THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

STRATEGY FOR IMPROVING HEALTH SERVICE DELIVERY 2016-2021

Presidential Directives For Health Sector Service improvements
To attain
Middle Income Status by 2020.

Table of Contents

The Presidential Directive.

Preamble.

The health of the Ugandan population is central to the socio-economic transformation of the country. The poor health status of our people will undermine the economic benefits of attaining middle income status by 2020, if health service delivery is not improved. We know that preventable diseases and health conditions are the major causes of poor health in Uganda. Despite this knowledge and the steady progress made in the last two decades, the high levels of maternal mortality, infant mortality, malnutrition, poor sanitation and hygiene are at unacceptable levels. The inadequacy of interventions against common health conditions and the inefficient use of available health resources is a challenge we must overcome as we move towards middle income status.

The Ministry of Health shall focus on;

1. Sensitizing communities on The "7 Tips for a Healthy Life Style"; Eating Healthy and exercising regularly, Immunizing children and others at risk, Observing personal hygiene and sanitation, Fighting malaria, TB, HIV and other common infections, Avoiding drugs and alcohol abuse, Practicing responsible sexual behaviour and safe parenthood, Attending regular medical check-ups and seeking medical care early.
2. Responding promptly to emerging health challenges of the country including epidemics and non-communicable diseases.
3. The Ministry of health shall take pragmatic steps to address bottle-necks that constrain health service delivery. Specific actions shall be on;
    a. Theft of medicines, Negligence of duty, Corruption in the sector, Poor Service Delivery, Shoddy work in Health infrastructure, focused Infrastructure Development in District, Constituencies, and Sub Counties, Infrastructure Projects, Health promotion, Education and Communication, Support Supervision, Diversion of funds to private clinics, Human resources for Health management among others.

Foreword

The strategy for improving health service delivery draws its authority from the 23 Strategic Guidelines and Directives provided by His Excellency the President of the Republic of Uganda, for the Minimum Program for Uganda to attain Middle Income Status by 2020 and Vigorous Implement the NRM Manifesto 2016-2021. The health sector priorities herein were discussed and agreed upon in the health sector consultations. These priorities have further been harmonized with the five year Health Sector Development Plan and will guide health sector interventions for the next five years as outlined;

1. Scaling up Public Health Interventions to address the high burden of preventable diseases in the country. To this end, Community Health Workers will be introduced as part of the health system to scale up Health promotion, education and effective communication to the population. Emphasis will be laid on prevention of the high burden of HIV/TB, malaria, Nutritional challenges, Environmental Sanitation and Hygiene, Immunization, Hepatitis B and Non Communicable Diseases.
2. Improvement of Reproductive, Maternal, Neonatal, Child and Adolescent health services to reduce avoidable deaths of mothers and Children and improve their health status.
3. Human resources for health training, attraction, job scheduling, motivation, retention, and development will be prioritized. Additional resources for recruitment and incentives will be mobilized.
4. Infrastructural developments will be guided; constructions, rehabilitation and remodeling will focus on functionality of HC111, HC1V and Hospitals in addition to Districts with special needs like islands, difficult terrain, large populations and teaching Hospitals with the view to increase access to services for all.
5. Mobilization of additional resources for; medicines, laboratory supplies, reagents and Safe Blood Transfusion Services.
6. Effective and well-structured Support Supervision to the Local Governments.
7. Effective and functional referral system at all levels of health care.

In solidarity with all key stake holders in the health sector, it is my sincere hope that these strategies will help guide health interventions and efficient use of resources to improve quality and effectiveness of health service delivery to our people.

Dr. Jane Ruth Aceng

Minister of Health

Acknowledgement

The production of this strategy to improve health service delivery took time, effort and commitment from a strong team that worked tirelessly to expound on the Presidential guidelines and directives to streamline health sector operations in line with the aspiration of the program for propelling Uganda to Middle Income Status by 2020 and implement the NRM manifesto 2016-2021.

I take this rare opportunity to thank the members of the Senior Top and Top Management Teams of the Ministry of Health for the initial draft that formed the basis for the discussion with His Excellency the President of Uganda, General. Yoweri K. Museveni.

I thank the key stakeholders of the Ministry of Health who accompanied the Minister of Health to the Interface meeting with the President in Entebbe on 3rd September 2016 where consensus was built on the directives in this document.

Special thanks go to; Members of the Senior Top and Senior Management of the Ministry of Health, Representatives of the Boards and Staff of Semi-autonomous bodies of the Ministry of Health, Representatives of Ministries of Finance, Public service, Executive Directors of National Referral Hospitals, Directors of Regional Referral Hospitals, and Representatives of District Health Officers,

Dr. Diana Atwine

Permanent Secretary

Detailing the Presidential Directives for health sector improvements

To attain

Middle Income Status by 2020 and Vigorously Implement the NRM Manifesto of 2016-2021.

Introduction:

On the 23rd of June 2016, His Excellency the President of the Republic of Uganda issued strategic guidelines and directives for the minimum program for Uganda to attain the middle income status by 2020 and vigorously implement the NRM manifesto 2016 to 2021. In the guidelines, key tasks of the government are highlighted and those specific for the health sector are also identified. He further directed each sector to develop strategies for implementation of these directives and streamline the service delivery operations of each sector.

The key issues in the health sector included;

- Theft of medicines and stock outs of medicines
- Neglect of duty and absenteeism.
- Corruption
- Poor Service Delivery
- Shoddy work in Health infrastructure
- Infrastructure Development (District Hospitals per District, HCIVs per Constituency, and HCIII per Sub County)
- Health promotion, Education and Communication
- Support Supervision ,poor governance and poor communication
- Diversion of funds to private clinics
- Human resources (Contract staff, interns, Senior House Officers-Post Graduate Medical students, Public Servants).
- Motivation of Health Workers using non-monetary incentives
- Effective Planning and Budgeting

The Process:

Ministry of Health constituted a technical committee that discussed the bottlenecks in health service delivery and proposed strategies to overcome the constraints. The Minister of Health presented the strategy paper to The President of the Republic of Uganda.

The 70 member strong delegation, led by the Right Honorable Prime Minister, consisted of high level representations from Ministries of Health, Finance, Planning and Economic development, Public Service, Local Government, the Presidency and the NRM Secretariat. Ministry of Health team included representation from the Senior Top Management, Boards and Commissions, Top Management of the Ministry of Health, Executive Directors and Directors from Health Institutions and Regional Referral Hospitals, and District Health Officers and medical superintendents.

The President welcomed and reminded the delegation of the enclave economy Uganda was, in a sea of poverty in the region at independence. Due to years of political turmoil in Uganda, the enclave economy had contracted from six major exports to two by 1986. The resuscitation of the collapsed 3Ts and 3Cs economy is evidence of the NRM record of being able to do more with the little resources. (3T stands for Tourism, Tea and Tobacco while 3Cs stands for Coffee, Cotton and Copper). He encouraged Health sector to do the same and noted improved immunization coverage, growing population, increasing life expectancy as some of the on-going good examples of doing the same in the health sector.

He emphasized general health education for health promotion and disease prevention saying 'prevention is better that cure' and wants to see heighted focus on Hygiene, Sanitation, Nutrition, malaria control using IRS through PPPH approaches, HIV/AIDS, Life style diseases and Drug Abuse.

H.E the President challenged the Ministries to design interventions to cub medical tourism that is draining national resources. He noted that the common health conditions that require treatment abroad are known; the Brain, Liver, Heart and the kidneys and directed the investigation capacities in the country to be improved to provide super specialized services. He reassured that such a capacity developed in partnership with the private sector, will reduce cost of treatment and can also attract patients from the neighboring countries due to the relative lower cost.

The Right. Hon Prime Minister welcomed the Hon .Minister of Health to present the planned strategic interventions to improve service delivery to the H.E the President. This document is the final version of the strategy paper presented by the Hon. Minister of Health, Dr. Jane Ruth Aceng to H.E the President. It adopted specific inputs and recommendations from the President as a working tool to improve health service delivery as we move towards middle income status.

Background.

The health of the Ugandan population is central to the socio-economic transformation of the country. Along with increased literacy rates and vibrant economic growth, health outcomes are improving which translates to better health indicators. Over the last two decades, the Government of the Republic of Uganda has increased access to health services two fold. By 1997, only 47% of the population who needed health care could access outpatient services (NHP 1999). During that time, health facilities were few and far from communities, and the health system that was degraded by years of civil strife and mismanagement was just beginning to recover. This figure has since improved to about 110%, underscoring the ease of access to health facilities by the population (DHIS2 2015/16).

These improvements to a large extend are attributed to;

- Increased funding of the health sector in the last 5 years as indicated below

Table 1:Total GoU Budget and Health Sector Budget (FY 2010/11-2016/17.Ushs Billions

Year	Billions (UGX)				Health as % of total budget
	Health Budget Ush	Growth	Total Government Budget	Growth	
2010/11	660		7,377		8.9
2011/12	799	21%	9,630	31%	8.3
2012/13	829	4%	10,711	11%	7.7
2013/14	1,128	36%	13,065	22%	8.6
2014/15	1,281	14%	14,986	15%	8.5
2015/16	1,271	-1%	18,311	22%	6.9
2016/17	1,828	44%	26,400	44%	6.9

Source: MOFPED; Background to the Budget, 2016/17. Details of the interventions and outputs are contained in annex 1 attached.

- The investment in health infrastructure and decentralization of the health system. Hospitals, Health Centre IVs, HC III and HC IIs were constructed in most Counties, Sub Counties and Parishes. This intervention reduced the average walking distance to health facilities for most communities.
- Abolition of User fees (2001) that reduced financial hardship when accessing services especially for the rural and majority poor.
- Increase in health resources in nominal terms; the number of health workers increased from 52% in 2010 to 70% in 2016, and availability of medicines also improved from about 35% in 2007/08 to 75% in 2015/16.
- Improved health awareness and health seeking behavior of our people among others.

Health indicators as per UN estimates have significantly improved over the last 15 years (2000-2015 from; MMR 506/100,000 Live Births to 360/100,000 Live Births, IMR 56/1000 Live births to 38/1000 Live births, U5MR 90/1000 Live Births to 54.6/1000 Live Births, NMR 27/1000 Live Birth to 19/1000 Live Births and Life expectancy 63 years at birth up from 35 years in 1986. Ministry of Health cannot claim the credit for the improvements in health status indicators but has been a major contributor to their attainment.

The national capacity to produce health professionals has tremendously increased. Currently the country trains and graduates about 1010 pharmacists, graduate nurses and graduate medical officers of which about ; 450 are medical doctors. Annually government recruits about 155 medical officers into public service leaving out about 855 qualified medical professionals seeking employment. Many others are absorbed in the private health sector that is also steadily growing.

After attaining increased access to basic health services, Quality of health care provided in health facilities has become the main challenge to overcome. The ordinary citizen now demands for better quality of care from the health system. The Ministry of health commits to offer better quality health services to the citizens of Uganda.

The Problem statement:

The health system response to quality and safety of health services, social and financial risk concerns of the community is inadequate, leading to public outcry.

Objective:

To improve the management of health resources for effective health service delivery.

Expected outputs:

- *Critical policy inadequacies identified, specific interventions articulated and implemented*
- *Structural inefficiencies identified, and appropriately addressed*
- *Professional/technical deficiencies, unethical and corrupt Behaviour identified and appropriate measures put in place to curb the vices.*

Organization of the document:

The following sections address the critical health systems issues of public concern with respect to the issues highlighted in the guidelines and directives provided by His Excellency the President.

1.0 Medicines and Health Supplies

1.1 Stock out of Medicines in Public Health facilities.

Ministry of Health recommits to ensure the right medicines of good quality are available in all health facilities all the time when needed, stored under acceptable conditions and rationally prescribed.

Availability of essential medicines in public facilities has increased to 75% in the last five years. This means most health facilities are out of stock of medicines for two weeks out of eight weeks of a delivery cycle. The ministry of Health is aware of the public outcry stock outs generate, as health workers ask relatives to buy medicines out of pocket during the stock out periods, sometimes with dire consequences for patients. The stock outs due to budget shortfalls notwithstanding, theft of medicines and mismanagement significantly contribute to stock outs in public health facilities.

1.1.1 Theft of Drugs at Health Facility Level

Instituting controls at dispensing and storage levels, and delivery points will control this vice. These controls will include;

- Provision of tools for management of stocks of medicines at dispensing and stores levels and at points of delivery by the National Medical Stores.
- Regular multi stakeholder support supervision, inspection, and auditing of medicines
- Community awareness on embossment of medicines to check on theft of medicines and discourage pilferage.
- Disciplinary action including speedy prosecution of those found to steal medicines

1.1.2 Expired Medicines and Health Supplies.

Health facilities receive medicines and health supplies from different warehouses supported by Government of Uganda, Non-Governmental Organizations and Health Development Partners as well as directly from implementing partners and individual donations. Some medicines are stored in unauthorized storage areas.

Ministry of health will;

- Stream line the supply chain of medicines to health facilities through designated ware houses
- Regulate donations of medicines and medical equipment to health facilities,
- Regulate the permissible shelf-life of medicines for donations to health facilities to 4 months,
- Increase funding for medicines, vaccines, reagents and health supplies
- Provide guidance to actors in the pharmaceutical sector on management of expiries; this will include retrieval and incineration of expired medicines.
- National Drug Authority will enforce management of expiries in the private sector

1.2 Medical records management

The evidence for improving health service delivery is generated through medical records. Ministry of Health will support;

- Health facilities with medical stationery and technologies
- Innovations to generate evidence for improving health service delivery including record of medical supplies in health facilities through e-health solutions.
- Ministry of health shall develop e solutions for all patient records and link it up to a national dash board.
- The Planning and Policy directorate shall provide to Senior top management the half yearly comprehensive health indicators performance for indicators that can be measured on quarterly basis.

2.0 Human Resources for Health.

2.1 Absenteeism of health workers and negligence of duty

Absenteeism of health worker's cheats government of up to 40% of their time of employment. This malpractice affects the quality of patient care and destroys team work. Staff absenteeism arises from;

- Late coming on duty and early departure from duty,
- Negligence of duty,
- Dual employment or practice,

- Inappropriate facility duty rosters and off duty guidelines
- Study leave without authorization.

Ministry of Health will improve its vigilance in enforcing statutory provisions on human resource management. The Ministry in partnership with Local Governments will;

- Take Swift disciplinary action on staff missing or absconding duty as per the revised standing orders.
- Introduce attendance registers (Manual or digital) in all health facilities and institutions.
- Carry out spot checks and inspection of health facilities for action on absentee workers.
- Duty rosters and work schedules that maximizes staff time on duty
- Communicate to health partners to desist from dual employment of public officers.
- Engage on other aspects of management to manage absenteeism;
    - Guidance to partners for engaging health workers in trainings, workshops, and travels
    - Review of the public service standing orders in collaboration with Ministry of Public Service.
    - Revise job schedules and reporting systems at all levels in the health sector
    - Establish positions of deputies in health institutions to help with delegation
    - Recruit health workers on transferable terms and conditions
    - Proper authorization of study leaves and develop off duty guidelines for health facilities
    - Support the professional councils to; verify, register and issue practicing licenses to staff with scanned-in photographs.
    - Recentralization of some key staff in Local Governments
    - Provision and mandatory wearing of uniforms by health workers
    - Induction of new health workers
    - Additional wage for recruitment and promotion of critical cadre as Ophthalmologists, Anesthetists etc.
- All staff in the health sector shall continue to be employed on permanent and pensionable terms and conditions of service. There shall be clear tasks and supervisory structures and job schedules at all levels and departments and agencies in the health sector.
- New employees shall be provided with clear job descriptions, schedule of duties in their appointment letters and they will undergo mandatory induction and ideological orientation into public service and government priorities.
- All health entities shall have clear annual training/staff development plans that should indicate the skills needs, the officers to be trained and the funding sources and the new deployment provisions.
- In consultations with Ministry of Public Service, amend the standing orders in order to enforce discipline.
- Explore the recentralization of some key health workers to improve management and stewardship. Review the decentralization policy and Local Government act with a view to amend sections that constrain service delivery.
- To ensure proper management and supervision of decentralized health services, human resources gaps at management levels such as DHOs and ADHOs should be filled in FY 2017/18.
- Capacity of the professional councils shall be built to help develop and regulate the sector. An office block at Butabika shall be funded in the medium term for the professional bodies.

2.2 Motivation of Health Workers

In partnership with related Ministries and agencies of Government, the Ministry of health will explore non-monetary incentives to motivate health workers. These will include;

- Provision of accommodation for new staff, low cost housing for health facilities
- Rewards and recognition for good performance
- Preferential scholarships and promotion for upcountry staff.
- Special concessions for health workers; tax waivers on cars, building materials and developing designated shops to be explored
- Under the non-monetary incentives, vehicle tax exemptions issues for senior consultants and other health workers shall be discussed further with the tax policy department of MoFPED.
- Enhance salaries of health workers in a phased manner focusing on specific cadres annually.
- Targeting health workers to benefit from other government programs for wealth creation and SACCOs. Ministry of Health shall explore creation of a health workers SACCO in financial year 2017/18 to benefit from the overall wealth creation program. One billion shillings was pledged by H.E towards the SACCO.
- Synchronize the retirement age of senior consultants with those working in Universities.

In principle, increasing salaries in a phased manner for scientists ahead of other cadres in the public sector is feasible and acceptable. The core group and auxiliary health cadres should be catered for first in a phased manner in the medium term before 2021.

2.3 Training of Health Professionals.

In order to ensure production of quality health professionals that are competent and competitive within the East African Region and internationally, Ministry of Health and Ministry of Education and Sports will urgently;

- Develop a standard criteria of entry for all cadres of health professionals for pre service training.
- Regulate intake into the pre service Health Training Schools to match existing training capacity.
- Health Training Schools for Certificate and Diploma level should be considered for reverting back to MoH after consultations with Cabinet and Ministry of Education and Sports.
- MOH and MOES should work with the National Council of Higher Education to fix nationally acceptable and decent minimum grades of university entry into medical courses.

2.4 Internship Training.

Year	Budget provision-Billions	Number of Interns-Government sponsored	Total number of interns (privately sponsored and Government sponsored	Payment for all interns Ushs Billions	Budget Deficit-Ushs Billions	If Government sponsored interns are paid	Implied Savings if only Government sponsored interns are paid for
2013/14	6.43	350	688	6.0		3.1	2.9
2014/15	7.47	350	754	6.6		3.1	3.5
2015/16	9.43	350	877	7.6		3.1	4.5
2016/17	9.43	450	1010	12.8	3.37	3.8	9

Ministry of Health has been financing training of interns in both public and private health facilities without legally binding documents and guidelines. The numbers of interns (nurses, Doctors, Pharmacists) has been increasing exponentially beyond annul budgetary provisions and the capacity of the health facilities to handle them effectively.

The result has been;

- Repeated strikes by interns due to inadequate budget provision to cater for allowances, accommodation and meals.
- After the one year internship training the officers are released on to the streets and only a small number are recruited into the public service causing government a shortage on returns to investment.
- Even the few who are recruited into the public service work for only one or two years and leave public service.
- The internship training sites lack the capacity (accommodation, facilities, and supervisors) for effective and meaningful training.

Internship

- Medical interns shall rotate in four major discipline areas of: Internal Medicine, General Surgery, Paediatrics and Child Health, and Obstetrics and Gynaecology for a period of three months each;
- That the medical intern proceeds for training after qualifying from University and this should be considered as a continuation of medical training;
- That the medical intern should acquire the prescribed competencies by the end of the internship training;
- That each Health Professional Council/Board should inspect and scrutinize all accredited training centers for interns to ascertain that the specified requirements are adhered to;
- That each intern training center should have at least two supervising specialists in each discipline.

Ministry of health guidelines on internship training.

- The Uganda National Internship Guidelines (2016) has been developed by the Ministry of Health in conjunction with the Health professional councils/Board who are the regulators of the internship training program and relevant stakeholders. This has been duly approved by Top Management of Ministry of Health.
- Ministry of Health has appointed the Uganda Medical Internship committee (UMIC)with a Secretariat at the Ministry of Health. All matters concerning internship will henceforth be handled from the Ministry of Health
- The period for internship training shall be one year
- All foreign qualified medical personnel will be required to cater for their internship in terms of upkeep, welfare and allowances. Government will not facilitate them. Should they wish to go back and do internship in their countries, they are free to do so.
- Special consideration for recruitment of specialist medical officers to fill gaps in supervision of graduate medical officers/interns
- As the budget to the health sector improves, government shall review the internship sponsorship terms and conditions annually.

2.5 Senior House Officers.

Senior House Officers (Post Graduate Students) are of three categories; Government, Donor and privately sponsored.

MOH will ensure;

- Candidate for post graduate trainings shall declare source of funding for the psot graduate to the internship committee and breakdown of the sponsorship as follows; tuition, accommodation and welfare.
- A sustainable way of post graduate training is reached with the public training institutions in face of the exponential increase in enrolments.

3.0 Corruption

Causes/Forms: Under table payments (Bribery), Extortions, Greed, Absenteeism, Negligence, Callous attitude, Low salaries and incentives to health workers, False accountabilities, Shoddy work, Inflated bills of quantities for civil works, Dual employment because of projects, partners-financed work-plans not disseminated and tabled to accounting officers.

3.1 Strategies to address corruption:

3.1.1 General

- All health workers shall be identified by provision of uniforms to all staff in a phased manner within 5 years.
- Strengthen stewardship and leadership at Local Government level and health facility level
- Sensitize the population to identify corrupt officials, Empower the patients, clients, disseminate the client's charter and provide mechanism for clients to report on any corruption cases.
- Fast track the introduction of National Health Insurance Scheme (NHIS) to eliminate under the table payments and motivate the health workers. (MoH requires support from Cabinet and MoFPED to expedite the process)
- Serious Sanctions as per Anti-Corruption Act must be instituted on corrupt officers and the culprits exposed in the media as a deterrent to others
- Verification of activity implementation by supervisors at all levels to improve accountability and value for money.
- The Ministry quality assurance department shall revise the service standards and indicators and develop new reporting mechanisms, harmonize Local Government collaboration in areas of performance monitoring. Develop clear reporting guidelines on roles played by Local Governments in central Government Health Institutions.
- Review performance at regional level through regional joint reviews and introduction of results based financing.
- Ministry of Health in conjunction with professional associations, councils and health training institutions shall sensitize health workers on ethics and professionalism.

3.1.2 At the Ministry of Health Headquarters

- Funds have been decentralized to the different departments so each head of department/vote controller shall be responsible for accountability of all these resources in conjunction with the accounting officer
- Top management shall scrutinize, re-prioritize and approve activities in line with the strategic plan emphasizing those that are of a preventive nature and have impact.
- All Funding from partners (whether implementing or development) to the Ministry of Health(MOH) and the Local Governments shall be through the accounting officer of the MOH in line with an MOU agreed upon.
- The accounting officer will communicate to the partners to adhere to this guidance and avoid releasing funds to departments/programs for activities that have not been approved by senior top management.
- The accounting officer shall put in place mechanisms to track with details (source, activities, amount, and beneficiaries) all partner support (technical and financial) to the MOH and share with the partners on quarterly basis and during the JRMs.

- Ministry of Health shall reactivate high level engagement meetings with partners on quarterly basis to review the partnership contributions, accountabilities in line with the HSDP compact.
- Implement and report on progress of the annual aide memoire

3.1.3 Fleet Management

- Ministry of Health shall introduce a vehicle tracker system to monitor movement of vehicles for control of fuel consumption and minimize on false fuel accountabilities.
- Ministry of Health shall procure and prequalify at most three competent garages through framework contracts and a competent officer shall be in-charge of all Ministry of health vehicle repairs.
- The transport officer shall enforce use of Log Books and tracking system to manage fleet movement.

3.1.4 Shoddy works in Health Sector

- MoH Structure & Engineers: Inadequate numbers of dedicated engineers at all levels to ensure regular and effective supervision. There is need for Ministries of Works and Public Service to review the HR structures and qualifications for engineers at all levels and increase the numbers to accommodate the heavy workload.
- For the Ministry of Health Headquarters, the HR structure was reviewed and approved. The review upgraded the Infrastructure division to a department level and provided for an increased number of engineers from the current number of engineers (4 in number) to 14 engineers in the new structure. Ministry of Health shall recruit additional engineers to effectively monitor civil works in the health sector.
- Collaboration with District Engineers: Ministry of Health shall work closely with Local Governments to encourage them to facilitate the District Engineers to supervise all health sector civil works and report quarterly on progress to the District Technical Planning Committee and the Ministry of Health.
- Supervision and inspection by Ministry of Health Top Management. Ministry of Health top management shall supervise Health sector civil works on quarterly basis for progress, quality assurance, and value for money and provide a report on centrally funded civil works before commissioning completed works.
- Supervision by infrastructure division. The engineers under this division shall supervise the infrastructure development on planned and continuous basis with special attention to details and shall share the reports with top management on quarterly basis. A final report by MOH engineers on completion of civil works shall be prepared before handover of civil works.
- Poor quality of materials–The problem of poor quality materials will be addressed by ensuring that contractors use locally manufactured materials that are UNBS certified and checked by dedicated works supervisors.
- Lack of standard designs that are costed- Ministry of Health shall develop modern standard designs for medical buildings and staff houses for each health facility level.
- Bloated Bills of quantities for works: Unrealistic engineer's/quantity surveyor's estimates and high quotations by bidders is wasteful to resources; Ministry of Health shall engage an independent quantity surveyor to estimate the costs for each of the designs.
- Procurement Malpractices and poor procurement planning-
    - Ministry of Health shall ensure availability of costed modern designs for health sector civil works and standard specifications for medical equipment's.
    - Bid documents shall spell out key stringent requirements for qualification and evaluation of contractors to adhere with stipulated requirements.

- One of the issues promoting procurement malpractices is the appointment of the evaluation committee by the contracts committee on advice of the PDU. There is need to review the PPDA regulations with regard to appointment of evaluation committee members and Members of the contracts committee.
- The PDU staff who do not follow the procedure should be dealt with under the law. Delays in procurement should be directly supervised by the Accounting Officer who will be required to report the progress to Top Management on monthly basis.
- Regular post evaluation by the responsible officers.
- The Ministry shall establish an independent inspectorate committee to evaluate all civil works and medical equipment's procured and share an annual report with management.

- Where there has been loss of money and shoddy civil works in the health sector the responsible officers shall be held responsible.

4.0 Medical Equipment

- The Ministry of health requested the Auditor General to carry out a comprehensive inventory of all medical equipment's at all health facility levels to ascertain value for money, functionality and suitability. The report shall be used to redistribute the equipment, train health workers on their use and development of a maintenance plan.
- All health facilities shall be required to update and submit an inventory report on medical equipment on an annual basis to the Permanent Secretary, Ministry of Health
- To address maintenance of medical equipment's, the Ministry of Health will recruit Biomedical Engineers/ technicians and deploy them in the regional workshops to ensure regular maintenance.
- Medical equipment user training shall be undertaken at all levels.
- MoH shall contract a service provider to service and maintain highly specialized and imaging equipment. This contract will be reviewed annually to ensure value for money.
- Ministry of health shall develop equipment's leasing policy to guide the operations and maintenance of medical equipment's.
- The MoH will undertake to build capacity of National Advisory Committee on medical equipment (NACME) to ensure that the equipment government procures meets international specifications and attains value for money.
- The MoH will explore the possibility of leasing of medical equipment which includes a package of maintenance as well as replacements in the event of obsolesce/ change in technology.
- All medical equipment and furniture procured by government or donated must be engraved before installation and users comprehensively trained for at least 2 weeks.
- All donated medical equipment and furniture shall be cleared by commissioner Health infrastructure-Ministry of Health on advice from NACME and allocated to the right level of facility.

5.0 Health Infrastructure

Facility based health services require health infrastructure that is developed nearer to the people for physical access and improvement of quality of care. Thus, the MoH will invest in comprehensive infrastructure development i.e. Medical buildings, staff housing, and equipment types for different levels of care, medical furniture, transport and communication systems, and water and electricity utilities for health facilities, incinerators and any other waste management technology.

5.1 Health Facilities infrastructure.

The National Health Policy recommends that a general hospital should serve a population of 500,000 people, HCIV serves 100,000 and HCIII serves 20,000 and HCII 5,000 People. His Excellency directed that each district should have a General hospital, constituency a HCIV and evry sub county a HCIII.

In line with the above directive, in 2016 there were 59 districts without a General hospital, 29 Constituencies without HCIVs and 225 sub counties do not have HCIIIs as depicted below.

Level of Facility	Popn	Total no of HF	Govt	NGO	PRIVATE	No of LGs without Government facility	Health facilities to be constructed	HF to be upgraded
National Referral Hospital	35M	2	0	0	0	NA	NA	03
Regional Referral Hospitals	2 M	19	14	5	0	NA	NA	09
General Hospital	500,000	147	63	64	20	59	59	59
HCIV	100,000	193	170	15	8	29	29	29
HCIII	20,000	1250	916	264	70	225	225	
HCII	5,000	3610	1695	520	1395			
Total		5221	2858	868	1493	377	377	164

5.1.1 District Hospitals

His Excellency the President of the Republic of Uganda directed that each district should have a General hospital following the Ministry of Health Guidelines.

Whereas there is demand to have a General Hospital per District, currently with the 147 general Hospitals each general hospital is serving a population of 230,000 people which is just about half of the recommended number of 500,000 per hospital.

- There are disparities in geographical distribution and accessibility. Of the 59 Districts that do not have public General Hospitals
- 18 of them have NGO Hospitals which receive government PHC non-wage grants.(Agago, Amolatar, Amudat, Budaka, Bushenyi, Ibanda, Kabermaido, Kalungu, Kiruhura, Maracha, Mayuge, Mpigi, Mukono,Napak,Ngora, Oyam, Rukungiri and Zombo)

- 02 of them have private hospitals (Buhweju and Sembabule). These two Districts need to be included in the prioritization of new General hospitals to be constructed.
- 39 Districts have no General hospital at all (Alebtong, Amuria, Amuru, Bukedea, Bukomansimbi, Bulambuli, Buvuma, Buyende, Dokolo, Gomba, Isingiro, Kalangala, Kaliro, Kamwenge, Kibuku, Koboko, Kole, Kotido, Kween, Kyankwanzi, Kyegegwa, Luuka, Lamwo, Lwengo, Manafwa, Mitoma, Nakapiripirit, Namutumba, Namayingo, Ntoroko, Otuke, Pader, Rubirizi ,Serere, Sironko, Kibale, Kakumiro,Rubanda and Omoro)
- Government shall review its policy enshrined in the NHP II of a hospital per 500,000 people and construct a General hospital per district, then priority shall be given to the 39 Districts without any hospital followed by the 2 Districts that have private hospitals and other strategic hard to reach areas.
- The estimated cost per hospital for construction of a new hospital, human resources, Medicines and Medical Equipment's and others is estimated at a startup average cost of UGX.31.3 Billion.

Below is a table showing the detailed breakdown of the costs.

Development	Estimated unit cost per Hospital –In Billions-UGX	Total costs for 41 General Hospitals- UGX
Development		
infrastructure	20	820
Equipment	6.5	266.5
Sub Total-Dev't	26.5	1,086.5
Recurrent		
Wage-planned	3.2	131.2
Non-Wage Recurrent-planned	1.2	49.2
Medicines-planned	0.4	16.4
Sub-Total Recurrent	4.8	196.8*
Grand Total	31.3	1,283.3

*The recurrent cost of 4.8 Billion will be required per hospital per annum, Should Government construct all the 41 General hospitals it will translate to Shs 196.8 Billion per annum.

- The Development cost can be phased starting with Districts that have relatively high population (Isingiro, Amuria, Manafwa, Serere) or deserve special attention because of their geographical location like the island Districts(Buvuma, Kalangala, Namanyingo-Mayuge).
- The Uganda Hospital and Health Centre IV census survey report 2014 shows that the country has more Hospitals than is recommended by Ministry of Health and majority of the Hospitals are not functional to the required capacity. It also found that the distribution of the Hospitals and level IV PHC facilities was fairly even across the country with a high density in the central region.

5.1.2 Health Centre IVs.

The Ministry shall revamp and make functional all the Health Centre IVs and upgrade HCIIIs to HCIVsin constituencies where they do not exist. Of the 290 constituencies only 29 do not have HCIVs. The existing HCIIIs in these constituencies shall be upgraded.

Below is the breakdown of the estimated costs for upgrading and operationalization.

Development	Estimated unit cost per HCIV–In Billions-UGX	Total costs for upgrading 29 HCIIIs to HCIVs-UGX In Billions
Development		
Infrastructure	3.5	101.5
Equipment	1.5	43.5
Sub Total-Dev't	5.0	145
Recurrent		
Wage	0.373	17.98
Non-Wage	0.092	1.02
Medicines	0.047	0.61
Sub-Total Recurrent	0.512	19.61
Grand Total	**5.512**	**164.61**

The total cost for this upgrade is Ushs 164.6 Billion

5.1.3 Health Centre IIIs

Development	Estimated unit cost per HCIII–In Billions-UGX	Total costs for Constructing 318 HCIIIs - UGX In Billions
Development		
infrastructure	1.8	572.4
Equipment	0.35	111.3
Sub Total-Dev't	2.15	683.7
Recurrent		
Wage	0.131	197.2
NWR	0.045	11.13
Medicines	0.021	6.678
Sub-Total Recurrent	0.197	215
Grand Total	2.347	898.7

- 225 Sub Counties have HCIIs that need to be upgraded to HCIIIs while 93 sub counties have no government health facility at all.
- Priority will be given to the 93 sub counties without any government health facility and subsequently the 225 sub counties will be considered in a phased manner. The cost for construction of 93 HCIIIs is estimated at Ushs. 247 Billion.
- No more construction of HCIIs and the existing HCIIs must all be upgraded in a phased manner to HCIII's in line with the president's directive.

Action points agreed upon under Health Infrastructure development.

i. Health center IIIs and HCIVs should be the focus in the short term on construction, functionality and equipment. Need to consolidate and make the facilities fully functional with all the health systems requirements.

ii. Construction of new General Hospitals shall be a special consideration for improving access challenges related to unique terrain, island and ethnicity in phase 1, then population and other factors can be taken on in phase II of the plan.

iii. HCII's in sub counties which have HCIIIs shall be used as health posts for VHTs and CHEWs. While existing HCIIs in all sub counties without a HCIII shall be upgraded to HCIIIs. New HCIIIs will be constructed in all sub counties without any government health facility. In big and large sub counties, additional new HCIII's shall be constructed to attain a 5km working distance to a health facility. (4M*4M) square mile distance.

iv. No more construction of Health Centre II's shall be funded nor approved for funding beginning financial year 2016/17.

v. Improve the investigative capacity in the centers of excellence to manage health conditions related to the Brain, Heart, Cancer, and Kidney. Improve the super specialist centers to reduce on medical treatments abroad (Medical tourism). MoH should explore the PPPH mechanisms for improving health infrastructure and leasing of high technology medical equipment.

vi. Ministry of Health shall consider upgrading university teaching regional referral hospitals to a status that allows allocation of resources that meet their peculiar needs.

vii. Ministry of Health shall equipment regional Hospitals with specialized medical equipment and construct blood banks in the regional Hospitals.

viii. Ministry of Health shall Complete hand over of PNFP facilities for government ownership to be considered on case by case basis should this fit in the overall government policy of health facility distribution and the medical bureaus plans (e.g.Rushere in-Kiruhura District.)

6.0 Health Promotion and Disease prevention

Disease burden: About 75% of the country's disease burden is preventable with communicable diseases topping the list of causes of high morbidity and mortality. The 5 leading causes of mortality are; Malaria, Diarrheal diseases, Road traffic Accidents and injuries, HIV/AIDS, and nutritional related complications including anemia. Non Communicable Diseases are also on the increase due to changes in the lifestyle of the population.

On a good note, Pneumonia which used to be the second leading cause of mortality and measles are no longer major cause of illness due to successful childhood vaccination program. Introduction of Rota virus vaccine in the year 2018, will prevent diarrhea from continuing to be a major cause of childhood illness and deaths.

Ministry of Health undertakes to address this high burden of preventable diseases to ensure that the health status of the population improves and they become more economically productive to contribute to the attainment of the middle income status by 2020.

To this effect, the Ministry of Health will;

- Re prioritize the sector plans/budgets to re-focus on preventive interventions especially community mobilization and empowerment, immunization, sanitation/hygiene, Malaria prevention and control, HIV / Aids, NCDs and nutrition. To undertake this a directorate of public health has been created in the new structure and recruitment will soon commence.
- Redesign health messages to the population and communicate in a manner that gives adequate time for the population to understand specific messages at a time and avoid confusion. This shall be done in close collaboration with all key stakeholders
- Ministry of Health shall implement the Community Health Extension Workers policy and strategy (CHEWs) to enable the sector engage easily and effectively with the communities and impart critical health educative messages and promotion programs. Some VHTs shall be integrated into the CHEWs program.
- Ministry of Health shall work closely with other key sectors and the Local Governments and provide guidelines to enforce sanitation and hygiene (latrine coverage, hand washing and home improvement campaigns).
- Implementation of the CHEWs strategy was agreed upon and Ushs. 30 Billion shall be provided for in FY 2017/18.

- All epidemic human disease outbreaks shall be investigated by the Director General of Health Services and communicated to the Minister of Health before a media and press declarations are made by the Minister of Health.

7.0 Other Service Delivery issues.

Ministry of Health recommits itself to achieving Universal Health Coverage aimed at ensuring that every citizen gets services they need, when and where they need them, without suffering impoverishment or financial hardship.

- The National Health insurance bill has been submitted to MoFPED for financial implication clearance.
- The Ministry shall develop guidelines for an efficient and effective referral system.
- The Ministry of Health shall develop clear guidelines and eligibility criteria for consideration for medical referrals abroad.
- The Ministry of health shall develop and operationalize the ambulance policy and strategy to improve ambulance management systems including ambulance tracking system.
- The Minister of Health shall issue press statements on information and knowledge related to epidemic outbreaks and health disasters after approval at senior top management level.
- All health facility managers should separate the national grid facility operations utility metres from the staff houses to manage utility bills at the facility level.
- All new health facilities Must have rain water harvesting provisions beginning financial year 2017/18 to cut down on water bills.

8.0 Effective and efficient Planning and Budgeting-

Interventions to improve planning and budgeting:

- Re prioritize the sector plans/budgets to re-focus on preventive interventions especially community mobilization and empowerment, immunization, sanitation/hygiene, Malaria prevention and control, HIV / Aids, NCDs and nutrition. To undertake this a directorate of public health has been created in the new structure and recruitment will soon commence.
- Ensure Functionality and regular meetings of Councils, boards ,committees and Technical working groups
- Ministry of Health shall move away from incremental budgeting to performance based budgeting (Allocate funds based on critical and priority interventions as opposed to historical basis)
- Review and revise all key performance/out put indicators and service standards for all health facilities at all levels in financial year 2017/18.
- The Planning directorate shall provide annual progress report on implementation of the NRM manifesto to the Senior top management and provide all planning statisitcs to top management for effective planning and budgeting.
- Roll out results based financing mechanism of purchasing health care services
- Alignment and harmonization of development partner work plans with LG plans
- Mapping of all sources of health financing and introduce health insurance to ensure universal health coverage is implemented in a phased manner.

9.0 Funding of Private facilities

After verification and validation which is currently, those facilities that meet the eligibility criteria and are not private for profit shall receive PHC non-wage grants.

Ministry of health shall review annually the PNFP grant eligibility criteria in line with Cabinet directives.

Ministry of Health shall develop a guideline for creation of a credit line at JMS for medicines for eligible PNFP facilities in financial year 2016/17.

10.0 Contract Staff

The Ministry of Health has been employing staff on contract due to lack of an updated human resource structure at the Headquarters. By close of FY 2015/16 there were over 200 contract staff on the Ministry payroll.

- A new human resource structure for MOH Headquarters that provides for more staff has been approved. Ministry of Health is developing new job descriptions and will embark on recruitment process in financial year 2016/17
- All recruitments in public health sector agencies especially contract staff shall be discussed and approved at the Senior top management level before any advert.

11.0 Technical and integrated Support Supervision.

Ministry of Health will harmonize all the support supervision guidelines and standards into one document based on the health systems building blocks;

- Service delivery
- Human resources for Health
- Pharmaceutical products (Medicines and Health supplies)
- Governance and leadership
- Financing
- Health information systems

Very clear support supervision and on spot inspection tools will be developed as a check list to cover the six areas above. Support supervision will be carried out in an integrated and comprehensive manner involving all stakeholders and reports will be shared in bi –annual regional and national review meetings.

These directives shall be implemented in line with other relevant Health sector regulations, protocols and guidelines preceding this framework.