacy as 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.

Operational 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. Several studies have already been identified (costing of services, human resource development, and legal options) but it may prove necessary to add others as implementation progresses. In addition to own use of research, UCMB also promotes operational research by 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.

7.6. THE ORGANISATIONAL CAPACITY AND SET-UP OF THE HEALTH COMMISSION AND 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.

The Health Commission
The Health Commission is the "board of governors" of UCMB in the name of the UEC. It is composed of representatives of the key internal stakeholder groups (hospitals, diocesan coordinators, UCS, UMU, and JMS) and chaired by a bishop. The Health Commission (HC) 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 another 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 ensured structural and timely consultation of the RC health service network and other internal stakeholders concerning the specific issue. When necessary this approach will be used for the implementation of this strategic plan as well.
Two new structural committees resulted from former Task Forces: the Standing Committee for the Pastoral Care for the Sick and the Standing Committee for the Health Training Institutions and Training. These committees are to lead the processes and advice the HC regarding policy and implementation decisions. These committees will increasingly exercise a function of control over resources budgeted for the implementation of activities under their mandate.

Capacity of UCMB
The functions of UCMB were first extended in 2001 to achieve the strategic and operational goals and strengthen the functioning of the RC health services. As indicated the high level of technical support is to continue during this operational plan period as well. This extension of the functions will always remain temporary as the main aim is to enable the peripheral actors to take up their respective responsibilities.
The standard institutional support activities need to be secured in the interest of the overall purpose of UCMB. However, 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 for hospitals, HTI, and Diocesan Health Coordinators;
- Publication of the news letter, the Bulletin, at least twice a year;
- Data collection, analysis and feed back provision;
- Information exchange between the RCC health services and with the external partners and dissemination of national policies and guidelines;
- Representation of the RC health services in the mother organisation UCS, in JMS, and national and international fora.

Targets for each of these activities will be developed in the annual work plans and presented and reported progress reported under the sixth strategic area.

The Core Team

This team consists of Executive Secretary (ES), Assistant Executive Secretary (AES), an administrator, data operator / documentalist, secretary, and driver. This team is first of all charged with the core functions of UCMB. For the extended functions the ES is the main representative of the Bureau and s/he will lead the implementation of the Strategic and Operational Plan. Both core tasks and specific tasks resulting from the Plan will be divided between the ES and AES.

Team of Technical Advisors

In the former period the Health Commission / UCMB attracted Ugandan technical advisors in Human Resources, Financial Management, Organisational Development, and Information, Communication, and Data Management (ICDM). The last three to replace the expatriate advisors. By the end of 2006 the basic tasks of the Financial Management, Organisational Development, and the ICT component of Information, Communication and Data Management will have been handed over. However, the handover of the Data Management and Analysis (DM&A) component requires more time still. The reason is that the development of the systems and capacities, in the institutions, still needs considerable strengthening.

The Human Resources Management Advisor has seen his tasks in managing the Scholarship fund grow to nearly 60% of his time. This means that developing new approaches / solutions for HR development may require additional person time. In addition, this is quite a specific expertise that is hard to find in Uganda. Part-time external expertise could accelerate the process of integrating HRH development capacity into the work of the multi-disciplinary team of UCMB.

The Support Desk for the Health Training Institutions

This desk is only singled out here as it is new and still has to become operational. The desk will function as integral part of the technical advisor team of UCMB as all expertises contribute to the development of the schools. This integrated approach will also facilitate the schools taking their rightful place in the organisation of the hospital.

This desk requires an officer trained as a tutor with experience in management. As building relationships and negotiating with partners at national level are important aspects of the work, the person needs to be knowledgeable about training and health policies. Technical assistance is foreseen for the entire period, though progressively reducing in time, 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.

External Expertise

There are an important number of new factors that complicate the taking-over by the technical advisor team. These pertain to the new approaches and tools required to access and to use Global Health funds ('vertical' project) 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 current expatriate Organisational Development Advisor and Financial Management Advisor have been very instrumental in the achievements of the RC institutions and UCMB thus far. They are therefore best placed 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.

Technical 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 and therefore type of expertise required cannot be fully determined now. It is highly probable though that it will be in the field of Public Health combined with experience in emergency / rehabilitation situations and experience in working with church owned 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. .

Special Policy Advisor
The consultants and Focus Group advised that the current Executive Secretary move to a behind the scene supportive position: special policy advisor. From this position he would be able to facilitate and support the transition to a new Executive Secretary, and offer policy analysis and strategic guidance to the RC network. He would then also be well placed to assist in the critical crosscutting objectives (assist the congregations in enhancing their roles; developing the cooperation with UMU; developing proposals for a clearer legal defined legal arrangements of the large institutions).

7.8. PLANNING, MONITORING AND EVALUATION OF THE STRATEGIC AND OPERATIONAL PLAN

UCMB and the RC members have learnt 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 and these will build on ongoing monitoring and the annual evaluation exercise using the indicators developed for each level (see annex V Logical Framework and the list of Indicators that will be presented at the conference).
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.

7.9. INDICATORS AND MEANS OF VERIFICATION[13]

First of all the four key indicators that UCMB developed to monitor "Faithfulness to the Mission" (access, equity, efficiency, and quality) will continue to be used as key outcome indicators to monitor progress towards the purpose, strategic goals and operational objectives. The plan is to gradually improve the quality indicator (or index) by including more aspects than those considered thus far.

[13] The List of indicators is being finalised and will be subject of discussion during the Consultation Conference. The logical framework, in the annex provides an overview of all the indicators. The final selection will be made as described in this chapter.

Then based on the national PEAP and HSSP II indicators, a number of outcome indicators have been selected to assess progress towards the purpose of the Plan. These are completed by indictors per Strategic Goal to monitor progress towards their attainment. These indicators can be either outcome, output, or process oriented.
This set of around 50 indicators will form the basis of annual progress assessment and will be reported on in the annual report.

For the ongoing internal planning for - and monitoring of - the Operational Plan 2007 – 2009 and the annual plans the team will use the indicators that result from the primary and secondary targets set per objective under each strategic goal. In principle these will not be used for annual reporting. When lack of progress in the strategic gaol indicators demand they will be used to determine and explain the reasons.

As the present economic situation is a threat to the sustainability of the health institutions, it may be necessary to develop an index to measure sustainability. Whether this is possible will have to be investigated first, as this is a complex issue.

The means of verification to determine the progress are mainly the various forms of annual reports of RC member institutions, analysis of the data presented, government reports, as well as activity reports of the UCMB team. In some cases a survey is planned as routine data would not provide adequate insight. (see means of verification in the logical framework annex V).

7.10. BUDGET FOR THE OPERATIONAL PLAN

The budget for the Operational Plan 2007 – 2009, as it has been presented above, stands at Euro **3,121,481**. Compared to the budget of the previous Operational Plan (2.9 M Euro) this budget is higher by 14%, which is slightly above the inflation rate.
The income that is known and / or pledged by development partners amounts to Euro **1,779,100**. Thus a gap of Euro **1,342,381** still needs to be covered. Annex I provides an overview of the total budget and estimated income.
This time UCMB has not yet developed a second scenario as it is hoped that the difference can be covered with assistance from development partners, existing or new partners. If this is not the case the results foreseen will have to be scaled down.

The income consists of local contributions Euro 237,300, representing 8% of the budget. Of this local income the contributions from the RC health institutions amount to Euro 105,000 which is 44% of the local income and 3% of the budget. This picture changes considerably if compared to the core functions of UCMB: a total of Euro 360,843 is required to assure these functions. The contributions of the members cover 30% of this budget and the total local income 66%. These percentages of local versus external funding compare fairly with the national health system, where the government provides around 46% of the national health budget, of which only half is local tax revenue. This means that tax revenues only contribute 15% of the total resource envelop for health.

For this new Operational Plan the budget has been developed according to the principle of cost centres that reflect the main objectives and methodologies of intervention (see annex I). This aims at improving management of the budget and monitoring the combination of inputs versus outputs of the Bureau. It has also allowed to define packages of work that can, if necessary, be presented as projects to new development partners. It has to be noted that the latter possibility is only meant to facilitate the entry of new development partners. The strategies belong together therefore also the budget has to maintain a high degree of integration and flexibility.

7.11. Assumptions, Preconditions, and Risks

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 those directly related to the Bureau.
The assumptions related to the external environment are:

- the political and economic environment, in which the RC health services operate, does not worsen compared to the assessment in this plan;
- the security in the north and north east really improves following the outcome of the peace negotiations;
- the political commitment for the Public-Private Partnership in Health is fully regained and maintained and the Sector Wide Approach is continued;
- the subsidies to the PNFP health facilities are continued at least at constant real value and include an increase to cater for the present salary gap between government and PNFP sector;
- 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 and UCMB in striving towards realisation of the RC Mission.

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 RC Mission continues to inspire them while they strive towards technical excellence;

Of these factors the highest risks are at present:

- Securing the technical expertise required to develop and implement new strategies. The assessment of the external consultants indicated that required level of expertise is rare in Uganda. If they can be found, their salary demands lie far beyond the Catholic Secretariat's level and this leads to distortions within the mother organisation. If obtained from abroad they are more expensive but less apt at causing distorting effects given their clear recognition as temporary.
- Another concern applies as well: if new high level technical experts (national or foreign) have to be recruited afresh the planned results may not prove attainable as they will need much more time to be induced in the system and get acquainted with the development so far before they can start producing the desired result.
- The gap in the budget: all the results planned correspond with the high need to develop the system and respond adequately to the current new challenges. At the start of the previous Operational Plan a similar budgetary gap existed but

all the internal and external partners agreed that the ideal plan should be pursued. Within the first year the required additional funding was found.
Thus the first key question to the Participants of the Consultation Conference is:

Do the Operational Objectives and Targets planned correspond to your assessment of what needs to be done?
Depending on the answer to this question either the missing budget has to be sought or the plan scaled down.

7.12. Feasibility and Sustainability

The overriding conclusion of all parties is that the strategic directions 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 Euro (compared to 2.9 M during 2004-2006).
The UCMB Team and Focus Group members deem this Operational Plan feasible, on condition that the identified assumptions and preconditions 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 / spokesperson 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.

Sustainability of the RC Health Institutions
With respect to sustainability: it has to be stressed that improving the sustainability of the RC health services remains the essential underlying purpose of the Strategic Plan. The explicitly chosen system strengthening approach aims, first and foremost, at improving the institutional and social sustainability. The first way to achieve this is by ensuring the RC institutions become operational parts of the national and district health system. Strengthening the cooperation and increasing the contributions of the RC services, towards the national objectives increased, allows to gradually assure institutional embedding in the system. The second way is by enabling the RC institutions to become strong organisations that can take full responsibility for their own development, performance, and role within the national health system.

Financial Sustainability: first of all it has to be stressed that the provision of health services, at a level that really contributes to reduction of poverty, cannot be financed from local revenues. In Uganda the cost of the Minimum Health Care Package is estimated at 28 USD per person / per year, excluding ART's. The present budget

reaches 9 USD per capita / per year of which more that 50% is covered by external financial support.
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 is covered by a variety of (unevenly distributed) inputs from different donors and support initiatives.
However, increasing financial sustainability through increases in user fees can only be a last resort option, if the RC institutions are to remain faithful tot their Mission.
This plan includes range of measures to enhance financial sustainability of the RC institutions. In the first place advocacy at national and district level to assure that funds that can be accessed are accessed. Secondly by improving efficiency or at least containing costs. And thirdly by facilitating access to – and optimal use of - new funds available like Global Health Initiatives and the Social Health Insurance Scheme.

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. The past years have seen a rise in the local income, mainly from the member institutions, to reach a total of 64 M USHS per year and 38% Up from 10% in 2002) of the annual cost for the core functions (168,202,000 M USHS). This certainly reflects the value the RC members attach to the services. The previous paragraph indicates that a further rise of the local contributions can hardly be expected.

UCMB tried several other ways to increase the local financial basis but these proved limited and have been curbed as well. The first were investment of reserve funds and favourable exchange rates. But now treasury bills have become less profitable and currency conversion policies less favourable.
Since 2002/03 the MOH allocated a subsidy to UCMB to facilitate coordination at central and district / diocesan level (18 Million USHS). 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 Health Units, 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.

The most supportive results could be booked by efficient use of the resources. This was largely made possible 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.
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.

ANNEX I SUMMARY OF THE BUDGET BY HEAD ITEMS (CENTRES)

EXPENDITURE

Budget Item Group - Centre attribution	Budget sub-item group	1	2	3	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	60,600	45,350	30,300	136,250
	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		**223,021**	**216,906**	**196,189**	**636,116**
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**

EXPENDITURE cont.d

Budget Item Group - Centre attribution	Budget sub-item group	1	2	3	Grand Total
E Capacity building - Scholarships	A Employment cost	9,659	9,921	10,196	29,776
	S Scholarship fund	170,000	170,000	130,000	470,000
E Capacity building - Scholarships Total		**179,659**	**179,921**	**140,196**	**499,776**
F Capacity Building - HTI&T	A Employment cost	8,557	8,790	9,033	26,380
	B Technical assistance	36,400	25,250	20,650	82,300
	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		**100,957**	**116,040**	**111,683**	**328,680**
G Research, studies and expertise	C Expertise	42,000	35,250	9,000	86,250
	V Research and studies	23,000	9,500	14,000	46,500
	W Operational Research	4,000	4,000	4,000	12,000
G Research, studies and expertise Total		**69,000**	**48,750**	**27,000**	**144,750**
H Special Programs	X Special Programs	40,000	40,000	0	80,000
H Special Programs Total		**40,000**	**40,000**	**0**	**80,000**
Y M&E - Accountability	Y Accountability	3,000	3,000	53,000	59,000
Y M&E - Accountability Total		**3,000**	**3,000**	**53,000**	**59,000**
Z 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
Z Overheads Total		**119,100**	**119,100**	**118,800**	**357,000**
ZZ Contingency	Contingency	31,000	32,000	30,000	93,000
ZZ Contingency Total		**31,000**	**32,000**	**30,000**	**93,000**
Grand Total		**1,092,287**	**1,074,448**	**954,746**	**3,121,481**

INCOME

Income centre	Income Budget item Group	Income Budget item line (origin)	1	2	3	Grand Total
A Local	AA Local Carried forward	Recoveries cfw	6,000			6,000
	AA Local Carried forward Total		6,000			6,000
	AB Local donors	GoU	6,000	6,000	6,000	18,000
		JMS	28,000	28,000	28,000	84,000
	AB Local donors Total		34,000	34,000	34,000	102,000
	AC Local Revenues	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
	AC Local Revenues Total		38,500	43,300	47,500	129,300
A Local Total			78,500	77,300	81,500	237,300
B External	BA External carried forward	AVSI	21,000			21,000
	BA External carried forward Total		21,000			21,000
	BB External transfers	Cordaid	150,000	150,000	350,000	650,000
		IICD	77,800			77,800
		PSO	400,000	351,662		751,662
		SVFOG	25,000			25,000
	BB External transfers Total		652,800	501,662	350,000	1,504,462
	BC External revenues in kind	Work in kind AVSI	18,000			18,000
	BC External revenues in kind Total		18,000			18,000
B External Total			691,800	501,662	350,000	1,543,462
Grand Total			770,300	578,962	431,500	1,780,762

ANNEX II

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.

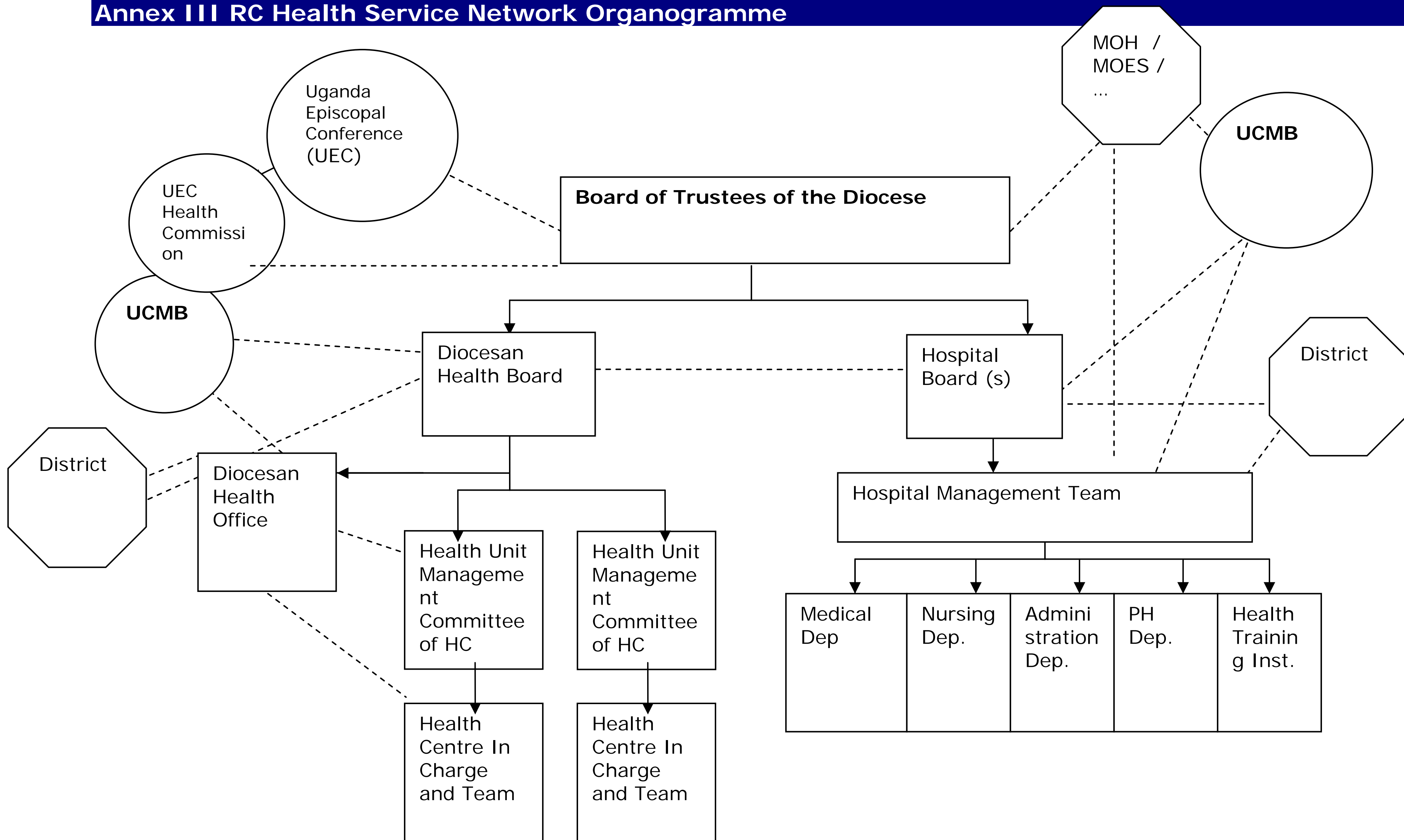
Ministry of Health and Government

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. Annual Health Sector Performance Reports 2003/04, 2004/05, 2005/06.
14. Uganda National HIV/AIDS Sero - Behavioral survey 2004/05, MOH March 2006.

Others

15. Budget ceiling and Health in Uganda, Dr. J. Odaga and Dr. P. Lochoro, WEMOS and Caritas Internationalis, January 2006,

Annex III RC Health Service Network Organogramme



ANNEX IV **RC Health Service Strategic Plan 2007 – 2011 and Operational Plan 2007 – 2009**

Flowchart

Faithfulness to the RC Mission as Stewards

Strategies:
Core functions
Representa-tion
M&E
Capacity Building:
- Tailored Training
- Technical WS
- Support supervision
- On demand hands-on support
- Exchange support
- Develop-ment of tools
- Development of leadership skills

Strategic Alliances

Staff

Internal Actors

Hospitals
HTI
DHD's

Congregations

Mgt

Board

Goals and Objectives

Improved Governance & mgt

Enhanced Partner-ships

Improved HR Development and Prof Training

Increased Sustain-ablity & Quality

Improved Advocacy

Cross cutting f.i. Enhanced Legal entities

Performance

Indicators
Services:
Quality

Management:
Access
Equity
Efficiency
Efficiency

Transpar-ency

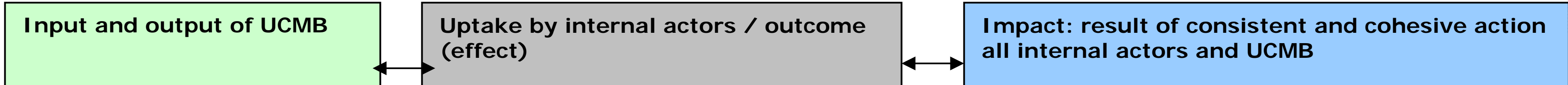
Accounta-bility

Credibility

Construc tive Relation ships

Contributing to HSSP and MDGs / Established place in national system

Favourable / Enabling internal and external environment



ANNEX V

LOGICAL FRAMEWORK

NOTA BENE

THIS DOCUMENT IS ADDED HERE
TO PROVIDE AN OVERVIEW
OF ALL THE OBJECTIVES
AND PRIMARY TARGETS.

THE INDICATORS LISTED ARE NOT YET FINAL.