THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

THE ROADMAP FOR HEALTH SERVICES AND SYSTEMS INTEGRATION IN UGANDA

November 2025

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MINISTRY OF HEALTH

UGANDA

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FOREWORD

The Government of Uganda remains firmly committed to building a resilient, efficient, and people-centred health system that guarantees universal access to quality health care for all Ugandans. Over the past decades, Uganda has made remarkable strides in expanding access to essential services, reducing the burden of communicable diseases, and improving maternal and child health outcomes. However, these gains have been challenged by persistent fragmentation in the way health services are organised, financed, and delivered. This fragmentation has often resulted in inefficiencies, duplication, and inequitable service delivery—undermining progress toward Universal Health Coverage (UHC).

The *Integration Roadmap for Health Services and Systems in Uganda* provides a strategic framework to guide the country's transition from fragmented, program-specific service delivery to a unified and integrated health system. It aligns with the aspirations of the National Development Plan (NDP III), the Health Sector Development Plan, and the commitments under the Lusaka Agenda on Health System Transformation. The Roadmap articulates a clear pathway for coordinated, phased implementation—starting with system stabilisation, through consolidation for efficiency, and culminating in full institutionalisation of integrated service delivery.

This Roadmap is the product of collaborative effort among the Ministry of Health, academic and research institutions, development partners, and civil society organisations. It builds on lessons from Uganda's longstanding Primary Health Care (PHC) approach and the renewed emphasis on joined-up action across sectors. The framework presented herein emphasises distributed leadership, community engagement, and sustainable financing—principles that are essential to achieving equitable, efficient, and resilient health systems.

The Ministry of Health commends all stakeholders who contributed to this important work. Implementation of this Roadmap will require sustained collaboration, innovation, and accountability at every level of the health system. Together, we can ensure that integration becomes not only a guiding principle but a lived reality for all Ugandans.

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ACKNOWLEDGEMENT

The development of the *Integration Roadmap for Health Services and Systems in Uganda* was made possible through the collective effort of many individuals and institutions whose contributions are gratefully acknowledged.

The Ministry of Health extends special appreciation to the National Advisory Committee on Integration (NACI) for providing strategic guidance throughout the process, and to the Directorate of Planning and Development, the Department of Health Services, and the Health Policy Advisory Committee (HPAC) for their technical leadership and coordination. We are particularly grateful to Prof. Freddie Ssengooba and Dr. Aloysius Ssennyonjo from the *Department of Health Policy, Planning and Management (HPPM), Makerere University School of Public Health (MakSPH)* for leading the analytical work and drafting the Roadmap. Their expertise and dedication have been instrumental in shaping a practical and evidence-driven framework for Uganda.

We acknowledge with deep gratitude the technical and financial support provided by our development partners, including the World Health Organization (WHO), UNICEF, USAID, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United Kingdom Government through the Foreign, Commonwealth & Development Office (FCDO) and the Clinton Health Access Initiative (CHAI), whose contributions ensured that this process remained consultative, data-driven, and aligned with global best practices. Our appreciation also goes to the members of the Integration Taskforce, district health teams, civil society representatives, and private-sector actors who shared valuable insights during consultations and validation workshops. Their field experiences provided the practical grounding that makes this Roadmap relevant and implementable.

Finally, we extend sincere thanks to all Ugandans—health workers, community leaders, and service users—whose daily commitment to health and well-being continues to inspire the transformation of our health system. Their resilience remains the foundation upon which successful integration will be built.

Dr. Charles Olaro

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ABBREVIATIONS

ART	Antiretroviral Therapy
CAO	Chief Administrative Officer
CHW(s)	Community Health Worker(s)
CPE	Cross-Programmatic Efficiency
CSO(s)	Civil Society Organization(s)
DAH	Development Assistance for Health
DHT	District Health Team
DHIS2	District Health Information System, Version 2
EMR	Electronic Medical Record
FPP(s)	For-Profit Provider(s)
GHIs	Global Health Initiatives
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRIS	Human Resource Information System
HPAC	Health Policy Advisory Committee
HPPM	Health Policy Planning and Management (MakSPH Department)
HSSI	Health Services and Systems Integration
HTA	Health Technology Assessment
ICCM / iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
JMS	Joint Medical Stores
LMICs	Low- and Middle-Income Countries
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MEL	Monitoring, Evaluation, and Learning
MOF / MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
NACI	National Advisory Committee on Integration
NCD(s)	Non-Communicable Disease(s)
NGO(s)	Non-Governmental Organization(s)
NMS	National Medical Stores
NTRL	National Tuberculosis Reference Laboratory
OBT	Output-Based Tool (Budgeting Framework)
OPM	Office of the Prime Minister
PHC	Primary Health Care
PLWA / PLHA	People Living With HIV/AIDS

PNFP(s)	Private Not-for-Profit (health providers)
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PPPH	Public–Private Partnership for Health
QIs	Quality Indicators
HSIMF	Service Integration Maturity Framework (also referred to as Health System Integration Maturity Framework)
SPHC	Selective Primary Health Care
SWAp	Sector-Wide Approach
TB	Tuberculosis
TWG(s)	Technical Working Group(s)
UHC	Universal Health Coverage
UVRI	Uganda Virus Research Institute
VHT(s)	Village Health Team(s)
WHO	World Health Organization

EXECUTIVE SUMMARY

Over the past two decades, Uganda's health system has made substantial progress in expanding access to essential health services and reducing the burden of communicable diseases. The country's achievements in immunisation, maternal and child health, HIV, tuberculosis, and malaria reflect strong national commitment, effective partnerships, and community engagement. However, these gains have not been uniform or fully sustained. Persistent fragmentation in the organisation, financing, and delivery of services continues to undermine efficiency, equity, and progress toward Universal Health Coverage (UHC).

This fragmentation is driven by multiple factors: the proliferation of vertical, disease-specific programmes largely influenced by donor funding models; parallel systems for supply chain management, human resource deployment, and data reporting; and limited alignment between external support and national priorities. While these vertical programmes have achieved measurable disease control outcomes, they often operate outside a unified national framework, duplicating efforts and increasing transaction costs. When external funding shifts, many of these initiatives diminish or collapse, exposing gaps in sustainability.

To address these challenges, the Integration Roadmap for Health Services and Systems in Uganda (2025–2030) provides a coherent, evidence-based framework to guide the country's transition from fragmented to integrated, people-centred, and resilient health service delivery. The Roadmap builds on Uganda's strong legacy of Primary Health Care (PHC), the Sector-Wide Approach (SWAp), and ongoing decentralisation reforms, aligning with global commitments such as the WHO Framework on Integrated, People-Centred Health Services (2016) and the Lusaka Agenda on Health System Transformation (2023).

- **Vision:** The Roadmap envisions "a unified health system that delivers comprehensive, equitable, efficient, and sustainable care for all Ugandans."
- **Goal:** Its overall goal is to accelerate progress towards Universal Health Coverage and health security through a phased and structured approach to service and system integration.

Strategic Approach and Phasing

Recognising the complexity and diversity of Uganda's health system, the Roadmap proposes a three-phase approach to integration, enabling gradual, adaptive, and context-specific implementation:

1. **Phase I – Stabilisation:** Focused on maintaining essential service continuity in the face of funding transitions. Priority actions include safeguarding the delivery of essential medicines and supplies, protecting and retaining the critical health workforce, rationalising partner support, and ensuring continuity of key services while integration mechanisms are established.

2. **Phase II – Consolidation:** Aimed at enhancing efficiency, coordination, and quality of services. This involves standardising care pathways, developing multidisciplinary service delivery models, harmonising data and information systems, strengthening district-level planning and supervision, and fostering cross-programme collaboration to reduce duplication and waste.
3. **Phase III – Transformation:** Focused on institutionalising integration within governance, financing, and accountability frameworks. Actions include embedding integration principles in national policies and sector plans, establishing formal structures for integrated governance, aligning budgets to pooled or on-budget financing, strengthening supply chain and information system interoperability, and embedding integration competencies in workforce development and performance management systems.

Key Enablers of Integration

Integration requires systematic and coordinated action across seven interdependent enablers, each reinforcing the others:

- **Service Delivery Design:** Promoting continuity, coordination, and people-centred care across health programmes and platforms.
- **Supply Chain Integration:** Ensuring the continuous availability of medicines, diagnostics, and essential commodities through harmonised forecasting, procurement, and distribution.
- **Leadership, Policy, and Governance:** Establishing clear direction, regulatory alignment, and accountability for integrated planning and implementation.
- **Community Engagement:** Strengthening co-production of care, supporting self-care, and addressing social and behavioural determinants of health.
- **Health Workforce Development:** Building adequate numbers, competencies, and incentives for integrated, team-based service delivery.
- **Sustainable Financing:** Aligning domestic and external resources to support integration priorities and reduce reliance on fragmented donor streams.
- **Integrated Information Systems:** Promoting interoperability, standardised indicators, and use of data for joint monitoring, review, and decision-making.

Progress in one area is contingent on reinforcement from others—underscoring the need for a holistic, system-wide approach to change.

Multi-Level and Joined-Up Implementation

Effective integration requires coordinated action at three interconnected levels:

- **Macro (National Level):** Policy direction, financing reforms, and governance mechanisms that align all actors under a common integration agenda.

- **Meso (District/Sub-National Level):** Translation of national policies into operational plans, harmonisation of partner support, and resource allocation to integrated service delivery.
- **Micro (Facility and Community Level):** Delivery of comprehensive, person-centred services through PHC, community systems, and partnerships with private and civil society actors.

A joined-up, whole-of-system approach will bring together ministries, development partners, the private sector, civil society, and communities under shared accountability. The Roadmap promotes distributed leadership and co-ownership, ensuring alignment, sustainability, and continuous learning across all levels.

Expected Outcomes

Implementation of this Roadmap is expected to result in:

- A resilient and efficient health system capable of delivering continuous, equitable, and high-quality services across the life course.
- Optimised service platforms that reduce duplication, improve coordination, and expand access to integrated, people-centred care.
- Strengthened district health systems with enhanced planning, resource management, and accountability.
- Institutionalised integration, embedded in national policies, governance structures, financing frameworks, and workforce systems.
- Accelerated progress toward UHC, health security, and the SDGs through more coherent and efficient use of resources.

Conclusion

Uganda's long-standing commitment to PHC and sector-wide planning provides a strong foundation for integration. This Roadmap consolidates those efforts into a unified, phased, and adaptive framework that links service delivery, governance, financing, and community engagement. By building on existing structures and aligning the actions of government, partners, and communities, Uganda will move closer to achieving a truly integrated health system—one that is people-centred, equitable, efficient, and sustainable.

1 INTRODUCTION

1.1. BACKGROUND

Health system integration is pivotal for improving healthcare efficiency, patient outcomes, and sustainability, especially in contexts facing funding shifts and chronic health burdens like Uganda. This chapter hights a set of issues driving the policy agenda on health system and service integration (HSSI) in Uganda. Uganda, is estimated to have a population exceeding 46 million people, has made substantial progress in improving health outcomes over the past two decades. Life expectancy has increased, maternal and child mortality have declined, and coverage of essential health services such as immunisation and HIV treatment has expanded [1]. However, the country continues to face significant health challenges driven by a dual burden of communicable and non-communicable diseases (NCDs), persistent health inequities, and resource constraints that threaten the sustainability of these gains [2].

1.2. HEALTH BURDEN AND DISEASE PROFILE

Uganda's health system must simultaneously address high-prevalence communicable diseases—including HIV/AIDS, tuberculosis (TB), malaria, and vaccine-preventable illnesses—while responding to the growing challenge of NCDs such as hypertension, diabetes, and cancer. HIV remains a major public health issue, with over 1.2 million people living with HIV and requiring long-term care and treatment. Malaria accounts for millions of cases annually, imposing a heavy toll on households and the health system. At the same time, the NCD burden is rising rapidly, fuelled by demographic change, urbanisation, and lifestyle risk factors, adding pressure to an already stretched health workforce and service infrastructure [3].

1.3. HEALTH FINANCING LANDSCAPE

Uganda's health sector is financed through a mix of domestic public funding, out-of-pocket [4] payments, and development assistance for health (DAH). Public domestic financing remains modest—estimated at around 22% of total health expenditure—reflecting constrained fiscal space and competing national priorities [5]. Out-of-pocket payments account for approximately 31–34% of total health spending, creating a significant risk of catastrophic health expenditures for households, particularly the poor and those in rural areas. Development assistance continues to play a crucial role, contributing about 42% of health funding, with a substantial share earmarked for specific diseases such as HIV, TB, and malaria.

While external resources have been vital in scaling up life-saving interventions, they have also entrenched vertical programming and donor dependency. These financing patterns often leave critical system functions—such as supply chain integration, health workforce development, and multi-disease surveillance—underfunded.

1.4. HEALTH SYSTEM FRAGMENTATION

The Cross-Programmatic Efficiency (CPE) study conducted by the Ministry of Health (MOH) and the World Health Organization (WHO) in 2023 highlighted extensive fragmentation in Uganda's health system. The study found that multiple, uncoordinated health programs—often funded and managed through separate governance, supply chain, and monitoring systems—were generating significant resource waste [6]. Duplication in human resource deployment, parallel health information systems, and disconnected commodity procurement mechanisms created inefficiencies, undermined service quality, and limited the system's ability to respond cohesively to emerging health needs.

This fragmentation is driven largely by the dominance of donor-funded, disease-specific vertical programs, each with their own priorities, timelines, and accountability mechanisms. While these programs have achieved important disease control outcomes, they have often failed to integrate into the broader national health system, missing opportunities for economies of scale, shared infrastructure, and holistic patient-centred care [7].

1.5. RISKS FROM ABRUPT FUNDING CUTS

Recent geopolitical developments have amplified the risks of over-reliance on external financing. The abrupt suspension of substantial U.S. government funding to Uganda's health sector in 2024—affecting critical programs such as HIV care—has exposed the vulnerability of essential services to donor decisions. This cut threatens continuity of antiretroviral therapy (ART) for thousands of people living with HIV, disrupts HIV prevention and maternal-child health integration, and risks reversing hard-won gains in epidemic control. The funding gap also jeopardises the retention of health workers previously supported by donor payrolls, the maintenance of laboratory and diagnostic services, and the integrity of supply chains for essential medicines.

Such shocks underscore the urgent need for resilient, integrated health systems that can maintain core functions even when external resources fluctuate. Building this resilience will require better alignment of donor investments with national priorities, diversification of health financing, and stronger institutional mechanisms for integrating vertical programs into Uganda's Primary Health Care (PHC) platform.

1.6. RATIONALE FOR THE ROADMAP

This Roadmap responds to the dual challenge of maximising the efficiency of existing resources and building a unified, people-centred health system capable of delivering comprehensive care across the life course. It recognises that integration is not only a technical exercise but also a governance and financing reform, requiring action across multiple levels of the health system—national, district, facility, and community—and the coordinated engagement of all stakeholders, including government, development partners, civil society, the private sector, and communities themselves.

By leveraging existing service delivery platforms—from PHC facilities and hospitals to schools, workplaces, and community health worker networks—and addressing the key enablers of integration such as supply chain alignment, workforce capacity, financing reform, and interoperable information systems, Uganda can reduce fragmentation, improve service quality, and ensure sustainable access to essential health services for all [8].

This Roadmap outlines a 3-phased approach – Stabilisation, Consolidation, and Transformation – to guide integration efforts in a realistic and sequenced manner, ensuring that immediate service continuity needs are met, efficiency gains are achieved in the medium term, and full institutionalisation of integration is realised in the long term.

1.7. HISTORY OF PRO-INTEGRATION REFORMS IN UGANDA'S HEALTH SECTOR

Uganda has a long and consistent pro-integration reform history stretching back to the adoption of the Primary Health Care (PHC) approach after the Alma-Ata Declaration in 1978. Over the decades, successive reforms – including decentralization, sector-wide approaches (SWAps), and public-private partnerships – have sought to expand integrated, people-centred care. These efforts have aimed to align service delivery, financing, and governance to provide comprehensive preventive, promotive, and curative services across the country [4,9].

However, progress has been cyclical, with notable advances in integration often followed by reversals. Gains made through PHC consolidation and coordinated donor alignment have at times been undermined by shifts in global health priorities and funding models.

Global Health Initiatives (GHIs) and broader global health reforms have played a dual role. On the one hand, they have injected substantial resources, strengthened infrastructure, and introduced patient-centred models that could be leveraged for broader integration. On the other hand, their disease-specific mandates, parallel systems, and vertical funding streams have contributed to fragmentation of national health programs – creating separate supply chains, data systems, and human resource arrangements that work in silos [8,10,11].

This dynamic has meant that while Uganda's health system has periodically achieved high levels of integration, the persistence of vertical program structures and donor-driven priorities has repeatedly challenged efforts to build and sustain a fully unified national health service.

Table 1: History of pro-integration reforms in Uganda's Health System

Short Reform Description	Reform Period	Main Success Factors	Main Challenges
Adoption of Comprehensive Primary Health Care (PHC) post-Alma-Ata (1978)	Late 1970s–1980s	Emphasized universal access, equity, prevention, participation, and intersectoral collaboration; targeted rural-urban disparities; addressed reliance on costly curative care; promoted community engagement.	Financing constraints limited the scope; comprehensive PHC was difficult to sustain at scale without adequate resources.
Shift to Selective PHC (SPHC) – GOBI-FFF model	1980s–1990s	Prioritized cost-effective, high-impact interventions to reduce childhood mortality; targeted scarce resources to priority diseases; improved focus on measurable outcomes.	Narrower focus reduced comprehensive service coverage; risked neglecting broader system strengthening; still donor-dependent.
Decentralisation of Health Services	Mid-1990s–present	Shifted governance and planning from central to district level; empowered District Health Teams; improved local accountability and responsiveness; allowed integration of preventive, promotive, and curative services closer to communities.	Uneven district capacity; resource allocation disparities; local political influence on health priorities; difficulty sustaining quality standards across districts.
Sector-Wide Approach (SWAp)	Early 2000s–2010s	Unified planning/funding around a single national health strategy; pooled funding and reduced off-budget spending; vertical programs integrated into PHC; expanded iCCM and VHTs.	Momentum slowed by the re-introduced global health priorities (GHIs) and vertical funding; dependency on external aid; persistent silos in some program areas.
Public-Private Partnership for Health (PPPH)	1990s–present	Leveraged PNFP and private sector to expand access; improved supply chains, workforce training, and coverage; promoted multisectoral collaboration.	Variable capacity/quality control among partners; reliance on donor subsidies; uneven integration of private sector contributions into national systems.
Community Health Reforms (e.g., VHTs, iCCM)	Early 2000s–present	Brought integrated case management to community level; expanded access to treatment for malaria, pneumonia, and diarrhoea; improved health promotion and disease surveillance through Village Health Teams.	Volunteer fatigue and attrition; inconsistent supply of medicines and equipment; limited incentives; variable supervision and performance.
Era of vertical priority programs – HIV, TB, malaria MCH.	2000s–2010s	MDGs attracted large donor funding (Global Fund, PEPFAR, GAVI, PMI); produced measurable disease-specific results; aligned with MDG targets; improved HIV, TB, malaria and MCH outcomes.	Fragmentation of health system; high transaction costs; parallel administration, infrastructure, supply chains, and reporting systems; reduced systemic integration.
Integration supported by Global Health Initiatives (GHIs)	2000s–present	Infrastructure investment; pooled procurement; patient- centred models for HIV/TB; integrated NCD care into HIV platforms; enhanced efficiency in HIV care.	Maintained disease-specific silos; parallel funding streams; donor-driven priorities; sustainability concerns.
Abolition of user charges in Public Facilities	2001–present	Increased service utilization, especially among poor/rural populations; promoted equitable access to PHC services.	Reduced facility-level revenue; required sustained government and donor

Short Reform Description	Reform Period	Main Success Factors	Main Challenges
			budget support to maintain service quality.
COVID-19 Integration Lessons	2020–2022	Reinforced need for resilient, integrated systems; highlighted maintaining essential services during health shocks; spurred rethinking of integration approaches.	Diverted funding from routine services; disrupted supply chain
Cross-Programmatic Efficiency (CPE) Initiatives	2023–present	Identified resource waste from program fragmentation; policy/legal frameworks exist for integration; clear recommendations for governance and coordination improvements.	Weak implementation of integration policies; donor-driven fragmentation; duplicated HR, information systems, and supply chains; overstretched workforce.

1.8. THE PROBLEM AND ITS DIMENSIONS

Donors and Global Health Initiatives (GHIs) have played a central role in shaping the architecture of health service delivery in Uganda over the past three decades. Their involvement typically follows a clear pattern: first, by drawing global attention to a specific health problem and setting it high on the international development agenda; second, by mobilising substantial financial resources to address the identified challenge; and third, by developing guidelines, program frameworks, and operational models for countries like Uganda to adopt. This model has been effective in rapidly scaling up responses to high-burden conditions such as HIV/AIDS, tuberculosis, malaria, and maternal health. It has also brought innovations in service delivery, laboratory systems, supply chains, and data management, often achieving measurable disease-specific outcomes in relatively short timeframes.

However, these externally driven programs have often been introduced as vertical initiatives—operating with their own funding, management, and monitoring systems—rather than being embedded within the broader national health system from the outset. Uganda, like many recipient countries, becomes "locked in" to the vertical models, constrained by donor requirements and reporting frameworks that prioritise accountability to external funders over alignment with national systems. High-powered incentives – such as visibility of results, donor payments linked to siloed reporting structures and jobs linked to country level project implementation units – all combine to sustain verticalization, fragmentation and multiplicity of health partners [12,13]. This results in fragmented financing flows, parallel service delivery structures, and multiple, uncoordinated monitoring systems. National guidelines for adapting, scaling up, and integrating these externally designed programs into the country's existing health service framework have tended to be weak, inconsistently applied, or delayed . Consequently, opportunities to harmonise disease-specific interventions with Primary Health Care (PHC) platforms and broader health system strengthening are frequently missed [14].

The sustainability of these vertical programs is a persistent challenge. When external funding diminishes or ends, as has been seen with some donor-funded HIV and

reproductive health projects – many of these programs wind down or collapse, leaving gaps in service coverage and eroding hard-won gains and weaken the trust in the health system. This vulnerability underscores the importance of strong domestic policy leadership, financing mechanisms, and institutional capacity to integrate new programs into national systems from the start [15,16]. Building these capacities would enable Uganda to retain the benefits of donor-driven innovations while ensuring they are institutionalised, scalable, and resilient to fluctuations in external funding. Ultimately, a deliberate and well-coordinated integration strategy is essential to transform short-term, donor-driven gains into sustainable improvements in population health.

1.9. METHODS: WHY A FRAMEWORK FOR INTEGRATION ROADMAP?

The task of developing the Roadmap was guided by several prior work such as the Situation Analysis and Progressive Maturation Model for health system/service integration [17]. In the literature on integration there are over 200 different definitions, different aims and purposed that serve integration efforts from many perspectives. The approach to identifying a suitable framework was guided by the literature review, WHO Framework on integrated people centred health service and key informant interviews drawing from the sector stakeholders at the national, district, facility and community levels [18].

Frameworks help to understand health service integration by clarifying the complex interactions within a healthcare system and provide a structured approach to improving service delivery. Frameworks also offer a common language and a set of elements/concepts that can guide decision-making, planning, and evaluation of integrated care initiatives. Without a framework, efforts to integrate services can be fragmented, inefficient, and potentially fail to address the full spectrum of patient needs [19–21].

In health programming, frameworks provide the conceptual structures that serves as a flexible guide or a "scaffolding" that helps to organize complex ideas and processes for complex phenomenon such as health service integration. While frameworks themselves are not the same as policies, guidelines, or strategies, they provide the underlying structure that informs and supports these elements. A framework helps to:

- Provide a common language: It establishes a shared vocabulary and set of concepts, which is essential for collaboration among different stakeholders, such as policymakers, healthcare providers, and community members.
- Offer a systematic approach: It breaks down complex health problems into manageable components, outlining the relationships between various factors and interventions.
- Identify key elements: It highlights the essential components that need to be addressed to achieve health goals.

- Guide decision-making: It provides a basis for making informed choices about where to allocate resources, what interventions to use, and how to measure success.

To assess health system integration, a robust integration assessment tool was developed using a modified SELFIE framework, covering domains such as governance, service delivery, workforce, financing, health information systems, supply chains, and community engagement [20]. Each domain was scored on a five-point Likert scale (1–5), representing integration levels from "not integrated" to "fully integrated." Tool development involved literature reviews, stakeholder consultations, expert validation, and iterative adjustments for local relevance. The work was enriched by the operational level experience gained by the MOH integration Taskforce and preliminary assessment of health services that was conducted across 67 facilities in the country during April – May 2025.

After a scoping review of the literature on service/system integration for health services, a customised framework was developed and approved by the NACI to aid the assessment of integration, designing the Roadmap and elaborating a tracking tool assess the maturing of the integration initiatives at different levels of the health system. Table 2 outlines the framework. The conceptualization of the framework was drawn from four main perspectives to health service and systems integration. These were:

- The WHO (2016) framework on integrated people-centred health services that was adopted by the 69th World Health Assembly [18].
- The chronic health and multi-morbidity health care models that centers the person for care planning, delivery and empowerment (SELFIE) [20,22].
- The health systems building blocks that centers the health system improvement from the complex interplay of several operational components, governance and financing [23].
- The decentralised provision of PHC services that assigns roles to the national, regional/district and community level actors [24];

The WHO framework on health systems building blocks and the SELFIE frameworks have been used widely in Europe and LMICs to explore and design programs to support chronic care especially for the elderly and contexts with HIV, TB and NCDs. First published in 2018 and have over 250 references and applied to about 47 projects that were exploring or planning health service integration projects. The framework also breaks down the different actions that need to be undertaken at the national, sub-national and facility levels to ensure that are comprehensive, complementary and coordinated across the change-management value chain.

Table 2: The Framework for Health Service Integration as adapted to Uganda

Components	Short Description
1. Service Delivery at the core (person /family)	Core focus on person-centered care tailored to health, social, economic, and environmental needs of individuals with multi-morbidity.
	Promotes coordinated, continuous, and team-based care across providers, system levels, and sectors to ensure smooth patient transitions and comprehensive care platforms as appropriate.
2. Leadership & Governance	Involves policies, regulations, and accountable leadership structures that support integration across health and related sectors.
3. Workforce	Emphasizes multidisciplinary teams, clear roles, training, and community health worker involvement to deliver integrated care.
4. Financing	Aligns funding mechanisms (e.g. pooled or performance-based) to incentivise service integration, reduce stock-out for medicines/supplies.
5. Supply Chain	Supports interoperability, shared records, and access to essential supplies and digital tools for coordinated and efficient service delivery.
6. HMIS & Research	Uses routine data, EMR, evaluations, and evidence to guide integration planning, track progress, and ensure informed decision-making.
7.Community Engagement	Involve and co-produce solutions with end-users, beneficiaries and service providers to encourage appropriateness and user innovation and community empowerment.

2 SITUATION ANALYSIS FOR HEALTH SERVICE INTEGRATION

In Uganda's context, PHC integration involves creating a cohesive and collaborative healthcare environment where multiple providers work together to deliver comprehensive care [8]. Many definitions exit for health service integration. The definition that is closest to the vision of the Ministry of Health considers integration as "a variety of managerial and operational changes to health systems that bring together inputs, delivery, management, and organizations of particular service functions, in order to provide clients with a continuum of preventative and curative services, according to their needs over time and across different levels of the health system" [18].

> Irrespective of the definition used, integration "*is characterised by health services that are managed and delivered so that people receive a continuum of health promoting, disease prevention, diagnostics, treatment disease management rehabilitation and palliative care services that are coordinated across different levels and sites within and beyond the health sector and in accordance to the needs of the population throughout the life course* [25].

2.1. SERVICE DELIVERY

Integrated service delivery was characterized by seamless pathways, embedded within routine platforms without parallel structures. Key informants emphasized the importance of person-centered care, continuity, and minimizing patient movements through one-stop service models. Examples of successful integration include PMTCT programs leveraging maternal and child health services, significantly reducing HIV transmission rates. Interviews reflected a clear preference for unified chronic care clinics, with notable successes in managing co-morbidities, notably HIV and NCDs. However, constraints remain, particularly related to inconsistent EMR systems, which hinder patient data integration across multiple conditions. Facilities often operate multiple unlinked systems, causing service fragmentation and inefficiencies. Stakeholders advocated for streamlined clinical and referral guidelines to support integrated services and facilitate smooth patient transitions.

2.2. POLICY AND GOVERNANCE

Governance integration was envisioned as robust national leadership, clear mandates, and collaborative policy frameworks. Despite supportive policies, respondents highlighted ongoing challenges, including programmatic silos at national levels, vertical funding mechanisms, and competing performance indicators. Recent shifts toward integration were driven by necessity, such as donor withdrawal from HIV programs, prompting local governance to consolidate supervision teams and unify strategic planning and budgeting processes. Respondents advocated greater governmental leadership in integration, emphasizing transparent accountability structures and collaborative planning involving multiple stakeholders.

2.3. WORKFORCE

The integration of workforce management was found crucial for service continuity and efficiency. Challenges included disparities between permanent government staff and externally-funded contract employees, affecting morale and performance. Optimal integration required standardized remuneration, task-sharing, and multidisciplinary training to bridge skill gaps and ensure cross-program competencies. Interviewees recommended systematic staff development, supportive supervision, task-shifting, and adequate staffing levels as fundamental enablers. Workforce integration was recognized as essential for effective service delivery, particularly in resource-constrained settings.

2.4. FINANCING

Integration in financing was highlighted as one of the least developed areas, primarily due to fragmented, vertical funding mechanisms and rigid donor requirements. The integration ideal involved sustainable, on-budget domestic funding that minimizes external dependency. However, prevailing donor-driven, off-budget funding with rigidly tied outputs hindered resource reallocation flexibility essential for integrated services. Respondents recommended pooled funding mechanisms, increased domestic investment, and flexible budgeting aligned with integrated service goals. In the short-term, recommendations were made to pool donor funds to support the service stabilization following the abrupt withdraw of funding for health programs such as HIV, TB and Malaria by the US Government. Advocacy efforts for transparent financial processes and robust anti-corruption measures were considered essential to support integrated financing.

2.5. SUPPLY CHAIN MANAGEMENT

Supply chain integration faced significant fragmentation, primarily due to separate procurement systems for HIV, TB, maternal health, and other health programs. Respondents highlighted inefficiencies and duplication from parallel logistics systems, resulting in periodic stock-outs despite surpluses elsewhere. Unified procurement and centralized logistics management via national stores (NMS, JMS) were cited as ideal models. Stakeholders advocated for improved forecasting, enhanced facility-level procurement autonomy, and strengthened public-private logistics partnerships to maintain continuous supplies.

2.6. HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS)

HMIS integration was hindered by duplicative and unlinked data systems, causing inefficiencies at facility levels. Respondents described patients appearing multiple times across separate program registers, creating burdensome reporting requirements and data inaccuracies. Stakeholders strongly recommended unified EMR systems capable of cross-program data integration. Consolidating digital platforms into a single comprehensive system was highlighted as critical for accurate, efficient

monitoring and reporting. The main drawback is the slow scale-up of the EMR system – covering a handful of regional referral hospitals at the time of this study.

2.7. COMMUNITY ENGAGEMENT

Effective integration requires meaningful community engagement and leadership, ensuring that locally-led solutions are nurtured within government structures. Respondents stressed the importance of empowering community structures, civil society organizations, and local leaders, especially amidst shrinking civic spaces and restrictive legislation affecting minority groups' access to health services. Community-led interventions, comprehensive health literacy programs, and inclusive, accessible healthcare models were recommended to build integration from the grassroots level upwards. A particular focus on leveraging the capabilities of civil society and private sector provision already major contribution to care access are major driver for cost-savings and rapid UHC progress. From a clinical standpoint, stakeholders commended the model of co-production of healthcare healthy lifestyles for individuals, communities and peers as implemented for HIV/TB programming. Many innovations and community structures have been formed with HIV programs that provide local and feasible approaches to community empowerment, and relationships with health providers at all levels [8].

3 LEVERAGING SERVICE PLATFORMS FOR INTEGRATION

The assessment across selected health programs (e.g., HIV/AIDS, PMTCT, MCH, IMCI) indicated varied integration levels. MCH and IMCI showed relatively higher integration, particularly in governance, whereas HIV and PMTCT remained partially integrated, primarily constrained by financing and supply chain challenges. Policy and governance exhibited relatively advanced integration across programs, while financing remained notably weak. Diverse healthcare platforms– from primary healthcare facilities and maternal clinics to community outreach and specialized settings – exist and offer robust opportunities for strategic health service integration (see Table 3). Optimizing these platforms through targeted planning, resource allocation, workforce training, and effective management can ensure comprehensive, efficient, and person-centered healthcare delivery, contributing substantially to universal health coverage and improved population health outcomes.

Table 3: Service Delivery Platform of Integration Status

Service Platform	Description of Platform	Main Advantages for Integration	Examples of Services for Integration
Primary Healthcare (PHC) Facilities	Frontline clinics, health centers providing first-contact, ongoing community care.	Broad geographic coverage, close community proximity, holistic care.	HIV testing within maternal visits; Hypertension and diabetes screening; Integrated TB screening.
Maternal and Child Health (MCH) Clinics	Specialized facilities for maternal, antenatal, immunization, paediatric services.	Big user population, frequent contact, preventive care, early intervention opportunities.	PMTCT integrated within antenatal/postnatal visits; Combined child immunizations and nutritional assessments; Family planning integrated into routine care.
Hospitals and Chronic Care Clinics	Facilities providing advanced diagnostics, specialized and chronic care management.	Specialist services, diagnostic capabilities, referral coordination, co-morbidity care.	Joint HIV and NCD management clinics; Integrated TB-HIV diagnostic care; Mental health services integrated into chronic disease clinics.
Specialised HIV Clinics	Clinics dedicated to HIV testing, treatment, and chronic care management.	Established infrastructure, expertise in chronic care, good patient retention.	Integrated HIV and NCD care; Mental health and Cancer screening within HIV care; Reproductive and maternal health services for HIV-positive women.
Outreach Programs and Campaigns	Mobile or targeted health interventions delivered outside fixed sites.	Flexible service delivery, reaching underserved areas, tailored community-specific care.	Mobile HIV testing combined with vaccination drives; Family planning and nutritional screening outreach; Integrated cervical cancer screening campaigns.
Community-based	Grassroots health workers offering	Direct household engagement,	Home-based HIV and TB screening; Malaria prevention

Service Platform	Description of Platform	Main Advantages for Integration	Examples of Services for Integration
Platforms (CHWs, VHTs)	outreach, home-based care, health education.	personalized care, health promotion.	and family planning education; Chronic disease management at home, nutrition and lifestyle.
Private Sector Facilities (Clinics, Pharmacies)	Privately-run clinics and pharmacies expanding healthcare access.	Increased convenience, expanded choice, enhanced resource availability.	HIV medication refills alongside NCD treatments; Reproductive health and family planning services; Routine vaccinations and immunizations.
School Health Platforms	Health services provided within educational institutions.	Routine preventive interventions, captive youth audience, early behaviour change.	Integrated immunizations and nutritional assessments; HIV education and adolescent-friendly testing; Routine vision and oral health screening.
Workplace Health Sites and gymnasia	Health interventions delivered at employment/work out locations for staff, workers and clients.	Convenient access, improved workforce health and productivity, regular health engagement.	Occupational health NCD &HIV screening; managing chronic conditions (hypertension, diabetes); Mental health, nutrition and wellness programs.

Effective health service integration relies heavily on identifying and strengthening the existing platforms through which care is routinely delivered. Various healthcare platforms provide essential spaces, resources, and contexts to support integration efforts. Understanding and leveraging these platforms can significantly enhance service efficiency, patient experience, and overall health outcomes. The main platforms include:

1) **Primary Healthcare (PHC) Facilities** form the foundational level of healthcare delivery in Uganda. These frontline facilities, such as clinics, health centers, and community posts, offer comprehensive preventive, promotive, curative, and rehabilitative services. Their broad geographical coverage, proximity to communities, and routine care interactions make them ideal platforms to integrate additional screening and basic care services. For example, PHC facilities commonly integrate HIV testing within maternal visits, manage hypertension and diabetes screenings, and offer combined tuberculosis (TB) case identification during general consultations, thus minimizing patient burden and optimizing resources.
2) **Hospitals and Chronic Care Clinics** offer advanced diagnostic capabilities and specialized management for complex chronic conditions and co-morbidities. The hospital-based chronic care platform (as OPD clinics or admission) is essential for the integrated management of conditions such as HIV and Non-Communicable Diseases (NCDs), providing joint treatment and coordinated follow-up. Facilities offering integrated mental health screening within chronic disease management, and joint TB-HIV care further exemplify this potential. These platforms enhance referral efficiency and optimize patient management through specialized, comprehensive care approaches.

3) **Specialised HIV Clinics** represent well-established platforms dedicated primarily to HIV testing, treatment, and chronic management. Aside from recent financing disruptions, they offer an ideal opportunity to extend care integration due to existing infrastructures, specialized personnel, and the long-term patient-provider relationships typical of chronic care settings. Integrating NCD care, mental health and cancer screenings, and reproductive services within specialized HIV clinics provides seamless patient-centered management, addressing broader patient health needs within the familiar care context. Vulnerabilities of these platforms to donor dependency and vertical programming is a challenge in the short-to-medium term.

4) **Maternal and Child Health (MCH) Clinics** are highly frequented by mothers and children, making them especially suited for integrating additional health interventions. These clinics provide antenatal, postnatal, and pediatric services, thus offering repeated touchpoints for continuous and holistic care. Utilizing MCH platforms, Uganda has notably succeeded in integrating Prevention of Mother-to-Child Transmission (PMTCT) services into routine antenatal and postnatal care. Furthermore, integrated child immunization visits routinely include nutritional screenings and family planning services, providing comprehensive, person-centered healthcare under a single platform.

5) **Community-based Platforms** involving Community Health Workers (CHWs) and Village Health Teams (VHTs) serve as pivotal links between healthcare facilities and households. Their direct engagement with communities and households enables personalized health promotion, disease prevention, and adherence support. Community-based integration can include HIV and TB screening at household levels, malaria prevention education, family planning counseling, and nutrition and lifestyle education. This direct community engagement is particularly valuable in hard-to-reach and underserved populations.

6) **Outreach Programs and Campaigns** provide flexible health service delivery models that extend care to remote and underserved communities beyond fixed facility sites. Mobile health initiatives frequently integrate diverse services, such as combined HIV testing, safe male circumcision, vaccination campaigns, family planning, and cervical cancer screening programs, or nutritional counseling. These targeted interventions effectively leverage periodic mass mobilizations to offer comprehensive care, significantly improving access and community health outcomes.

7) **Private Sector Facilities** such as hospitals, health centers, clinics and pharmacies, complement the public health system by expanding service coverage and patient choice. The integration of services such as HIV medication refills alongside chronic NCD treatments, reproductive health, family planning, and routine immunizations within private facilities increases accessibility and resource efficiency. Utilizing private-sector infrastructure and expertise further enhances overall health system capacity and resilience.

8) **School Health Platforms** offer significant potential to reach children and adolescents through preventive interventions and health education. Schools provide structured environments conducive to integrating diverse services,

including immunizations, HIV education and testing, routine screenings for oral health, mental health, vision, and nutrition assessments. By reaching youth at an early age, schools play a crucial role in promoting lifelong healthy behaviors and preventing future disease burdens.

9) **Workplace Health Sites** extend integrated healthcare access directly to employed populations. They provide convenient, regular opportunities for health screenings, chronic disease management, mental health support, and preventive care within employment settings. Integrated workplace programs, including occupational health linked with HIV testing, diabetes and hypertension management, and wellness initiatives, significantly enhance workforce productivity and health.

Other innovative approaches, such as Surgical Camps and Child Health Days, also provide structured platforms for integrated service delivery, addressing specific community needs through targeted and timely interventions. Surgical outreach can encompass NCD screening, HIV testing, and maternal care, while National Child Health Days offer broad community mobilization opportunities for integrated immunization, nutrition, and maternal health services.

4 ENABLERS OF INTEGRATION

The evidence presented in the Table 4 below underscores that successful health service integration in Uganda cannot be achieved through isolated interventions efforts. Integration must be approached as a multi-level effort, with clear and complementary actions at all levels of the health system.

4.1. NATIONAL LEVEL ACTIONS

At the national level, strong health ministry, national policies, governance structures, financing arrangements, and multi-sector health partnerships provide the enabling environment for integrated service delivery. Without coherent policies, adequate financing, and national oversight, local integration efforts risk fragmentation or unsustainability.

National-level integration hinged upon robust policy frameworks, sustainable financing arrangements, regulatory alignment, and multi-sectoral collaborations. Clear contractual arrangements, advocacy for pooled funding, proactive health diplomacy, and anti-corruption initiatives were essential macro-level interventions. Strengthening collaborative public-private partnerships in service provision, procurement and logistics further underpinned national integration efforts.

The central role of MOH-level officials and funding partners in designing programs, creates privileges for priority programs in terms of mobilizing funds and special arrangements for implementing interventions. These mechanisms were found to be central to the genesis of new and vertical programs. The regulatory levers to address scale-up and integration at the design phase are limited or non-existent. A focus on how these programs are established and designed to achieve integration, and other forms of efficiency is a major regulatory lever for steering future programmes towards sustainable models of service integration.

4.2. REGIONAL/DISTRICT LEVEL ACTIONS

At the district level, leadership, facility networks, and regional coordination mechanisms help operationalize national strategies into actionable plans. These structures act as the bridge between policy and practice, ensuring that resources, skills, and partnerships are aligned and responsive to local contexts.

Table 4: Summary of Enablers for Multi-level Health Service and Systems Integration

Theme Subtitle	Purpose	National-level Actions	Regional/District-level actions	Facility-level Actions
Service Delivery	Integration requires action at many platforms to ensure broaden	Develop multipurpose service delivery platforms; build robust care networks; referral	Quality indicators (QIs), data analytics, adaptive learning; process mapping; care pathway redesign;	Patient empowerment and engagement; expert patient initiatives; peer support groups; multidisciplinary case

Theme Subtitle	Purpose	National-level Actions	Regional/District-level actions	Facility-level Actions
	access and all health determinants.	protocols; multisectoral action on health determinants, MOUs for partnerships.	navigation support to improve service processes.	management; chronic care continuity; clear clinical/referral guidelines; interoperable information systems.
Supply Chain	Addresses stock shortages, procurement efficiency, and budget-related constraints affecting integration.	Strengthen NMS/JMS partnerships; leverage private sector capacity; adjust budgets to reflect costs/needs; proactive supply; negotiate compacts on prices.	Balance risks from single vs. multiple procurement agents; data analytics to manage risks; improved planning/forecasting; integrate multiple service requirements.	Facility-level autonomy to manage stock shortages; maintain adequate stocks; data-driven stock control; reduce pilferage; train prescribers for rational medicine use.
Policy and Governance	Governance structures guide integration across system levels, ensuring alignment and accountability and resources.	Comprehensive policy frameworks; strategic leadership; clear regulatory guidelines; align financial incentives; multi-sector partnerships; advocacy; stakeholder engagement.	Coordinated management structures; formal collaboration mechanisms; shared governance frameworks; multi-stakeholder forums; accountability agreements; performance measurement systems.	Clinical leadership; decentralized decision-making; team-based management; clinical governance; frontline accountability for timely, patient-centered decisions.
Community person centredness	Focus on community health awareness, empowerment, and innovation in community-based health improvement.	Create enabling legal frameworks; strengthen CSO alliances and networks; expand civic space; repeal restrictive laws; collaborate across sectors; link to other development sectors.	Care coordinators /navigators; differentiated care delivery models; co-design with communities; nurture community-led initiatives; expand PLWA/CHW/HCW engagement.	Empower individuals/ families; health literacy and self-management; peer-to-peer support groups; tailored education; holistic needs assessment; person/family-centred care plans; CHW linkages.
Health Workforce	Workforce capacity and management are central to short- and long-term integration success.	Supportive, cooperative sector norms; incentives for supportive governance; transparency and trust-building to sustain workforce integration.	Manage change sensitively (e.g., contract staff absorption); shared vision and purpose; deliberate change management; open dialogue; supportive work environments.	Adequate staffing and skill mix; targeted training; recruitment and retention; task-sharing; supportive technologies; role restructuring; mid-level management empowerment.
Financing	Adequate, timely, and well-managed financing is critical for sustainable integration and its marginal costs	Contractual arrangements with PNFPs/FPPs; enhance resource pooling; advocacy and anti-corruption; manage donor aid transitions; health diplomacy for favourable aid terms.	Timely/sufficient financial flows to districts /platforms; increase transfer speed/volume; pooled financing; on-budget models to simplify accountability.	Adequate funds for medicines/supplies; joint budgeting with fund-holders; link consumption data to budgets; autonomy for quality improvement; competitive remuneration.

At this level critical integration enablers included capable management structures, quality improvement processes, streamlined care pathways, and effective data utilization. Stakeholders emphasized inter-organizational coordination, transparent communication, and clearly delineated accountability frameworks as vital for coherent, efficient service delivery. Tools to support local needs assessment, priority setting, planning and budgeting, and greater decision-autonomy were identified as essential to support adaptability and responsiveness of Local Governments, Regional and General hospitals and other agencies at this level.

4.3. FACILITY AND COMMUNITY LEVEL ACTIONS

At the facility/community levels, frontline health workers, facility managers, and community-based actors translate integration principles into everyday service delivery. Patient empowerment, multidisciplinary teamwork, clear clinical guidelines, facility-level autonomy in resource management and interoperable systems ensure that care is seamless, person-centred, and efficient. Effective integration necessitates reducing patient transfers, improving continuity of care, and empowering healthcare providers, CHWs and carers with cross-program training and effective coordination of clinical care inputs (medicines, supplies, staffing and equipment) – a process that leans heavily on facility and community level governance structures and clinical leadership. Quality assurance frameworks along with care guidelines are essential tools to support integration actions at this interface. As integration takes shape, costs necessary to address care platform needs and inputs (medicine, space and staffing), and care quality guidelines will require operational planning, budgeting and increased financial allocations. In addition, findings at this level indicate a growing multiplicity of rules, partners and practices that congest and constrain the space for decision making - ultimately reducing the capacity for managers to act more adaptively.

4.4. IMPLICATIONS FOR THE INTEGRATION ROADMAP

Uganda's journey towards comprehensive health service integration demonstrates significant achievements and ongoing challenges across multiple system components. Priorities for further integration involve addressing financing rigidity, unifying data and supply chain systems, harmonizing workforce management, and enhancing community involvement. This situation analysis identifies practical integration enablers at each health system level, providing clear guidance to sustain and expand health service integration effectively across Uganda.

4.5. IMPLICATIONS FOR JOINED-UP IMPLEMENTATION

This layered approach demands a joined-up approach - a deliberate effort to work together across ministries, local governments, regulatory agencies, development partners, private sector providers, civil society organizations, and communities [26]. Integration succeeds when all actors coordinate their actions, share resources and information, and align around a common vision for improved health outcomes. In Uganda's context, this means harmonizing vertical programs, aligning donor support

with national plans, strengthening district leadership, and fostering community ownership—so that every level of the system works in synergy to deliver comprehensive, sustainable, and equitable care.

4.6. IMPLICATIONS FOR COSTS EFFECTIVENESS OF INTEGRATION

Integration's economic aspects involved shared versus incremental costs. Shared costs included infrastructure and administration, typically remaining constant post-integration until all reserve capacity is exhausted. Incremental costs arose from additional staffing needs, additional medicines and supplies, and situations that require upgrades for the platform or support systems like EMR and staff training programs. Studies indicate potential cost efficiencies through task-shifting, bulk procurement, and differentiated service models reducing patient loads at expensive facilities, offering more cost-effective healthcare.

5 STRATEGIC DIRECTION

The situation analysis highlights the urgent pressures due to abrupt decline in donor funding and rapidly evolving healthcare needs, underscoring the necessity of strategic integration to safeguard essential health services in the short-term and transform and institutionalise HSSI in the long-term. A 3-phased HSSI theory of change and Roadmap are proposed to addresse the challenges identified in the situation analysis. The 3-phase Roadmap aligned with the purpose of Stabilisation, Consolidation, and Transformation of HSSI as expounded below. Together, these phases represent a comprehensive strategic response—addressing immediate service continuity needs, medium-term efficiency optimization objectives, and long-term systemic integration—necessary to achieve resilient, equitable, and sustainable health services and system in the national and sub-national levels.

5.1. PRINCIPLES FOR ROADMAP ON INTEGRATION

Across the expressed views and, expectants of stakeholders at the national and sub-national level, a set of principles were synthesized from the literature, stakeholder consultation and validated by the National Advisory Committee on Integration (NACI). These are outlined below and form the foundation for building an integrated health system that is equitable, efficient, and sustainable. People-centredness ensures that services are responsive and respectful; PHC provides the structural backbone; prevention and well-being safeguard long-term health; co-production with communities fosters ownership and relevance; addressing wider determinants ensures a multisectoral reach; a life-course approach maintains continuity; and distributed leadership enables coordinated, system-wide action. Together, these principles create the conditions for a health system that can adapt to changing needs, withstand shocks, and improve health outcomes for all.

5.1.1. People-Centredness

Integrated health systems are designed around the needs, preferences, and circumstances of individuals, families, and communities, rather than around diseases or institutional structures. People-centredness emphasises treating patients as active participants in their care, respecting their values, and recognising the broader social and cultural contexts that influence their health. It requires shifting from a provider-led model to one in which service users are genuine partners in planning, delivery, and evaluation.

5.1.2. Primary Health Care as the Foundation

Primary Health Care (PHC) provides the most effective platform for delivering integrated services. It ensures continuity of care, equitable access, and coordination across the health system. Integrated PHC promotes seamless referral pathways between community, primary, secondary, and tertiary levels. By strengthening PHC-

centred integration, health programs reach more people, reduce fragmentation, and enable holistic management of health needs.

5.1.3. Emphasis on Prevention, Health Promotion, and Well-being

A core principle of integration is shifting the balance of care away from reactive, curative services towards prevention, health promotion, and the maintenance of well-being. This includes early detection, vaccination, risk reduction, and community health education. Preventive approaches reduce long-term health costs, improve quality of life, and tackle risk factors before they result in disease – thus optimising efficiency and cost savings.

5.1.4. Co-production with Communities

Integration involves co-producing services with communities to support health awareness, self-care and active involvement in health decisions. This means enabling individuals and families to manage their own health through knowledge, skills, and resources, and ensuring community voices shape service priorities. It also includes facilitating peer support networks, which can improve treatment adherence, emotional well-being, and resilience.

5.1.5. Addressing Wider Health Determinants

Health outcomes are shaped by social, economic, and environmental factors such as sanitation, education, housing, nutrition, and employment. Integrated healthcare must work in partnership with sectors beyond health - such as social services, transport, agriculture, education, and infrastructure - to address these determinants. This multisectoral engagement ensures that services respond to root causes of ill health, not just symptoms.

5.1.6. Life-Course Approach

Integrated care should ideally spans all stages of life, from maternal and newborn health through childhood, adolescence, adulthood, and ageing. A life-course approach ensures that services are age-appropriate, responsive to changing health needs over time and designed to provide continuity of care across different age groups.

5.1.7. Distributed Leadership and Joined-Up Action

Integration requires distributed leadership - empowering decision-makers and champions at all levels of the health system, from national ministries to district managers and community leaders. Multi-level leadership ensures actions for change-management are coordinated across stakeholders, enabling a joined-up approach where government, civil society, donors, and communities work together toward shared objectives. Distributed leadership fosters ownership, accountability, and adaptability, making integration efforts more sustainable.

5.1.8. The Challenge of Uniformity and the "3-Ones" agenda

The Three Ones principle—*one agreed plan, one consolidated budget, and one unified monitoring and evaluation* (M&E) framework - was commonly expressed by stakeholders especially at the national level to promote coherence, efficiency, and alignment across national health responses. In theory, it creates a common vision for all stakeholders, aligns resource allocation with national priorities, and establishes a single performance measurement system that all partners use. This approach has the potential to inspire the reduction of duplication, improves accountability, and supports national leadership in steering integration.

However, stakeholders close to the practice interface, found the 3-ones approach unrealistic in the short to medium term – due to highly complex program environments such as Uganda's health sector. The diversity of programs (HIV, TB, malaria, maternal and child health, NCDs, emergency preparedness, etc.), the multiplicity of activities, goals and indicators, and the wide range of actors - many with strong motives to stabilise their care models - make full adherence to the principle difficult in the short-run. Additionally, the sheer volume and complexity of activities across national, sub-national, and community levels means that a single, fully unified plan, budget, and M&E system can be unwieldy and politically sensitive especially as decentralization and community engagement innovations become more rooted in the local preferences as opposed to being universal. Instead of pursuing the 3-Ones as an absolute principle in the medium-term, it can be applied as a flexible guideline - with a focus on satisfactory alignment rather than perfect uniformity.

6 THE THEORY OF CHANGE FOR HEALTH SYSTEM AND SERVICE INTEGRATION

For the long-term impact, we envisage a fully integrated and sustainable health service delivery system that effectively meets population health needs, achieves financial efficiency, and provides equitable, high-quality care nationwide.

Overall Goal: Achieve a sustainable, equitable, and resilient integrated health system in Uganda using a 3-phase approach to easy-in the reforms with minimal disruption.

1. **Phase 1:** Stabilisation (Immediate). **If** we rapidly identify and address immediate care and resource gaps caused by abrupt reductions in donor funding, secure essential medicines and supplies, protect critical workforce and HMIS capacities, and invite stakeholders' inputs,

2. **Then** critical disruptions to health services will be minimized, essential health services will continue with minimal interruptions, and the foundations for integration will be secured.

3. **Phase 2:** Consolidation (Short-to-Medium Term): **If** we systematically streamline service delivery by forming multidisciplinary teams, expanding service platforms, task-shifting, standardizing care protocols, integrating and digitizing data platforms, enhancing inter-organizational collaboration, and applying data-driven quality improvement mechanisms,

Then efficiency, resource utilization, quality, and cost control across Uganda's healthcare system will significantly improve, enhancing service access, sustainability and effectiveness of integrated care.

Phase 3: Transformation (Medium-to-Long Term): **If** we institutionalize integration through establishing formal integrated governance structures, embedding integration strategies within national policies, creating sustainable financing mechanisms, developing workforce, community health programs and strengthening planning, budgeting and design capacities, and address procurement and supply-chain processes,

Then health service integration will become sustainably embedded across Uganda's health system, ensuring ongoing resilience, responsiveness, and improved health outcomes for the population.

6.1. PHASE 1: STABILISATION OF HEALTH SERVICE PLATFORMS

The **Stabilisation Phase** prioritizes immediate interventions to mitigate service disruptions resulting from abrupt reductions in donor resources. This stage ensures continued access to critical health services through emergency resource mobilization, rapid workforce retention measures, and immediate procurement strategies. This phase started February 2025 with the MOH Circular and taskforce on the Integration of Health Care Service delivery [27]. Actions proposed here complement these MOH efforts. This phase is envisaged to take about one year concluding February 2026.

Strategic Objective 1: Secure continuity of health services following abrupt reductions in donor funding.

Preamble: The Stabilisation Phase focuses on rapidly addressing immediate threats posed by recent reductions in donor funding, ensuring that essential health services in Uganda remain operational and uninterrupted. In particular HIV, TB, and services such as NCDs and MNCH that share service delivery platforms in both public and private sector were affected by the abrupt withdrew of funding and closure of USAID and its programs. This phase is crucial to prevent service collapse and maintain public trust in the health system. Priority actions include rapid resource mobilization, emergency procurement to maintain medicine and supply chains, and workforce protection through staff retention and absorption measures. Engaging stakeholders urgently—including government, development partners, and communities—is critical to aligning available resources effectively. This rapid-response approach will create a stable foundation for subsequent integration actions aimed at efficiency, sustainability, and long-term resilience.

Priority Actions:

1) Conduct rapid assessment to identify critical needs for the major service platforms that offer opportunities for immediate operationalisation of the integration actions.
2) Develop Operational plans to address the service stabilization for HIV, TB, and chronic services as guided by MOH integration guidelines and standards and informed by stakeholders at all levels..
3) Protect essential workforce capacity through temporary staff absorption, retention strategies, and short-term incentives.
4) Establish robust emergency procurement plans to ensure continuous availability of essential medicines, supplies and diagnostic commodities.
5) Mobilize immediate domestic resources and emergency allocations to sustain key services (e.g., HIV, maternal health).
6) Engage development partners urgently to align remaining donor resources strategically with critical health services.
7) Co-produce stabilization action plans informed by stakeholders at the national sub-regional, facility and communities levels.

Table 5: Phase-1 Priority Actions for Service Continuity at National and Sub-national level

Action	Description	National Level	Sub-national/Facility Level
Rapid assessment of service and resource gaps	Quickly identify critical financial gaps and urgent resource needs threatening health service continuity – especially for HIV and other affected programs.	Enables targeted emergency action plans and resource mobilization.	Allows hospitals to clearly articulate immediate financial and resource shortfalls.
Mobilize immediate domestic resources	Emergency mobilization and reallocation of government funds to sustain essential health services.	Secures national-level emergency funding to prevent disruptions in services.	Guarantees operational stability and continuity of care at hospital level.
Emergency procurement of medicines and supplies	Rapid and prioritized procurement to maintain essential medicine and medical supply availability.	Stabilizes national medicine stock and reduces risk of nationwide shortages.	Ensures uninterrupted availability of essential supplies at hospital level.
Workforce protection and retention	Temporary absorption of contract staff and retention strategies to maintain critical workforce/skills.	Maintains overall health workforce stability and morale at the national level.	Sustains local staffing levels, morale, and continuity of patient care.
Strategic engagement with development partners	Immediate coordination with donors to align remaining resources strategically to priority health needs.	Facilitates coordinated national resource allocation and mobilization efforts.	Aligns partner resources directly with hospital-specific and sub-national priorities.
Government financial subsidies to private providers	Provide financial subsidies to private providers, enabling them to continue essential HIV and NCD services.	Expands national service coverage and maintains service continuity for priority populations.	Supports continuity of essential HIV and NCD services provided by private providers at the local level.
Laboratory and diagnostic functionality	Secure and sustain laboratory capacity, diagnostic services, and related consumables to ensure uninterrupted diagnostic functionality.	Ensures consistent national-level disease monitoring, surveillance, and clinical management.	Maintains hospital capacity for accurate and timely patient diagnostics and disease management.

6.2. PHASE 2: CONSOLIDATION FOR EFFICIENCY AND PATIENT-CENTRED CARE

Preamble: the Consolidation Phase strategically builds upon immediate stabilisation efforts, focusing on enhancing efficiency, streamlining operations, and controlling costs across Uganda's health system in the short to medium term. During this phase, deliberate integration actions such as the establishment of multidisciplinary teams, task-shifting, and shared data platforms are prioritized to minimize duplication and optimize resource use. Efforts at this stage also include standardizing care protocols, strengthening inter-organizational coordination, and promoting evidence-based management practices. Collectively, these targeted integration strategies facilitate improved care quality, better resource management, and higher productivity within the health sector, ensuring that the benefits of stabilisation are sustained and expanded into a resilient, efficient, and cost-effective national health service delivery system. This phase is expected to take up to three years.

Strategic Objective 2: Streamline and optimize health service delivery platforms through targeted integration strategies

Priority Actions:

- Implement multidisciplinary teams and task-shifting strategies to enhance staff productivity and reduce costs.
- Establish shared data platforms (e.g., integrated DHIS2 systems) for improved efficiency in monitoring and reporting.
- Standardize care pathways and clinical protocols across integrated service areas to reduce duplication and wastage.
- Strengthen inter-organizational coordination (public-private partnerships, joint planning and monitoring, shared procurement) for improved efficiency.
- Apply rigorous data analytics and quality improvement mechanisms for responsive and person-centred care, evidence-based resource reallocation and continuous cost control.

Table 6: Phase-2 Priority Actions for Consolidation of Gains from HSSI

Action	Description	National Level	Sub-national/Facility Level
Multidisciplinary teams and task-shifting	Establish teams of optimal skill-mix and reallocate tasks to optimize workforce productivity efficiency.	Identify and support skills mix and resource mix that drive efficiency and optimise productivity.	Support staff productivity, manage workloads, and increases service responsiveness.
Shared data platforms (e.g.,	Implement integrated digital systems for	Enhance national-level planning,	Enable timely local decision-making,

integrated DHIS2)	unified reporting, data analysis, and decision-making across services, and performance accountability	monitoring, and efficient resource allocatio, data on performance and surveillance	improved patient monitoring/outcomes; reduced reporting burdens.
Standardize care pathways and clinical protocols	Develop uniform guidelines and care pathways to reduce service duplication and variation.	Ensure consistent, quality service provision nationwide and efficient resource utilization.	Reduce variability in clinical practices, enhances quality, and lower service costs.
Inter-organizational coordination	Strengthen joint planning, resource-sharing, and partnerships between public, private and CSO in the health system.	Facilitate cohesive national health service delivery, reducing fragmentation and inefficiency.	Enhance local service coordination, resource sharing, and reduces service gaps and duplication.
Data analytics and quality improvement mechanisms	Apply rigorous data-driven approaches to inform decisions, improve service quality, and identify cost-saving opportunities.	Drive national evidence-based decision-making, cost control, and service optimization.	Insights and trends for local needs, quality improvements, operational efficiency, and cost management.

6.3. PHASE 3: TRANSFORMATION AND INSTITUTIONALISATION OF HSSI

Preamble: The Transformation Phase represents the long-term strategic goal of institutionalizing health service integration within Uganda's healthcare system withing a PHC approach. Building upon previous phases, this stage ensures that integration principles and practices become embedded in policy, planning, budgeting, and day-to-day operations at all health system levels. It focuses on expanding care platforms, formal integrated governance structures, aligning national health policies, regulations, and financing mechanisms, and developing (MDAs Committees, TWGs etc) sustainable workforce capacities. Additionally, this phase prioritizes community empowerment and health literacy for the health promotion and prevention agendas, strengthening and institutionalizing procurement and supply-chain processes to guarantee the continuous availability of essential health commodities and strengthening MOH stewardship roles for the Nos-state health providers. By consolidating integration strategies through comprehensive policy frameworks, robust resource management, and coordinated sector-wide partnerships, the transformation phase ensures the sustained resilience, quality, and responsiveness of national and sub-national health system entities, ultimately delivering equitable and efficient healthcare to all communities nationwide. This phase is expected to take

shape from year-3 and continue, as a recurrent operational imperative to sustain HSSI programming approach.

***Strategic* Objective 3**: Embed health service integration as a standard, sustainable practice across all levels of the health system.

Actions:

- Expand service platforms including at private sector, community outreach, workplace sites, schools etc to expand access and coverage.
- Formalize integrated governance structures at national, district, and facility levels for enduring accountability.
- Incorporate integration measures into national health policies, regulatory frameworks, and strategic planning documents.
- Ensure reliable long-term financing through dedicated national budget lines, pooled funding, and sustainable partnerships.
- Institutionalize comprehensive workforce development, including regular training, supportive supervision, and clear career pathways linked to integrated service delivery.
- Strengthen supply-chain resilience and integrated procurement processes to guarantee reliable, continuous access to health commodities.
- Empower community-led health actions and expand health literacy and self-care models where feasible.
- Strengthening the stewardship role of MOH for health technology assessment and provider payments systems.

Table 7: Phase-3 Priority Actions for Transformative Improvements in HSSI

Action	**Description**	**National Level**	**Sub-national/Facilities Level**
Expand service platforms for more access	Operationalise integrated service platforms at private, community, school, workplace etc to expand access and UHC.	Coordinate multi-sectoral partnerships, CSOs and private sector to expand integrated care platforms.	Operationalise more integrated services models at CHWs, PNFPs, CSOs, Out-reach services, school health, workplaces and sports centers etc.
Integrated governance structures	Formalize governance frameworks for integration at national, regional, and facility levels, ensuring clear accountability.	Establishe coherent leadership and oversight for HSSI, Donor alignment to national systems.	Clarifie roles, responsibilities, and local accountability for integrated service delivery.
Policy and regulatory alignment –	Embed integration strategies within national policies, laws, guidelines,	Institutionalize integration and HTA within MOH	Provide clear directives for facilities and districts to improve integrated

Action	Description	National Level	Sub-national/Facilities Level
Govt, NGOs and Donors.	and strategic health documents.	policies, plans and routines.	services models – static & outreach.
Sustainable financing mechanisms	Establish dedicated, predictable, and pooled financing systems to ensure sustainable support for integrated services.	Guarantee long-term, reliable financing for integrated service delivery.	Ensure sustained financial resources for hospitals to deliver integrated care effectively.
Comprehensive workforce development	Develop ongoing training programs, supportive supervision structures, clear career progression pathways, and aligned incentives.	strengthen the national health workforce including CHWs for long-term integration goals.	Strengthen hospital staff capacity, enhances morale, retention, and quality of integrated service provision.
Strengthened procurement and supply-chain processes	Formalize procurement, enhance forecasting and stock management, and integrate public-private partnerships to sustain essential supplies.	Ensures resilient national-level management of essential commodities.	Ensure facilities have uninterrupted access to essential medicines, supplies, and operational Lab./equipment and commodities.
Empowering community-led health actions	Strengthen community capabilities through resources, training, and support structures, enabling local advocay and action.	Enhance community resourcing, responsiveness, accountability, and ownership.	Improve local-level engagement, enhances trust, responsiveness, and community-driven health initiatives., training careers
Health literacy and self-care models	Institutionalize nationwide programs and educational campaigns promoting health literacy, patient empowerment, and self-care.	Reduce national disease burden by empowering individuals and communities with proactive health practices.	Strengthen local patient engagement, promotes self-management, reduces unnecessary facility visits, and enhances treatment adherence; peer support and Networks for PLHA.

7 IMPLEMENTATION ARRANGEMENTS

The evidence presented in the table of actors below underscores that successful health service integration in Uganda cannot be achieved through isolated interventions. Integration must be approached as a multi-level effort, with clear and complementary actions at the national, subnational, facility and community levels of the health system.

- At the national level, strong national policies, governance structures, financing arrangements, and multi-sector partnerships provide the enabling environment for integrated service delivery. Without coherent policies, adequate financing, and national oversight, local integration efforts risk fragmentation or unsustainability.
- At the subnational level, district leadership, facility networks, and regional coordination mechanisms operationalize national strategies into actionable plans. These structures act as the bridge between policy and practice, ensuring that resources, skills, and partnerships are aligned and responsive to local contexts.
- At the facility and community level, frontline health workers, facility managers, and community-based actors translate integration principles into everyday service delivery. Patient empowerment, multidisciplinary teamwork, and interoperable systems ensure that care is seamless, person-centred, and efficient.

Table 8: Expected Stakeholders and their Contributions for the Roadmap

Action	**Description**	**Key Contribution**	**Key Stakeholders**
Rapid assessment of funding gaps	Quickly identify critical financial gaps and urgent resource needs.	Enables targeted emergency budgeting and strategic planning: Allows hospitals to flag immediate financial and operational shortages.	MoH Planning Dept, Ministry of Finance, Development Partners, DHO Office, Int-Taskforce
Mobilize immediate domestic resources	Emergency mobilization/realloc ation of government funds.	Secures national emergency health funding, Stabilizes hospital operations and service delivery.	MoH, MoFPED, Cabinet CAO/District Health Office, Parliamentary Health Committee
Emergency procurement of medicines & supplies	Rapid procurement processes to prevent stock-outs.	Ensures national commodity availability, Prevents hospital-level service disruption.	MoH Pharmacy Dept, NMS, JMS, District Health Office; Hospital Management

Workforce protection and retention	Absorb contract staff and provide retention incentives.	Maintains national workforce stability; Sustains frontline staffing and morale.	MoH, MOF-Treasury, DHR Dept, Public Service Commission, District HR Committee, Facility Managers, HR-TWG
Strategic engagement with development partners	Coordinate with donors to align remaining financing.	Guides national resource allocation. Directs partner support to facility/prioritized needs.	MoH Donor Coordination Unit, HPAC, PEPFAR, Global Fund, MOFPED, District Health Office
Financial subsidies to private providers	Subsidize private providers to sustain HIV and NCD services.	Expands national service coverage; Keeps private facilities open for essential services.	MoH, Private Providers Assoc., PHARM Council, District Health Office
Strengthen lab/diagnostic functionality	Secure and maintain lab/diagnostic capacity and consumables.	Supports national disease monitoring and surveillance. Ensures timely diagnostics at hospital level.	MoH, CPHL- Lab Services, UVRI, District Lab Supervisors, NMS, NTRL and private Labs.

This layered approach demands a joined-up approach—a deliberate effort to work together across ministries, local governments, regulatory agencies, development partners, private sector providers, civil society organizations, and communities. Integration succeeds when all actors coordinate their actions, share resources and information, and align around a common vision for improved health outcomes. In Uganda's context, this means harmonizing vertical programs, aligning donor support with national plans, strengthening district leadership, and fostering community ownership—so that every level of the system works in synergy to deliver comprehensive, sustainable, and equitable care.

7.1. MONITORING, EVALUATION, AND LEARNING FRAMEWORK

The Health Services and Systems Integration (HSSI) Roadmap represents Uganda's strategic shift towards a more sustainable, equitable, and resilient health system. This transformation requires a robust Monitoring, Evaluation, and Learning framework that does more than track activities and outputs. It must enable continuous improvement, institutional accountability, and strategic learning. This MEL framework is designed to operationalize the theory of change, guide implementation across the three phases of the HSSI roadmap, and ensure alignment with the Uganda Health System Integration Maturity Framework (HSIMF), which serves as the backbone for measuring progress across core health system domains.

7.2. PURPOSE AND OBJECTIVES OF THE MEL FRAMEWORK

The primary purpose of this MEL framework is to support the real-time management, learning, and accountability mechanisms necessary for the successful implementation of the HSSI roadmap. It does this by enabling actors across the health system—from national policymakers to district health teams—to systematically monitor progress, assess effectiveness, and generate timely learning to inform decisions.

Specifically, the MEL framework aims to achieve the following five objectives:

1. Monitor the evolution of integration across integration dimensions (such as governance, workforce, financing) using measurable indicators.
2. Evaluate whether implementation is resulting in improved results such as service continuity, efficiency, and system resilience.
3. Support adaptive management through evidence-informed reflection, feedback, and course correction.
4. Ensure institutional learning by embedding structured inquiry and shared analysis at all levels of implementation.
5. Promote transparency and accountability among stakeholders, including government actors, development partners, civil society, and communities.

7.3. ALIGNMENT WITH THE THEORY OF CHANGE FOR THE HEALTH SERVICES AND SYSTEMS INTEGRATION ROADMAP

This MEL framework is directly aligned with the phased implementation structure articulated in the HSSI theory of change. As elaborated above, the roadmap is built around three sequential but overlapping phases: Stabilization, Consolidation, and Transformation.

a) The Stabilization phase addresses immediate disruptions, particularly those arising from abrupt reductions in donor funding. Its goal is to maintain the

continuity of critical services and create a minimal operational baseline for integration.

b) The Consolidation phase focuses on building efficiency, streamlining service delivery, and strengthening system performance by introducing multidisciplinary teams, shared data platforms, and standardized protocols.
c) The Transformation phase seeks to institutionalize integration through national policy reform, sustainable financing mechanisms, and governance realignment. This stage is about embedding integration in the day-to-day fabric of Uganda's health system.

Each of these phases is associated with a distinct set of objectives, expected outcomes, and indicators. They also represent different entry points for monitoring, performance measurement, and learning.

7.4. HEALTH SYSTEM INTEGRATION MATURITY FRAMEWORK: FOUNDATION OF MEL

The Health System Integration Maturity Framework (HSIMF) adapted from the SELFIE framework [20,22], serves as the organizing backbone for this MEL framework. It provides a structured scale-based and self-assessment approach to assessing and planning for integration across the health systems with particular reference to seven core health system domains:

1. Leadership and Governance
2. Service Delivery
3. Health Workforce
4. Health Financing
5. Health Information Systems and Research
6. Supply Chain Management
7. Community Engagement

Each domain is rated along a five-point continuum, from 1 (not integrated) to 5 (fully integrated). These maturity levels allow both national and sub-national actors to assess not just whether integration has occurred, but how deeply it has been institutionalized.

Importantly, the maturity framework is not simply a scorecard. It guides the sequencing of reforms, helps prioritize technical support, and frames the learning agenda. Indicators in the MEL framework are therefore designed to align with the HSIMF, such that annual maturity assessments can be populated with quantitative and qualitative data already being collected through routine systems.

The HSIMF scores are expected to guide resource allocation, performance-based programming, and capacity-building efforts, both at national and subnational levels. As districts and facilities progress along the maturity continuum, they will be encouraged to share lessons, innovations, and bottlenecks through structured learning platforms.

7.5. MONITORING AND EVALUATION FRAMEWORK

Monitoring and evaluation will be structured along the results chain, encompassing inputs, processes, outputs, outcomes, and impact. Indicators in Table 9 below are designed to be specific to each phase of the roadmap, while also contributing to the broader SIMF tracking system.

Table 9: Monitoring and Evaluation Framework

Phase	Main Focus	Selected Key Indicators	Data Sources	Frequency	Lead Actors
Phase 1: Stabilisation	Ensure uninterrupted delivery of essential services and protect core system functions	1. % of disrupted services restored within 6 months; 2. $ amount of emergency medicine procured; 3. % of critical workforce absorbed or retained; 4. % of donor-funded services transitioned to domestic oversight.	HMIS, HRIS, facility assessments, special atudy reports	Quarterly	NMS/JMS, MOH-Health Information Division, CAOs-DHTs, NACI Taskforce, HPAC
Phase 2: Consolidation	Improve efficiency, coordination, and quality of services	1. % of facilities with shared EMR or DHIS2 platforms 2. % of staff trained in multidisciplinary or integrated care models 3. % of standardized care pathways adopted 4. Improvement in client satisfaction scores	DHIS2, supervision checklists, quality audits, exit interviews	Semi-annual	HPAC, MOH SCAPP Dept, DHTs
Phase 3: Transformation	Institutionalize integrated systems and policies	1. % of MOH policies that embed HSSI principles 2. % of budget allocated to pooled or on-budget financing for integration 3. % of districts with formal integrated governance structures 4. % of facilities with uninterrupted access to integrated supply chains	Policy documents, OBT/Budget reports, annual facility surveys	Annual	MFP&ED; OPM; MOH Senior Mgt; HPAC; LGs, NMS-JMS

Across all phases, integration scorecards will track progress per HSIMF domain, triangulating indicator data with maturity levels and implementation milestones.

7.6. LEARNING AGENDA

Learning is central to how the HSSI roadmap will be adapted, improved, and sustained. The learning agenda is designed to focus on two key dimensions: the phase

of implementation and the domain of integration. Questions will be prioritized to reflect transition points in the maturity, where the health system is most likely to face resistance, uncertainty, or innovation. Table 10 below provides a sample of question across selected HSIMF dimensions.

Table 10: Phase- and Sample Domain-Specific Learning Questions

Phase	Selected HSIMF domain	Sample priority learning question
Stabilization	Governance & Policy	What emergency coordination mechanisms were most effective in protecting essential services?
	Health Financing	How were domestic funds mobilized and allocated in the face of abrupt donor withdrawal?
	Service Delivery	Which facilities/service platforms were most resilient and why?
Consolidation	Workforce	What incentives or models supported the formation of effective multidisciplinary teams? Which models were more effective for task-sharing and capacity building for integrated services?
	HIS	How did facilities/platforms integrate data systems for unified reporting, and how were trade-offs resolved?
	Supply Chain	How can commodity forecasting be harmonized across previously vertical programs?
Transformation	Governance & Policy	How has integration been institutionalized in national laws and policies?
	Community Engagement	What models of community engagements best expand and sustain, integrated person-centered services?
	Health Financing	What design elements make pooled financing mechanisms sustainable and responsive?

The goal of this learning agenda is not only to generate insights but to directly inform adjustments to operational plans, policies, and institutional arrangements.

Learning will be pursued through a mix of methods, including implementation and operational research, systems mapping (e.g. causal loop diagrams), political economy analysis, and joint reflection workshops. These methods serve different functions. Implementation and operational research will allow for in-depth understanding of what works in real-time contexts, how and why. Systems mapping will help actors see interdependencies and unintended consequences across sectors. Political economy analysis will expose underlying power dynamics, incentives, institutions and ideas that shape whether reforms succeed or stall. Learning workshops—organized regularly (e.g quarterly or biannually) will serve as spaces for stakeholders to interpret findings and co-design solutions. These workshops will be organized at various levels incorporating insights and representation from the immediate level below. For example, regional workshops should bring together several districts while district workshops should bring together several facilities.

7.7. DATA SYSTEMS, REVIEW MECHANISMS, AND FEEDBACK LOOPS

A strong MEL system must be underpinned by reliable data platforms and responsive review cycles. Uganda's HSSI MEL framework will rely on existing data platforms, such as DHIS2, HRIS, and the e-LMIS, but will also integrate a new Integration Indicator Matrix developed by MoH Health Information Division and M&E TWG to track integration efforts across the MoH. It is expected that the matrix above incorporates indicators on the integration objective and initiatives of the various MoH departments and units.

Quarterly review meetings at district and regional levels will allow for real-time course correction and feedback. National integration performance review meetings will be held annually, informed by integration dashboards, annual scorecards, and synthesized learning briefs.

Each district and facility will be encouraged to conduct self-assessments using the integration maturity model, followed by peer reviews and technical validation.

To ensure alignment and momentum, MOH will release annual integration performance reports, drawing from both M&E indicators and learning insights, to be discussed during Joint Review Missions and HPAC briefings.

7.8. INSTITUTIONAL ARRANGEMENTS FOR MEL IMPLEMENTATION

Implementation of this MEL framework will be shared across actors and tiers of the health system. Proposed institutional responsibilities are outlined in Table 11 below.

Table 11: Institutional Roles and Responsibilities for MEL Implementation

Actor	Key Roles in MEL
MOH Health Information Division and M&E Technical Working Group	Overall leadership, coordination of maturity model assessments, and integration of MEL into planning and budgeting
National Advisory Committee for Integration (with MEL Subcommittee)	Oversight of MEL implementation, synthesis of data, facilitation of learning loops and policy feedback
District Health Teams (DHTs)	Data collection, phase-specific monitoring, scorecard application, convening of district learning platforms
MakSPH and Academic Partners	Implementation research, political economy analysis, capacity-building, technical support for systems mapping and interpretation
Development Partners	Supportive supervision, financing of learning components, alignment of partner reporting with national indicators
CSOs and Community Platforms	Community-level monitoring, equity tracking, and citizen feedback integration into MEL cycle

Collaboration across these actors will be critical to ensure consistency, credibility, and use of MEL findings.

7.9. CONCLUSION: A MEL FRAMEWORK FOR ADAPTIVE INTEGRATION

Uganda's MEL framework for HSSI is intentionally designed to be more than a tool for performance assessment. It is a governance mechanism that is a structured way to align implementation with strategy, evidence with action, and accountability with learning. By anchoring MEL within the Integration Maturity Model, aligning indicators with reform phases, and embedding a participatory learning agenda, the framework ensures that integration is not just technically sound but politically and institutionally feasible.

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