GLOBAL HEALTH NETWORK UGANDA

GHN (U)

Five (5) Year Strategic Plan

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The Global Health Network (Uganda),
Makerere University Kampala,
School of Pharmacy Building
P.O Box 1131, Kampala
E-mail: ghn@webmail.org
Homepage: http://www.ghnu.org/

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Glossary of acronyms and abbreviations used

WHO	World Health Organization
GHN	Global Health Network
PHC	Primary Health Care
WB	World Bank
HIV	Human Immune Virus
AIDS	Acquired immune deficiency syndrome
IDP	Internally Displaced Persons
UNICEF	The United Nations Children's Fund
MDGs	Millennium Development Goals
TB	Tuberculosis
MCH	Maternal and Child Health
EPI	Expanded Programme on Immunisation
NRM	National Resistance Movement
MoH	Ministry of Health
NGO	Non-Governmental Organization
PLWAs	Persons Living with Aids
PWDs	Persons with Disabilities
GoU	Government of Uganda
PDCs	Parish Development Committees
FP & RH	Family Planning & Reproductive Health
PRA	Participatory Rural Appraisal
HC	Health Centres
LGs	Local Governments
M&E	Monitoring and Evaluation
SDPs	Service Delivery Points
ITNs	Insecticides Treated Nets
Wash	Water, sanitation and Hygiene

Executive Summary:

HIV, Malaria, diarrhea, Malnutrition and maternal health continue to be a major causes of morbidity and mortality in Uganda; annually more than 65 million cases of fevers associated with malaria are recorded, and yet only 28% of people especially women who seek antenatal care in Uganda, have their blood sample taken for further diagnosis. Nationally, the HIV/AIDS prevalence stands at 6.4%, compared to 18% fifteen years ago. In spite of the initial successes, it now appears that the prevalence rates have stagnated over the past five years. The stagnation presents a growing concern to our public health intervention strategies.

The Northern Uganda public health crisis has been aggravated by the long civil conflict, resulting in a situation of hopelessness, where the majority has no access to clean water, access to medical supplies and facilities are a thing for the privileged! As a consequence, primary health care programming in the North and East has been characterized by uncoordinated and insufficient prevention services, resource inequity and inadequacy, poor access or lack of health services, uneven distribution of treatment and referral services, social cultural disruptions, high illiteracy, powerlessness, poverty and desperation. These forces have merged as potent factors enhancing morbidity and thus mortality levels. Acholi and Lango sub regions contained more than 200 IDP camps, hosting more than 1.5 million people during the conflict. IDP camps became a single most important factor contributing to high mortality and high disease burdens for populations in Northern and Eastern Uganda. For instance, it is estimated that mortality rate due to malaria is 50%, making it the biggest killer in the region.

For this reason, GHN has designed an innovative community driven intervention strategy, focused at revitalizing primary health care as the best tool to avert HIV transmissions, and improve Malaria and Reproductive Health management services, water, sanitation and hygiene situation and Alleviating socio economic and social cultural impact caused by insecurity, conflict and powerlessness in Northern and Northern eastern Uganda.

The closure of IDP camps was critical for achieving the GHN goals. As the resettlement process takes root, it is fundamental that the population is holistically rehabilitated, re-empowered and re-integrated into the overall national and global community.

1.0 Introduction & Background

1.1 Global Situational analysis

In 1978, at the Alma-Ata Conference, ministers from 134 countries in association with WHO and UNICEF called for 'Health for All by the Year 2000' and selected Primary Health Care as the best tool to achieve it. Thirty years after the 1978 Declaration of Alma-Ata, it seems the world is still at odds on how best to implement the principles of primary health care. The slow progress in improving health outcomes for all raises questions about the effectiveness of current ways of doing business. Even before the ink could dry on the Alma-Ata declarations it had however already generated polarised antagonism. From a capitalist standpoint, it was a ridiculous proposition, both too costly and defying economic reasoning, and too socialist in its excessive emphasis on state-managed intervention. The conservative duo of J.A. Walsh and K.S. Warren launched the Selective PHC debate, arguing that it would probably more be efficient to save children and limit population growth, while the two main PHC proponents, WHO and UNICEF, soon drifted apart, with UNICEF promoting a selective package of low cost interventions. With resource flows following Selective PHC, Primary Health Care translated in most countries into a basic collection of services to be delivered at district and community levels based on a select number of interventions with some outreach services, with an accompanying watered-down district health package.

This approach has since had wide global appeal. Currently there are over thirty WHO resolutions on AIDS, TB or Malaria alone; more than all other subjects. The Millennium Development Goals (MDGs) have further entrenched this disease-specific approach to resource mobilisation. There are over 80 major global health initiatives linked to the health MDGs, providing over US$100 million annually. The Italian Global Health Watch reported in 2008 that the Global Fund has allocated approximately US$3.5 billion to countries for interventions on AIDS, TB and Malaria, mainly in Africa. Together, these initiatives have thrown billions of dollars at addressing diseases and improving clinical health conditions and made up a significant part of health sector budgets.

PHC is hardly mentioned in these initiatives, seldom highlighted by member states outside of anniversaries of the initiatives or occasional references to district health system strengthening. For various reasons the world assumed an emergency mode to address what are considered new and urgent public health issues. Single disease interventions that lend themselves to easily recognisable financial accountability, quantitative monitoring and evaluation held greater appeal for funders, especially when twinned with arguments of weak domestic governance and public policy failures and capacity limitations. While these initiatives on clinical determinants hummed with measurable outcomes on specific diseases, the nexus of poverty and ill health was exacerbated. On the back of a growing trend in urban slum development, decline in state services, market failures in privatised economies, growing food insecurity and massive deprivation of rights to health care, inequalities in health have deepened to a significantly greater level over the past 30 years.

While a lot has been done to deal with disease in individuals, the unique opportunity provided by the Alma-Ata Declaration to also address the determinants of health have largely been lost. Thirty years later we see the costs of this omission in levels of poverty which belie the levels of knowledge and technological advance achieved globally. As we walk through another anniversary for PHC, expectations are high. People expect that their physical and mental health will be promoted in a safe social, economic and political environment. They expect to have quality health systems that provide preventive services, and which diagnose, treat and manage disease injury and reduce the severity and repeated occurrence of disease. They do not expect to see wide social and economic disparities in these basic entitlements. In Africa, the region furthest from delivery on these expectations, the Ouagadougou declaration on Primary Health Care issued on April 30 2008 called for a renewal of the

Principles of Primary Health Care and its implementation in developing countries and by the international community.

1.2 National situational analysis

Uganda is a sub-Saharan country of 30 million people, with 85 percent of the population living in rural areas. Just like most countries in sub-Saharan Africa, it adopted PHC as the focus of health system development. Its implementation, however, was hampered in the early 1980's by continued bad governance and civil strife. By 1986, the health system was in a shambles. With the failure of the public system to provide for the health care needs of the population, private providers had easily entered the health care market with associated inequities and inequalities of all sorts, with a resultant lack of recognisable PHC activities.

Uganda as a country did not perform to expectation in implementing the PHC objectives, goals and strategies agreed on in Alma Ata in 1978. With the advent of the NRM government in 1986, a process of reconstruction and rapid development was started. The government had an opportunity to start planning for the country on a new platform. In 1986, the Expanded Programme on Immunisation (EPI) was relaunched; the Maternal and Child Health (MCH) programme, Family Planning and the AIDS control programmes were also introduced. The early 1990's were further characterized by the implementation of the health sector reforms. Central to these were decentralization, and the Structural Adjustment Programmes that urged government to reduce its responsibility for paying for social services, such as health, that produce few benefits to the society as a whole. This was aimed to free resources so that more could be spent on the 'poor'.

The decentralization process on the other hand had started in 1986 with power decentralization through 'resistance councils', and was reinforced as a government policy for effective service delivery in the 1995 constitution. The Local Government Act, which put into effect the provisions of the constitution, was passed in 1997 and substantially devolved powers previously exercised by the central government to the district local authorities. The Ministry of Local Government was made the key intermediary between Local Authorities and the Central Government. The decentralised system is based on the district as a unit, under which are lower local governments and administrative units. The care delivery health system was designed along this decentralised public system, with a corresponding health unit level for each level of local government or administrative unit. There was a resultant multi-layered health care system from Health Centre I – IV as lower level units, with a district hospital for each district.

Unfortunately, that dream (Health for all) never came true. The health status of Ugandan populations has not improved. In many cases it has deteriorated further. Currently, we are facing a national health crisis, characterised by growing inequalities within and between districts. New threats to health are continually emerging. This is compounded by negative forces of market place scenario, which prevent the equitable distribution of resources necessary for people's health, particularly the poor.
Within the health sector, failure to implement the principles of primary health care, as set out in the Alma-Ata declaration, has significantly aggravated the national health crisis. Governments and the international community are fully responsible for this failure.

It is now essential to build a concerted national and international effort to put the goal of 'Health for All' in its rightful place on the development agenda. Genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

1.3 Northern & Eastern Uganda situational analysis

In the Acholi, Lango and Teso sub regions, the morbidity levels have grossly increased. For example, HIV/AIDS is reported to outweigh death due to conflict. HIV prevalence (8.3%) is higher than national average (6.4%) and more than doubles the rates of surrounding regions. Prevalence is higher among women (9.2%) than men (7.1%). The HIV/AIDS situation in the north is characterized by poor access, uneven distribution, and poorly linked care and prevention strategies, inadequate treatment and referral services. Services are limited to municipalities and villages closest to towns. Malaria is endemic in 95% of Uganda. The remaining 5% of malaria transmission lies in the highlands of the South West and East, which are epidemic-prone. Malaria is the leading cause of morbidity and mortality, accounting for 39% of out patient's visits at health facilities, 35% of all hospital admissions and 14% of all hospital deaths. Nearly half of hospital in-patient deaths were to children under 5. Current estimated annual numbers of deaths from malaria range from 70,000 to 100,000. Cases of malaria have been increasing in recent years, with fever cases in 2004 estimated to be 65 million. Malaria mortality is very high in the North and Eastern part of the country, especially among children less than 5 years. A study conducted by WHO, MoH and Partners in July 2005 surveyed 3 districts in the North and showed malaria mortality ranging between 42.9% and 52.5%, making malaria the single most important cause of childhood mortality in the IDP camps. There is no documented success story for malaria prevention/control in these areas but there are opportunities for intervention to improve the health of the communities in general and Malaria control in particular. The picture for reproductive health is even gloomier as only 30% of women in the entire north have access to reproductive health facilities-according to Uganda demographic health 2006. A number of programs supporting the delivery of HIV/AIDS, TB and malaria services, and reproductive health, in the Acholi and Lango sub regions, are limited in geographical scope and have been situated closer to municipalities and main roads. Overall support has remained fragmented.

1.4 Origin of GHN

GHN is an indigenous Charity Non-governmental organisation, initiated by a network of Ugandan scientists with a shared vision and goal, after a realisation of the critical and strategic need for reshaping Primary Health Care approach in developing countries to best meet the most vulnerable population's health needs, more especially during a time when health systems are in crisis. GHN to-date, has participated in a number of international health advocacy, the latest of which was the Copenhagen climate change negotiations; highlighting the gruesome impacts of global warming to the health of most poor populations most of whom live in Sub-Saharan Africa. GHN is currently in the process of registration with the NGO Board as a Non-governmental Organisation and plans to start its operation in 10 districts in North and Eastern regions of Uganda, with worst health indicators, however commencing with 4 districts during the first 3 years and rolling over to the remaining districts in the preceding years.

The Global Health Network (GHN) has its roots deep in the most vulnerable populations in Uganda and owes its genesis to many health networks and activists who have been concerned by the growing inequities in health over the last 25 years. The GHN calls for a revitalization of the principles of the Alma-Ata Declaration which promised Health for All by the year 2000 and complete revision of international and domestic policy that has shown to impact negatively on health status and systems.

1.5 Headquarters and geographical scope

The headquarters of GHN will be situated in Kampala, and it plans to operate in the 10 districts of North and Eastern Uganda, within the first 5 years. This includes; Amuru, Pader, Oyam, Apac, Amolatar, Dokolo, Kaberamaido, Katakwi, Amuria, and Budaka. However, based on the prevailing situation and resources, GHN plans to start with 4 districts of Budaka, Dokolo, Apac and Oyam in the first 3 years of project implementation and slowly expand to cover the rest of the districts, especially districts that continue to show negative health indicators.

1.6 GHN Vision

GHN envisions a society in which a healthy life is a reality; a society that appreciates, respects and celebrates all life and diversity; a society that encourages and supports local talents and abilities; a society where the rights of people guide the policy and decisions that impact on our lives.

1.7 Mission Statement

To promote, protect and preserve the health of all Ugandans through good leadership, public, private partnership, innovation and concerted action in Primary Health Care and Reproductive Health.

1.8 Broad Principles of GHN

The structure, roles and responsibilities of GHN are based on the following principles:

- Active and intensive community participation in project identification prioritization, implementation and management
- Community contribution to the development effort
- Gender responsiveness
- Transparency and accountability to reduce corruption
- Re-inforce community self-reliance and indigenous knowledge utilization
- Non political interference
- Targeted interventions
- Evidence based practice
- Public Private Partnerships
- Utilizing existing institutions and strengthening the decentralization process.

2.0 Approach and Strategy

GHN's approach is working with rural communities and stakeholders to achieve 'health for all'. Communities are the primary target of any development initiative. The organization will collaborate and network with the local governments, local NGO's, academic institutions, research institutes, donor agencies and the private sector to build on the synergies that exist so as to maximise the utilization of the limited resources for maximum output and benefit for the targeted population.

2.1 Organisation objectives

The organisational objectives are eight-fold:

(a) Strengthen community participation, leadership development and encourage reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by advocating for universal access and social health protection.
(b) To promote the Health for All goal through an equitable, participatory and inter-sectoral strategy and as a Rights Issue.
(c) Initiate, promote, and advocate reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors.
(d) To participate in health services reform; around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world.
(e) To promote health along with equity and sustainable development as top priorities in local, national and international policymaking.
(f) To encourage people to develop their own solutions to local health problems.
(g) Facilitate ongoing relationships between patients and clinicians, within which patients participate in decision-making about their health and health care.
(h) Provide professional services in baseline studies, performance evaluations, market research and program designs.

2.2 Organisation analysis

Institutional Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

Strengths	**Weaknesses**
• Availability of qualified, committed and diligent staff & Board of Trustees • Existence of an established structure for planning, monitoring & supervision and administration • Community based approach to development • Availability of basic office space & equipments • Established collaboration and networking links with partners • Clear organisation policies on personnel, financial management and assets management	• Limited financial resources • Lack of an established management information system • Inadequate office space • Inadequate office equipment • Lack of clear understanding of roles among some key stakeholders • Over dependence on donors
Opportunities	**Threats**
• Good will of the current donors • Favourable policy environment for public/private/NGO sector partnership • Local initiatives/indigenous knowledge • The trend of increased awareness among the population and the need for targeted interventions at all levels including the community	• Donor fatigue & unfavourable donor conditional ties • Community complacency with traditional practices and living conditions

Challenges:

Institutional challenges

Technical capacity

- ♦ Provision of adequate office and field equipment
- ♦ Provision of adequate office space
- ♦ Recruitment and retention of qualified staff
- ♦ Ensuring continuous capacity building for Staff and Board of Trustees members
- ♦ Strengthening management information system
- ♦ Institutionalising monitoring and evaluation

Financial capacity

- ♦ Diversifying sources of funds
- ♦ Achieving financial self-sustainability

Management and administrative capacity

- ♦ Development and implementation of Organisation policies on personnel, finance and assets management

Partnership and collaboration challenges

- Acquiring and maintaining genuine partnerships

Beneficiary level challenges

- Expanding out-reach and meeting the diverse potential beneficiary needs
- Strengthening downward accountability and feedback mechanisms
- Increasing participation of the most disadvantaged sections of the population (e.g. PLWAs, PWDs, Orphans etc)

3.0 AREAS OF TECHNICAL INTERVENTION

Within the next 5 years, GHN's specific technical interventions will cover:

- Social and behavioural change/ research
- Water and Sanitation
- Reproductive Health
- Healthcare services
- Leadership, partnership and coordination
- Institutional capacity building
- Monitoring and Evaluation.

4.0 MANAGERIAL STRATEGIES

- Promotion of interagency collaboration and networking
- Intensive community participation in planning, implementation and monitoring and evaluation of development initiatives
- Capacity building: fostering individual, collective and institutional efficacy
- Community based approach with effective feedback mechanism
- Incentive based intervention: e.g. good sanitation practices rewarded with safe water source
- Integrated and multi-sectoral approach

4.1 Operational Strategies

The primary goal of the GHN PHC Strategy is to assist Government of Uganda (GoU) sector agencies contribute to wider endeavours by working cooperatively to prevent the further spread of diseases and promote support for those already infected. GHN support to the response in PHC will be based on the National Strategic Plan on PHC. The GHN identifies six focus areas for implementation over the lifespan of the strategy. A National Gender Policy and implementation plan developed as part of the GHN strategy identifies measures to integrate gender within each of the six focus areas.

- Water and Sanitation
- Social and behavioural change
- Reproductive Health
- Healthcare services
- Leadership, partnership and coordination
- Monitoring and Evaluation.

I. WATER, SANITATION AND HYGIENE	
Priority Area	Key Strategies
1. Community sensitisation	♦ Increased advocacy for sanitation and good hygiene practices ♦ Use of community based social workers ♦ Collaboration with relevant development agencies
2. Provision of safe water sources	♦ Improvement of existing water sources ♦ Establishment of new water sources ♦ Use of an incentive/reward scheme ties provision of water sources to ability of the community maintain good sanitation and hygiene practices
3. Strengthening community based structures	♦ Establishing Wash committees ♦ Training and equipping community based pump mechanics ♦ Build capacities of PDCs to plan and manage water and sanitation initiatives

II. SOCIAL BEHAVIOURAL CHANGE	
Priority Area	Key Strategies
1. Community sensitization	♦ Increased advocacy for best hygiene and disease prevention practises ♦ Use of community based social workers and village health teams ♦ Promotion of participatory approaches to enhance ownership
2. Education	♦ Training of community based social agents ♦ Development of informative materials ♦ Use of incentive schemes to motivate best health practices ♦ Collaboration and partnership with all stakeholders
3. Communication	♦ Creation of drama groups, traditional plays, skits ♦ Develop posters, flyers, charts etc ♦ Electronic and print media use

III. REPRODUCTIVE HEALTH	
Priority Area	Key Strategies
1. Advocacy	♦ Increased awareness about FP & RH ♦ Lobby for conducive national policies on FP & RH
2. Materials	♦ Produce electronic and print materials to aid effective communication ♦ create traditional drama groups and plays
3. Contraceptives	♦ Provision of contraceptive supplies
4. Logistics	♦ Service providers trained in RH and FP ♦ Provide counselling services to clients on FP &RH ♦ Provision of FP facilities/ units/ referral facilities

IV. HEALTH CARE SERVICES	
Priority Area	Key Strategies
1. Primary health care awareness raising	♦ Establish local music, dance and drama groups on primary health care ♦ Establish school outreach programmes for primary health care sensitisation
2. Support of Construction of HC IIs	♦ Facilitate PRA in communities and lobby for funding of community action plans generated
4. First aid training for youth	♦ Identify , train and equip youths to offer community based first aid services community

V. Leadership, Partnership and Coordination

Strengthening leadership, partnership and coordination at all levels is a key priority of GHN's response to PHC. Stronger leadership has been identified as vital for mobilising resources that the country needs in scaling up the response. Leadership is required to ensure PHC issues are articulated and included in all Government policies, strategies and plans. It is required to assist and galvanise community support.

Strategic Objective 1
To enhance leadership role and support for PHC response within GoU line ministry, district local governments and community level.

Output 1:
Increase the level of understanding and awareness of PHC issues amongst local governments and communities.

Activities:
- ♦ Review planning and implementation in order to identify the impact activities have in relation to PHC and the opportunities presented to reduce and prevent disease transmission
- ♦ Facilitate PHC training and learning opportunities
- ♦ Develop and disseminate information and materials on PHC
- ♦ Facilitate the participation of leaders in high level PHC for a
- ♦ Facilitate regular panel discussions and debates on PHC.

Output 2:
To strengthen accountability for PHC response within the local governments and community sector agencies

Activities:
- ♦ Support management implementing and reporting on specific PHC interventions within their departments.

Strategic Objective 2
To build capacity of local governments to integrate PHC into sector policies, strategies and plans.

Output 3:
To support LGs to develop and apply specific guidelines for integrating PHC interventions into their annual planning and budgeting processes

Activities:
- Review existing annual planning and budgeting processes to identify appropriate entry points for PHC responses
- Provide ongoing support to the LGs line sectors in applying guidelines for the annual planning process.
- Train key staff on the processes and procedures required in mainstreaming PHC responses.

Strategic Objective 3
To strengthen mechanism for collaboration and coordination of sector response to PHC at local and national level.

Output 4:
Establish and strengthen mechanisms for inter agency collaboration for a coordinated response within the health sector

Activity:
- Establish and strengthen inter agency PHC committee at the national and local level to foster collaboration and coordination in sector response.

Output 5:
Support LGs to establish links with national agencies and other strategic partners at the national level.

Activities:
- Facilitate regular dialogue between any PHC sector committees and National PHC committees
- Advocate for representation of a PHC sector representative on national health sector Committee.

TECHNICAL DOMAINS AND ILLUSTRATIVE KEY OUTPUTS

NO	Domain	Illustrative outputs
1	Water, sanitation and hygiene	♦ New water sources established ♦ Water sources rehabilitated ♦ Wish committees formed and trained ♦ Pump mechanics trained and equipped ♦ Sanitation facilities established ♦ Persons sensitised on sanitation and hygiene ♦ PDCs trained in planning, provision and management of safe water facilities
2	Social behavioural change	♦ Increase in Pit Latrine coverage, hand washing facility coverage, etc ♦ Communities adopting new sanitation and hygiene practices.
3	Reproductive Health	♦ Percentage of health personnel trained in midwifery ♦ Percentage of public sector expenditures on contraceptive commodities ♦ Percentage of service delivery points offering at least 2 methods of family planning. ♦ Percentage of service delivery points (SDPs) which routinely screen and provide referral for infertility ♦ Percentage of trainees provided with knowledge and skills on RH in a given year
4	Healthcare services	♦ Health promotion Music, dance and drama groups formed ♦ Support offered to home based HIV-AIDS and Malaria care providers ♦ Persons sensitised through public health outreach programmes ♦ Youth trained and equipped to provide first aid services in the community ♦ Number of individuals reached through community outreaches promoting hygiene, sanitation, abstinence, faithfulness and or use of condoms ♦ Number of households reached through community outreaches promoting primary health care activities ♦ Number of peer educators/individuals trained as trainers to promote PHC strategy. ♦ Number of households distributed Insecticide treated nets (ITNs) ♦ Number of households distributed malaria HOMAPAK kits ♦ Number of community health workers trained on HIV/TB/malaria prevention, as well as in WASH initiatives

5.0 MONITORING AND EVALUATION FRAMEWORK

GHN Monitoring and Evaluation (M&E) Framework will be separate document that shall be developed through a consultative process of interactions with stakeholders. Its main focus will be on increasing the utilisation, improving the quality, and strengthening the National Health system service delivery. Process, input, output and impact indicators will be developed to facilitate M&E process.

The major purposes of the M & E are to:

- Measure and report progress and performance in achieving the intermediate results
- Contribute to a culture of information use for planning, decision-making, and program improvement by making dialogue and feedback integral systems of M&E; and
- Provide evidence-based platform for discussions and advocacy

6.0 SUSTAINABILITY PLAN

GHN plans to undertake a number of activities to raise resources to sustain the program activities, besides seeking for donor support. This will include feasibility studies, baseline surveys, institutional development/capacity building, consultancy assignments and research activities.

7.0 RISKS

Risks	Implications	Mitigation strategies
Loss of community support for development programmes	Poor community participation in planning and management of development affairs Inadequate community contribution to community projects	Maintain strong contacts with the communities and strengthen community structures Improve community feedback mechanism and accountability
Changing Donor policy on provision of support to development programmes	Inadequate funds for implementation of planned activities and facilitation of development workers	Encourage local communities to provide community contribution (i.e. in kind) to development programmes
Shortage of skilled personnel	Delays in realising outputs Poor absorption of funds secured	Invest in leadership development skills Strengthen collaboration and networking with relevant partners
Sharp changes in Government policies	Time lost in adjusting to new a policy environment leading to delay in realising results	Evolve flexible implementation strategies Initiate negotiation forums for discussion of unfavourable policies

8.0 GHN Implementation Plan, Provisional Activities and Performance Indicators

A draft three-year Implementation Plan has been developed to assist GHN prepare implementation plans for the respective policies and strategies. It is anticipated that this Plan will be reviewed and updated by GHN on an annual basis, on advice from respective components.

GHN Strategy: Implementation Plan 2010-2012													
Objective	**2010**				**2011**				**2012**				**Performance indicators**
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	
Water, Sanitation and Hygiene **Strategic objective:** ***To promote hygiene practices among the community to enhance healthy living***													
Output 1: New water sources established													
Output 2: Water sources rehabilitated													
Output 3: Sanitation facilities established													
Output 4: Persons sensitised on sanitation and hygiene													
Output 5: PDCs trained in planning, provision and management of safe water facilities													
Output 6: Wish committees formed and trained													
Reproductive Health **Strategic Objective:** ***Enhance access to Reproductive Health information, services and products through comprehensive information, education and communication strategies, to 3,000,000 clients from the current 1.4million***													
Output 1: Increased awareness about FP & RH													
Output 2:Lobby for conducive national policies on FP & RH													

Output 3: Increased Provision of contraceptive supplies													
Output 4: Increased % of service delivery points (SDPs) which routinely screen and provide referral for infertility													
Output 5: Increased % of trainees provided with knowledge and skills on RH in a given year													
Healthcare services **Strategic objective:** ***Avert acquisition and transmission of new disease infections, through the promotion of an intensive awareness and education campaign programs.***													
Output 1: Established local music, dance and drama groups On primary health care													
Output 2: Established school outreach programmes for primary health care sensitisation													
Social behavioural change **Strategic objective:**													
Output 1:													
Output 2:													
Leadership, Partnership and Coordination **Strategic objective 1:** ***To enhance leadership role & support for PHC response within GoU line ministry, district local governments & community level***													
Output 1: Increase the level of understanding & awareness of PHC issues amongst local governments and communities.													
Output 2: To strengthen accountability for PHC response within the local governments and community sector agencies.													
Strategic Objective 2: ***To build capacity of local governments to integrate PHC into sector policies, strategies and plans.***													
Output 3: To support LGs to develop and apply specific guidelines for integrating PHC interventions into their annual planning and budgeting													

processes													
Strategic Objective 3: ***To strengthen mechanism for collaboration and coordination of sector response to PHC at local and national level.***													
Output 4: Establish and strengthen mechanisms for inter agency collaboration for a coordinated response within the health sector													
Output 5: Support LGs to establish links with national agencies and other strategic partners at the national level.													

9.0 CONCLUSION

This 5-year strategic plan has been prepared taking into account the Government of Uganda, GHN and target beneficiaries' development priorities. The activities provided herein may be adjusted depending on availability of resources. This document is subject to review and changes as warranted and negotiated with partners and stakeholders.

Annexure to be appended…….

Table of contents

List of abbreviations/acronyms to be included……..

Not to be quoted or cited for any purpose until approval by Board of Directors