THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

STRATEGIC PLAN II

2025/26 - 2029/30

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FOREWORD

The Fourth National Development Plan (NDP IV) aims to deliver the Uganda National Vision of moving the country from a peasant society to a modern and prosperous country by 2040. The health sector supports the supports second strategic objective of NDP IV to improve human capital development over the whole life cycle to ensure Uganda's population is healthy and productive, supporting socioeconomic development through accessible, high-quality integrated disease prevention, health promotion and general healthcare services.

MoH remains committed to raising the population's life expectancy, lowering fertility rates, enhancing disease prevention and nutritional outcomes, and fostering the growth of the "pathogen economy" and Centres of Excellence for Healthcare. These efforts demonstrate the importance of investing in health of the population as a catalyst for the country's double-digit growth potential by 2040.

The health of Ugandans is a major factor in the country's socioeconomic development and therefore, if disease prevention, health promotion and health care delivery is not improved, our people's poor health will jeopardize the economic rewards of achieving Universal Health Coverage by 2030 and the National Vision 2040.

The Ministry of Health in Uganda is responsible for overseeing and evaluating the health sector, utilizing evidence-based planning, management, and decision-making to ensure sustainable health service delivery. The MoH SP specifically places emphasis on health promotion and disease prevention at all levels across the country. This is because 75% of the disease burden is preventable, and therefore MoH has deliberately allocated about 20% of the total resources for the next five years to this effort.

This plan is designed to be practical, user-friendly and to be actively used by MoH management and staff and related stakeholders, to guide them in their operational/work planning processes over the next five years. I, therefore, call upon all stakeholders at sub-national, national and international level to support the implementation of this Strategic Plan.

HON. DR. ACENG JANE RUTH OCERO
MINISTER OF HEALTH

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ACKNOWLEDGEMENT

The MoH sincerely expresses gratitude to the National Planning Authority for the technical support that enabled the development of the Ministry of Health Strategic Plan 2025/26 – 2029/30.

The process was led by a Core Team from the Planning, Financing and Policy Department and we highly appreciate their commitment and indispensable input.

The development process was participatory and therefore, we acknowledge all stakeholders who provided input and participated in the review of this plan specifically the Health Policy Advisory Committee, Senior Management Committee and Technical Working Groups with representation from the Development Partners, Medical Bureaus, Civil Society Organizations, Private Sector and other MDAs.

This Plan will provide guidance to the MoH and her partners and facilitate decision making toward strengthening the health sector. It should focus us towards achieving the set targets for the National Development Plan IV, PIAP and Sustainable Development Goal targets for the health sector.

We look forward to working collaboratively with all the Health Partners and other MDAs to improve the health status of the Ugandan Population.

DR. DIANA ATWINE
PERMANENT SECRETARY

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ACROYNMS AND ABBREVIATIONS

AHSPR	Annual Health Sector Performance Report
ANC	Antenatal Care
ARV	Anti-retroviral
BFP	Budget Framework Paper
CeMONC	Comprehensive Obstetric and New-born Care
CHEW	Community Health Extension Worker
COVID	Corona Virus Disease
CPHL	Central Public Health Laboratories
CSO	Civil Society Organization
DGHS	Director General Health Services
DHIS2	District Health Information System – 2
DQR	Data Quality review
EMHS	Essential Medicines and Health Supplies
EmONC	Emergency Obstetric and New-born Care
EOC	Emergency Operations Centre
FY	Financial Year
GFTAM	Global Fund for TB, HIV/AIDs and Malaria
GAVI	Global Alliance for Vaccine and Immunization
GoU	Government of Uganda
HC	Health Centre
HCDP	Human Capital Development Programme
HDP	Health Development Partner
HiAP	Health-in-All Policies
HIS	Health Information System
HMB	Hospital Management Board
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRH	Human Resource for Health
HSDP	Health Sector Development Plan
HUMC	Health Unit Management Committee
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information Education Communication
IHR	International Health Regulations
IRS	Indoor Residual Spraying
JRM	Joint Review Mission
KCCA	Kampala City Council Authority

LG	Local Government
LLHF	Lower-Level Health Facility
LLIN	Long Lasting Insecticide Net
MDA	Ministries, Departments, Agencies
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MPS	Ministerial Policy Statement
MTEF	Medium Term Expenditure Framework
NCD	Non-Communicable Disease
NCRI	National Chemotherapeutic Research Institute
NDA	National Drug Authority
NDP	National Development Plan
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NICU	Neonatal Intensive Care Units
NMS	National Medical Stores
NPA	National Planning Authority
NTD	Neglected Tropical Disease
OOP	Out of Pocket
OPM	Office of the Prime Minister
PBB	Programme Based Budgeting
PBS	Programme Budgeting System
PHC	Primary Health Care
PHFP	Public Health Fellowship Program
PHP	Private Health Provider
PHR	Public Health Research
PIAP	Programme Implementation Action Plan
PNFP	Private-Not-For Profit
PPPH	Public Private Partnership for Health
PS	Permanent Secretary
RBF	Results Based Financing
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RRH	Regional Referral Hospital
SARA	Service Availability and Readiness Assessment
SBCC	Social behaviour Change Communication
SCAPP	Standards, Compliance, Accreditation and Patient Protection

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SDG	Sustainable Development Goal
SMC	Senior Management Committee
SOP	Standard Operating Procedure
SP	Strategic Plan
SRHR	Sexual Reproductive Health and Rights
SWAp	Sector Wide Approach
TB	Tuberculosis
TCMP	Traditional and Complementary Medicine Practitioners
TMC	Top Management Committee
TWG	Technical Working Group
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UgIFT	Uganda Intergovernmental Fiscal Transfer
UHC	Universal Health Coverage
UNIPH	Uganda National Institute of Public Health
UNMHCP	Uganda National Minimum Health Care Package
URMCHIP	Uganda Reproductive Maternal Child Health Improvement Project
VHT	Village Health Team
WHO	World Health Organization

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EXECUTIVE SUMMARY

The Ministry of Health is responsible for health policy formulation and dialogue, planning, setting standards and guidelines, supervision and monitoring, technical support, resource mobilization and management of disease outbreaks. This mandate is derived from the Constitution of the Republic of Uganda (1995 as amended) and the LG Act (1997 as amended).

The MoH Strategic Plan has been developed in line with the long-term national development goals and objectives as spelt out in the Vision 2040, and the fourth National Development Plan 2025/26 – 2029/30 whose goal is to *"achieve higher household income, and employment for sustainable social economic transformation"***.** It is aligned to the National Planning Framework and guidance provided by the National Planning Authority. The MoH SP focuses on amongst others, on improving life expectancy, fertility rates, nutritional outcomes and guiding the development of the "pathogen economy" and Centres of Excellence for Healthcare for medical tourism to boost double-digit growth potential of the Ugandan economy by 2040.

This plan provides the strategic direction to the MoH Headquarters over the five-year period which is consistent with the time frame and horizon of NDP IV. This strategic plan supports the NDP IV's second strategic objective, which is to enhance human capital development over the whole life cycle. The Vision of the MoH is *"A healthy and productive population that contributes to socio-economic growth and national development."* Our mission is *"To provide high quality and accessible health services to all people in Uganda, including addressing broader determinants of health."*

The process of developing the plan was participatory including the key stakeholders from within and outside of the Ministry. This involved a comprehensive review of existing policies, strategies, plans and frameworks to inform the plan and align with the already existing planning framework such as the Vision 2040, the NDP IV, third NHP, MoH SP 2020/21 – 2024/25, and sector performance reports, among others.

The Uganda Demographic Health Survey 2022 and the National Census 2024 show significant improvements in health outcomes, including increased life expectancy, reduced maternal and infant mortality rates, and total fertility rates. Sanitation coverage and hygiene have also improved, but challenges such as the growing burden of Non-Communicable Diseases and injuries remain. During the SP period 2020/21 – 2024/25, the Ministry registered significant progress in a number of interventions such as three Acts of Parliament namely Public Health (Amendment) Act 2023,

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Uganda Human Organ Donation and Transplant Act 2022, and Traditional and Complementary Medicines Act 2019 were passed. Local governments were supported, supervised, and mentored. Approval of the Community Heath Strategy and completion of the pilot phase of CHEWS in Mayuge district and Lira City. Health professionals received training, the National HMIS tools and manual were updated, data quality checks were conducted at a few chosen healthcare facilities, and statistical reports were generated on a quarterly basis. After the e-Health strategy and policy were completed, the regional referral hospitals began digitizing their medical records. The Knowledge Management Portal and MoH Call Center were operationalized to deliver current and timely information. Performance reviews were conducted, and sector performance reports were prepared on a quarterly and annual basis.

The goal of this SP is to increase access to high-quality healthcare services, which will improve health outcomes like lower rates of morbidity and mortality and quality of life. The following are the main anticipated results for the five-year SP period: decreased rates of stunting in children under five; decreased mortality rates for neonates, children under five, and mothers; decreased unmet family planning needs and increased use of modern contraceptives; decreased mortality rates from noncommunicable diseases and high-risk infectious diseases; improved access to hand washing and basic sanitation, decreased the prevalence of adolescent pregnancies, raised the proportion of disadvantaged individuals with health insurance, and raised the universal health coverage index.

This strategic plan seeks to fulfil the mandate of the MoH by improving department performance, coordinating stakeholders, and guaranteeing that all Ugandans have easy access to high-quality healthcare. MoH needs Ugx. 16,938.99 billion over five years to successfully execute this plan, with about 20% of total funding going toward disease prevention and health promotion. Health Development Partners and the Ugandan government will be the primary financing sources for this SP.

The Ministry will uphold the principles of transparency, anti-corruption and accountability in all processes and procedures used in the implementation of this five-year Strategic Plan.

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1. INTRODUCTION

1.1 BACKGROUND

The Ministry of Health Strategic Plan II (2025/26–2029/30) is Uganda's five-year blueprint for strengthening the health system and improving population health outcomes. It is aligned with Uganda's long-term development agenda, Vision 2040, and the Fourth National Development Plan (NDP IV). The plan addresses the Human Capital Development Programme (HCDP) aspirations of enhancing productivity and quality of life and global, regional and national commitments like the Sustainable Development Goals (SDGs), and the Regional Strategy for Health Security and Emergencies, 2022–2030 and Universal Health Coverage (UHC).

The MoH SP focuses on improving nutritional and health outcomes. Additionally, it offers recommendations for the establishment of the "pathogen economy" and Centers of Excellence for Healthcare for medical tourism, both of which are essential for enhancing the Ugandan economy's capacity for double-digit growth by 2040. The importance of funding population health is thus emphasized in this SP as a factor in the country's capacity for double-digit growth by 2040.

The plan provides key strategic shifts and guidance to the Ministry of Health (MoH) Headquarters on governance, planning, coordination, and policy implementation to ensure the delivery of quality, accessible, and affordable health services. It emphasizes key strategic shifts and priority investment areas, institutional responsibilities, and key interventions across various domains such as health promotion and disease prevention; communicable and non-communicable prevention, control, and response; reproductive, maternal, newborn, child and adolescent health; health facilities' infrastructure and equipment; digitization and research; and emergency response. It offers a framework for identifying public policy projects, field activities and the spells out the contribution of the private sector, faith-based organizations, other Ministries, Departments, and Agencies (MDAs), and Health Development Partners (HDPs).

It will serve as a roadmap for all parties involved in enhancing the MoH's stewardship role in achieving Universal Health Coverage (UHC) in Uganda. To operationalize the SP the departments will create yearly operating plans with quantifiable goals, guided by the MoH's Policy and Planning Division, aligning with the approved strategic plan and national planning cycle.

The plan, which is expected to require Ugx 16.94 trillion in funding, aims to lower mortality and morbidity, improve health equity, encourage multi-sectoral cooperation, financial risk protection, and hasten Uganda's transition to UHC by 2030. The plan builds on lessons from the previous SP and introduces reforms, in the next five years, to enhance accountability, efficiency, and alignment with emerging health challenges and demographic trends with specific emphasis on health promotion and disease prevention.

1.2 MANDATE

MoH is responsible for establishing policies, standards and resource mobilization. It also coordinates the actions of the health sector, and bringing together national, subnational, and community players to provide high-quality disease prevention, health promotion and healthcare.

The MoH bears the following responsibilities for the development and upkeep of the National Health System:

1) Governance and leadership which involves policy formulation and dialogue, collaboration with all stakeholders, coordination of health programs and ensuring transparency and accountability.
2) Strategic planning, resource mobilization and budgeting.
3) Setting regulations, standards and guidelines development and dissemination.
4) Supervision, monitoring and evaluation of the sector's overall performance.
5) Human resource capacity development and technical support.
6) Infrastructure development.
7) Health systems research, innovation and development.
8) Provision of nationally coordinated health services such as disease surveillance, disaster response and epidemic control.
9) Behaviour Change Communication services or Information Education Communication (IEC).

1.3 THE NATIONAL LEGAL AND POLICY CONTEXT

The Government of Uganda (GoU) upholds the Constitution's guarantees of everyone's fundamental rights to health care, nutrition and healthy lifestyles. Uganda Vision 2040 identifies human capital development as one of the fundamentals that need to be strengthened to accelerate the country's transformation and harnessing the demographic dividend.

The aim is to ensure that Uganda achieves its Vision 2040 aspirations, the NDP IV targets and the health-related SDG targets by 2030. The MoH SP focuses on amongst

others, on improving life expectancy, fertility rates, nutritional outcomes and guiding the development of the "pathogen economy" and Centres of Excellence for Healthcare for medical tourism to boost double-digit growth potential of the Ugandan economy by 2040.

The Ministry's mandate is based on the Constitution 1995, Public Health Act 1935 (as amended) and Local Government Act 1997(as amended). The Constitution guarantees equal rights, access to clean water, education, and healthcare. The Local Government Act assigns line ministries to monitor and coordinate government programs. The national health policy in Uganda aims to enhance the government's role in the health system, focusing on healthcare organization, regulations, technology access, human resource development, innovation, research, and financial protection strategies.

This plan provides the strategic direction to the MoH Headquarters over the five-year period which is consistent with the time frame and horizon of NDP IV. The NDP IV goal is to "achieve higher household income, full monetization of the economy and employment for sustainable social economic transformation". This strategic plan supports the NDP IV's second strategic objective, which is to enhance human capital development over the whole life cycle. The MoH Headquarters falls under the Human Capital Development Programme (HCDP). The goal of the HCDP is to have "a healthy, knowledgeable, skilled and productive population."

The Vision of the MoH is "A healthy and productive population that contributes to socio-economic growth and national development." Our mission is "To provide high quality and accessible health services to all people in Uganda, including addressing broader determinants of health."

1.4 REGIONAL AND INTERNATIONAL PROTOCOLS AND AGREEMENTS

MoH strives to abide by a variety of regional and global accords, conventions, and protocols. Among them are:

a) The Sustainable Development Goals (SDG) aim to improve global health impacts through the Universal Health Coverage (UHC) agenda. SDG 3 specifically aspires for a healthy life and promoting well-being for all at all ages is directly related to health. Other SDGs that support a population that is healthy and productive include SDG1, which calls for reducing poverty, increasing resilience via social protection, and ensuring that everyone has fair access to resources and basic services. SDG 2 asks for enhanced nutrition, food security, and the abolition of hunger. SDG 4 places a strong emphasis on promoting opportunities for lifelong learning, providing equitable, high-quality education, and fostering a skills revolution supported by innovation, science, and technology. While SDG 6 and Africa Agenda 2063 (target 1)

demand that everyone have access to clean water and sanitation, SDG 5 calls for gender equality and the empowerment of all women and girls.

b) The International Health Regulations (IHR) which guide the country on key actions needed to assure Global Health Security.
c) Ouagadougou declaration on Primary Health Care (PHC) and Health Systems – a re-iteration of the principles of the PHC approach, within the context of an overall health system strengthening approach.
d) The Astana declaration on PHC, and Africa Health Agenda International Conference 2019.
e) International Health Partnerships on Aid Effectiveness
f) African Union Agenda 2063: The Africa we want" sets the commitment to achieve UHC by 2030.
g) The Common African Position of the African Union.
h) United Nations Secretary General's Global Strategy on Reproductive, Maternal, Newborn, Children's and Adolescents' Health ("Global Strategy") provides a roadmap to advancing the health of women, children and adolescents.
i) International Human Right agreements such as International Declaration for Human Rights, Convention on the Elimination of All Forms of Discrimination against Women, Child Rights Convention, the International Conference on Population and Development programme of action and the Beijing Declaration and Platform of Action. These highlight human rights and the need to use human rights-based approaches, including recognition of the right to health, as well as the target related to UHC to enhance equity, accountability and participation.
j) United Nations Framework Convention on Climate Change urges countries to minimize the adverse effects on public health and put in place measures to mitigate or adapt to climate change.

The Ministry of Health integrates international commitments into its operational framework, collaborating with relevant MDAs to develop a National Global Health Strategy for policy coherence.

1.5 SP Development Process

This plan serves to outline the Ministry of Health's strategic direction and goals for the upcoming five-year term, which runs from 2025/26 to 2029/30. The MoH SP provides guidance on the areas of priority investment and anticipated outcomes and was developed based on the Sector Development Planning Guidelines issued by the National Planning Authority (NPA).

A core writing team was formed to steer the SP development process. The preparation process involved a review of existing national policies, plans and frameworks and harmonization or alignment with the already existing planning framework.

The SP is an amalgamation of the inputs made by various MoH departments and technical working groups. The draft SP was presented to the various Technical Working Groups for review and input, subjected to approval through the MoH governance structures namely SMC, HPAC and Top Management. In addition, comments were received from the health development partners. Thereafter a revised version was sent to NPA for their guidance and concurrence before by finalized by the Ministry.

1.6 STRUCTURE OF THE STRATEGIC PLAN

This document is designed to be practical, user-friendly and to be actively used by MoH Management, staff and stakeholders, to guide them in their day-to-day work planning processes over the next five years.

This SP has ten sections as outlined below:
Section 1: Introduction
Section 2: Situation Analysis
Section 3: The Strategic Direction
Section 4: Financing Framework and Strategy
Section 5: Institutional Arrangement for Implementation of the Plan
Section 6: Communication and Feedback Arrangements
Section 7: Risk Management
Section 8: Monitoring and Evaluation Framework
Section 9: Annexes
Section 10: References

2 SITUATION ANALYSIS

This section details the performance of the previous SP 2020/21 – 2024/25. It highlights the achievements, challenges, and emerging issues from the implementation of the previous SP and provides evidence to inform the strategic direction and priorities in the next 5-years period.

The health system in Uganda continues to face a significant burden of infectious diseases, a rising rate of non-communicable diseases (NCD), and a growing need for health services because of shifting epidemiological disease patterns and rapid population growth. Over the past five years, several health indicators have improved, but there is still much work to be done to enhance equitable access and quality of health services.

Malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis (TB) and perinatal and neonatal conditions remain the leading causes of morbidity and mortality. Seventy percent of overall child mortality is due to malaria (32%), perinatal and neonatal conditions (18%), meningitis (10%), pneumonia (8%), HIV/AIDS (5.6%) and malnutrition (4.6%). UPHIA 2022 indicated that among people aged 15 and over, the overall HIV incidence was 0.29% and the prevalence was 5.8%. It was estimated that 75.4% of individuals living with HIV had HIV viral load suppression. Therefore, to stop the HIV pandemic, the nation must achieve at least 95% viral load suppression.

Health promotion and prevention can avert 75% of Uganda's disease burden. Cultural attitudes, social behaviours, housing circumstances, access to safe water and sanitation, income and education levels, and availability of high-quality health care are all factors that impact health. 56% of children experience numerous deprivations, with greater rates in rural regions. These deprivations include health care and education, a social and familial life, clean and safe drinking water, enough housing, clothing, and regular meals with enough nourishing food. Addressing these concerns requires collaboration between stakeholders and the health sectors.

Amidst all the above, climate change is now humanity's most prominent health threat with a strong bearing on health service delivery system and health outcomes. Uganda is already experiencing severe climate change effects, such as heavy rains, windstorms, floods, droughts, and temperature changes, which contribute to direct and indirect health effects e.g., injuries and deaths, destruction of health infrastructure, increase in water-borne and vector-borne diseases, malnutrition and food-borne diseases, respiratory and heat related illnesses, mental and psychosocial problems.

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According to H-NAP (2024) a significant proportion of our health facilities are exposed to climate change-related hazards (see below)[1]. Vice versa, while delivering health services and patient care, health systems are also responsible for greenhouse gas emission, thus contributing to climate change. To effectively protect the health of population, health systems have the double responsibility of building climate resilience and reducing their own carbon footprint.

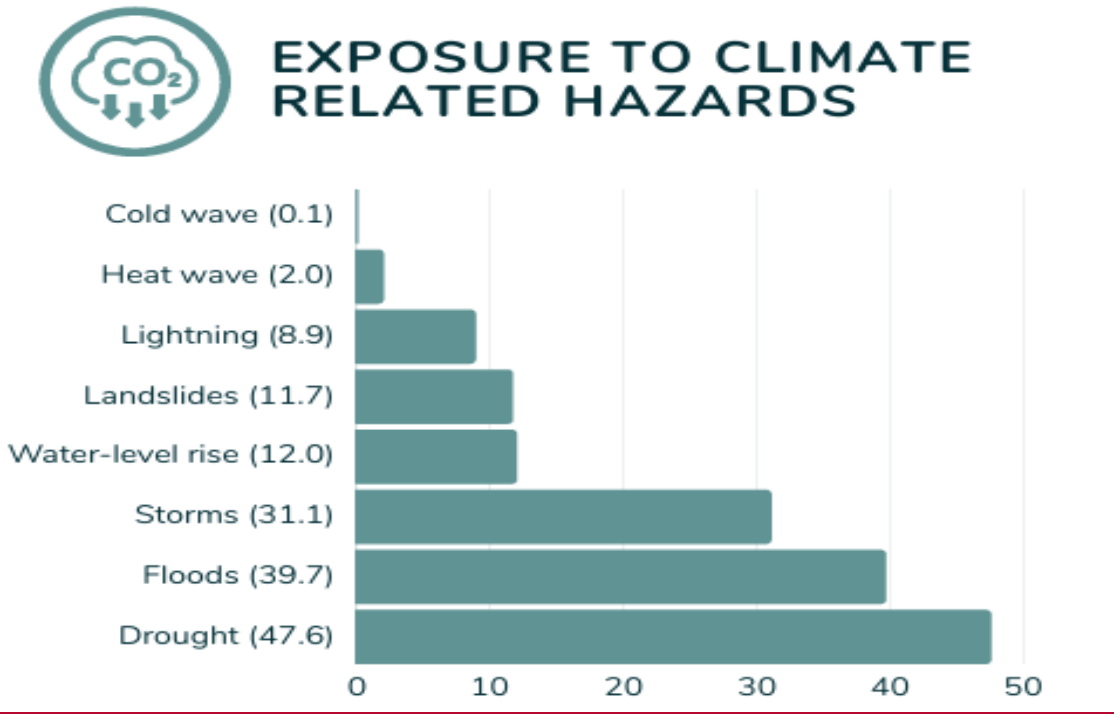

Figure 1: Proportion of exposure to climate change-related hazards

2.1 PERFORMANCE OF THE PREVIOUS PLAN

The MoH SP 2020/21 – 2024/25 focused on achieving seven objectives namely:

a) To strengthen health sector governance, management and coordination for UHC.
b) Strengthen human resources for health management and development.
c) Increase access to nationally coordinated services for communicable and non-communicable disease/conditions prevention and control.
d) Strengthen disease surveillance, disaster response and epidemic control at national and sub-national levels.
e) To ensure availability of quality and safe medicines, vaccines and technologies.
f) To improve functionality and adequacy of health infrastructure and logistics.
g) Accelerate health research, innovation and technology development.

An analysis of the implementation of the SP 2020/21 – 2024/25 is highlighted below.

[1] MoH (2024) Climate change Health National Adaptation Plan, Government of Uganda, Kampala

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2.1.1 To strengthen health sector governance, management and coordination for UHC

a) Performance of the Governance and Management Structures

MoH had elaborate governance and management structures with committed Senior Top leadership (MoH Governance & Management Structures Implementation Guidelines 2022). The implementation and coordination structure were clearly defined from the lowest level of the departments through TWGs, SMC, HPAC, and TMC to facilitate policy and strategy dialogue, formulation, development, implementation, monitoring and evaluation. It was determined that the majority of stakeholders had faith and confidence in the MoH's organizational structures. However, most governance and management structures operated sub-optimally due to the challenges posed by the Covid 19 pandemic. Majority of the structures, however, had to adopt to the use of online ICT platforms for meetings. The overall performance of the structures is summarized in Table 5 below.

Table 1: Performance of the different Management Structures at MoH

Governance Structure	Achieved FY20/21	Achieved FY21/22	Achieved FY22/23	Achieved FY23/24	Achieved FY24/25	Remarks
Top Management meetings held (%)	25	50	100	83	60	• FY 2020/21 performance was poor due to Covid-19 interruptions but improved with the use of online platforms like Zoom for meetings. • The decision-making processes need to be expedited.
HPAC meetings held (%)	50	75	100	100	90	
Senior Management meetings held (%)	92	100	100	100	92	• During meetings, the participation of several members has been minimal.
Technical Working Group meetings held (%)	65	100	100	100	75	• Key policy and strategic actions referred to SMC
Department meetings held (%)	70.4	80	100	80	50	• Meetings have been disrupted by competing priorities, necessitating the implementation of both virtual and physical provisions to ensure regular participation of departmental members.

During the SP period, significant achievements included transitioning from output-based to program-based budgeting with a focus on outcomes rather than outputs, conducting regular performance reviews, establishing a comprehensive policy framework, and enhancing stakeholder engagement. The ministry's stewardship

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function needs to be improved by encouraging more departments to hold regular meetings to cascade policy to the employees and also ensure actions of meetings are followed up to the later.

b) Implementation of the Health Information and Digital Health Strategy

i. Ensure secure timely availability and access to quality assured health data by 2025

This aimed to collect and collate health data for decision-making, achieving 99% HMIS 105 reporting in FY2024/25, with slight reductions due to USG funding disruptions.

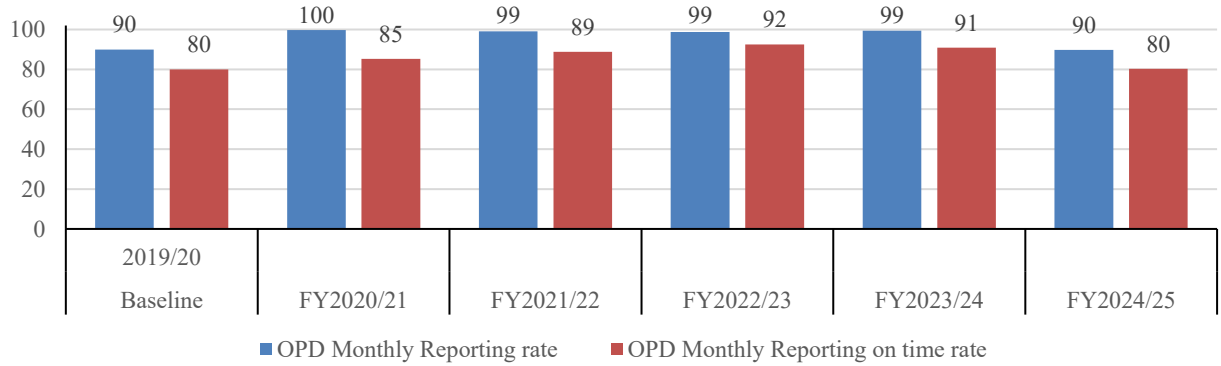

Figure 2: HMIS 105 OPD Monthly Reporting Rate

The Ministry of Health has revised HMIS tools and trained 146 biostatisticians, ensuring their availability in health facilities. Despite challenges, the tool availability averaged 62% during the 5-year strategic plan. The updated georeferenced database maintains 100% registration for government-owned facilities, with private facilities below 50%.

Challenges with facility registration range from continuation to operate without renewal of licenses as well as districts and city local governments artificially deflating the number of facilities to give a false impression of good reporting rate. MoH conducted data quality audits annually for correctness of data and effectiveness of data quality assurance processes, implemented a national data warehouse and strengthen death notification increasing it from 0% at baseline to over 20% by the end of FY2024/25.

ii. Ensure effective statistical, analytical and data visualization support for all functions at the national and sub-national levels by 2025.

This objective was to strengthen the Ministry of Health's ability to measure the impact framework of the health sector and ensure production and dissemination of key statutory reports as well as submit data to donors as part of accountability for funds received. In the Five-year period of the strategic plan, MoH produced five annual health sector performance review reports as well as 20 quarterly performance reports.

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iii. *Institutionalize within the health sector the use of patient-level digital systems at point of care by 2025.*

MoH implemented an electronic medical record system in healthcare facilities, increase the number of people using the system, and implement an integrated system at additional points of care. The number of government-owned healthcare facilities that use integrated electronic medical records increased from seven to seventy-seven during the strategy's five years.

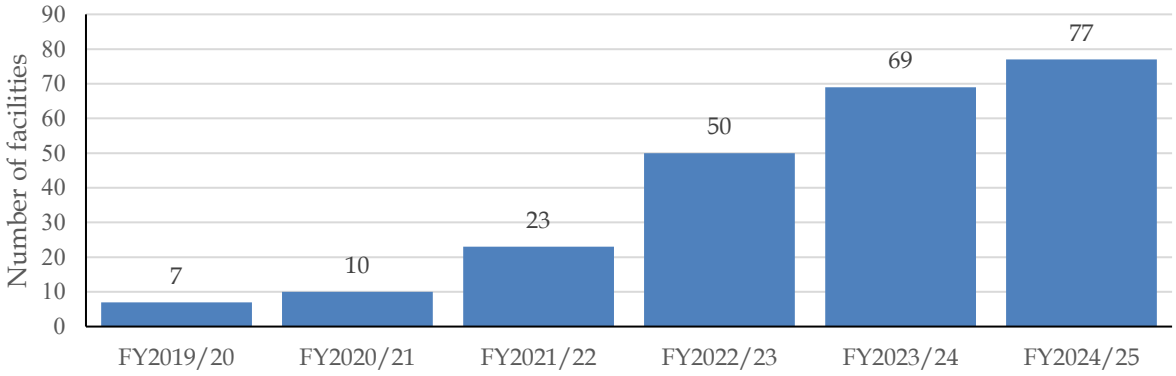

Figure 3: Government owned facilities with a Functional Electronic Record Management System

Figure 4: Picture showing Health Workers an Electronic Medical Record System

The Ministry of health also targeted to rollout the electronic community health information system to 45000 community health workers. By the end of the five years, the eCHIS had been rolled out to 18,933 VHTs and 1,242 CHEWS in 23 Districts. The Ministry of Health has also developed an integrated outbreak management system

collapsing multiple function specific outbreak management application systems into a single integrated system for management of outbreaks.

iv. Strengthen the enabling environment in Uganda's health sector for implementation of HIDH

This was intended to create an effective enabling environment for the implementation of health information and digital health strides in the health sector in Uganda.

MoH produced a total of 7 guidelines to guide implementation namely: Uganda Digital Health Enterprise Architecture, Standards and Knowledge Guidelines; Uganda Health Information Exchange and Interoperability Guidelines; Uganda Health Data Protection Privacy and Confidentiality Guidelines; Uganda Health Data Access, Sharing and Use Guidelines; Guidelines for the Introduction of Digital Health Solutions and Innovations in Uganda; Guidelines for the implementation of the Electronic Medical Records System; and Guidelines for Implementation of Uganda's Electronic Community Health Information System (eCHIS).

v. Develop a functional collaborative mechanism in the health sector to support HIDH implementation research and innovation by 2025.

The Ministry of Health has started the development of a framework for the adoption of Artificial Intelligence and Machine learning for health service delivery. This, however, had not been finalized by the end of the strategic planning period.

c) Health Legislation

Significant legislative progress was made during the previous SP, with three major Acts passed:

i) The Uganda Human Organ Donation and Transplant Act of 2022 established a regulatory framework for organ, tissue, and cell transplantation.
ii) The Traditional Medicines Act of 2019 formalized regulation of the practice of complementary and alternative medicine; and
iii) The Public Health (Amendment) Act of 2023 modernized the legal framework, repealed obsolete provisions, harmonized disease control laws, and updated fines.

The next crucial step is to operationalize the provisions of these Acts by developing relevant accompanying regulations.

At the end of the previous SP period, six key Bills are in advanced stages, including the National Health Insurance Scheme Bill, National Drug and Health Products Bill, Uganda Health Professionals Regulatory Council Bill, Human Fertility Bill, Specialized Hospitals Bill, and Infection Prevention and Control Bill. Most require Certificates of Financial Implications from the Ministry of Finance, Planning and Economic Development (MFPED) before submission to Parliament. Also, the Third National Health Policy (2025) awaits a Certificate of Financial Implications prior to discussion and approval by Cabinet.

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d) Multisectoral Collaboration and Partnerships

Uganda's Integrated Refugee Response Plan 2021/22-2024/25 has resulted into integrating refugees into primary healthcare systems and construction of 2 regional blood banks, 5 operating theatres, 4 HDUs, 35 HCIIIs in 9 refugee hosting districts. The challenges persist in providing adequate livelihoods, addressing social isolation, and ensuring sufficient international support.

Regional and international health partner meetings facilitated collaboration, knowledge sharing, and resource mobilization, leading to achievements in disease control, health system strengthening, and pandemic preparedness, but grappled with challenges such as funding gaps, weak health systems, and the need for more effective coordination among diverse partners.

Private sector engagement in health has led to increased access to services, innovation, and resource mobilization. However, challenges include weak regulation, inconsistent care quality, fragmentation and coordination, financial sustainability, limited public sector capacity, and lack of data. To achieve health goals, strategic engagement, public-private partnerships, capacity building, incentives, regulations, data sharing, transparency, and a mindset shift are needed. Public-Private Partnership in Health (PPPH) strategy and no framework for joint planning were developed during the SP period.

e) Results-Based Financing

Uganda has had experience implementing Results- Based Financing (RBF) interventions for over 20 years. National RBF Framework was developed as a result which guided the design and implementation of a nationwide scaled up of the RBF intervention under the Uganda Reproductive Maternal and Child Health Improvement Project (URMCHIP) and Enabling Health in Acholi (EHA) between FY 2018/19 and FY 2021/22 across public and private not for profit (PNFP) Health Centre IIIs, IVs, General Hospitals and Regional Referral Hospitals. These have been a mixture of demand side and supply side interventions.

RBF was scaled up nationwide under URMCHIP and EHA, covering HC III, HC IV, General Hospital and Regional Referral Hospitals (1,359 HF and 117 Hospitals) and later integrated into the Sector Conditional Grant (SCG) covering only HC III and HC IV totaling 1,847 Health facilities.

The implementation of RBF has resulted in several achievements including:

- Increased financing to the health facilities under the sector conditional grant with an additional Ugx. 35.5 billion annually, representing a 30% ration of SCG NWR.

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- Increased service utilization of key primary health care services such as ANC, PNC, institutional deliveries with an average growth of 4% realized across the indicators in the incentivized package.
- Improvement in quality with fewer facilities scoring below 65% (Star 0 and 1 (from 48% in 2021 to 29% in 2024) and increase in facilities scoring above 85% i.e., star 4 and 5 from 11% in 2021 to 14% in 2024
- Improvement in the quality of data especially regarding the accuracy across Primary registers and DHIS 2 with the proportion of non-penalized health facilities increasing from 25% in 2023 to 30% in 2024
- Strengthened evidence-based planning using bottlenecks analysis with over 75% of the LGs supervised in FY 2024/25 having adopted the HMIS 001 format to generate their workplan.

Despite these gains, there are challenges with implementation, some of which are listed below.

- There is a very huge lag between the time of assessment and realization of RBF funds due to limitations of the Public Finance Management framework. This affects the impact RBF may have as instant reward for performance would triggers faster reaction from the beneficiaries to address any issues.
- Weaknesses in quality assessment which focuses more on structural quality rather than functional quality.
- Absence of an incentivized package at tertiary level (General hospitals) to ensure a continuum for incentivized service delivery.
- Limited autonomy and flexibility as HFs cannot procure Essential Medicines and Health Supplies, major renovations, major equipment and direct reward for outstanding staff.
- Capacity gaps including limited technical skills at both LG and HF in governance, financial management and clinical practices.
- Limited resource tracking at HF level occasioning inefficiencies in fund utilization.
- Low coverage of verification for outputs as it is currently being done on sampling basis.

It is recommended that:

- RBF mainstreaming strategy needs to be reviewed to address aspects related to design of the mechanism, verifications, incentivized package and the inclusion of a package for GH.

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- The NWR Grant to allow for waivers aimed at allowing for more flexibility in the utilization of RBF funds.
- There should be fast tracking of the simplified computerized accounting and reporting tool (SCART) at Health facilities to aid tracking of utilization of funds and accountability.

2.1.2 To Strengthen human resources for health management and development

The previous MoH SP successfully implemented the HRH strategic plan 2020-2030, achieving staffing levels above 85%; timely salary, gratuity and pension payments; optimal contract staff support; operationalization of the Integrated Human Resource Information System (IHRIS); and CPD programs for health workers especially in emergency care and maternal health.

The human resource management at MoH was hampered by several issues. One of the most demotivating factors has been the compensation differences caused by the gradual salary improvement and lowering during the IPPS to HCM system conversion for personnel whose roles enable candidates with both medical and science/arts backgrounds. Duty attendance rates continued to fall short of the 95% goal. This is partly because the biometric system was turned off during COVID-19, and it was unable to record attendance for employees conducting fieldwork.

It is recommended that the IHRIS system be improved so that field activity attendance can be recorded and to eliminate salary discrepancies, the pay enhancement for all cadres should also be accelerated.

IHRIS has improved workforce data management, strengthened hiring and deployment procedures, and provided evidence for decision-making. Dual maintenance expenses and a lack of funding for ongoing system training and data updates are among the drawbacks.

2.1.3 To Increase access to nationally coordinated services for communicable and non-communicable disease / conditions prevention and control

a) Water, Sanitation & Hygiene (WASH)

There was significant progress against the three (3) WASH related interventions that include revitalizing Public Health inspection, increasing access to and monitoring of hygiene and sanitation. A functional multi-sectoral Sanitation and Hygiene Working Group has been revitalized at National level under the stewardship of MoH.

The development and validation of inspection tools and performance indicators for health inspectorate staff at the local government level have improved planning, stakeholder engagement, and monitoring of WASH interventions. However, the rollout of the WASH-MIS faced challenges due to its multisectoral nature and the COVID-19 pandemic's international travel ban, affecting its timely completion. The

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development environmental health sanitation and hygiene strategic plan was deferred and is now planned for the next SP period.

b) HIV /AIDS, and STIs

Uganda has continued to make progress towards HIV epidemic control with declining new infections, AIDS-related mortality, and HIV prevalence. According to the UPHIA 2020, a total of 1.43 million people were living with HIV.

Of the five priority indicators, performance against 3 indicators has consistently been above target over the MoH SP implementation period. These include HIV positive pregnant women initiated on ARVs for EMTCT, HIV exposed infants with first DNA/PCR test within 2 months and ART Coverage. This was largely due to strengthened patient literacy and attachment of PLHIV to community linkage facilitators, peers, or mentor mothers.

However, the targets to improve patient retention on ART at 12 months and Patient Viral load suppression were not met. Retention performance stagnated around 77% over the three years while viral suppression greatly fluctuates between the years. The fluctuation is largely due to low suppression rates among children, adolescents, and men. For example, in the year 2022/2023, whereas the overall suppression rate was 94.1%, viral suppression among children was 85%, for adolescents it was 87% and 93% among men.

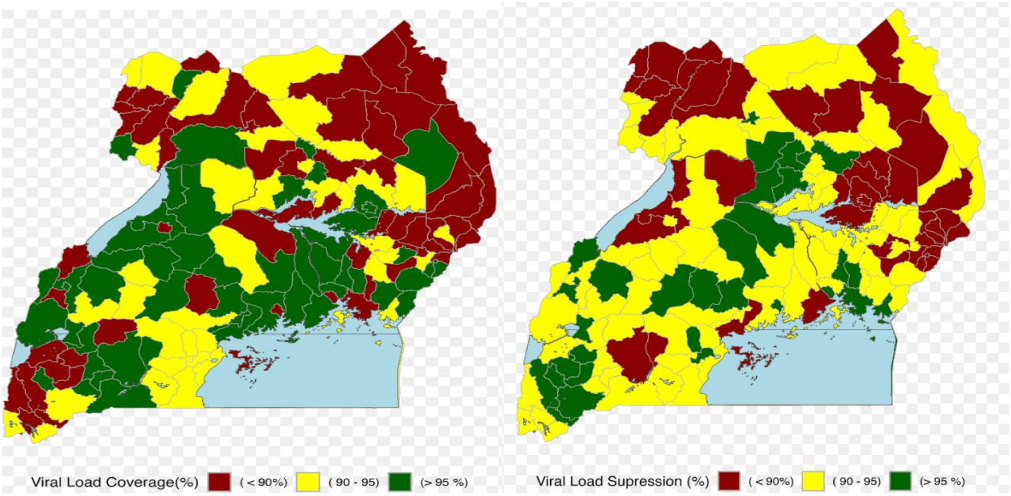

Figure 5: Viral Load Coverage and Suppression

The main challenges are the unique needs specific for various age groups, sex and population categories that demands for tailored planning. Among the most important lessons learned are that peer-to-peer connections increase the coverage of interventions and that the use of birth cohort monitoring enhances the adoption and retention of Early Infant Diagnosis (EID) services.

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c) Tuberculosis & Leprosy

Over the last five years, significant strides have been made in the fight against leprosy and tuberculosis, showcasing innovative programs and a strong governmental commitment. The program has achieved and sustained a 54% reduction in TB and TB/HIV mortality, a significant public health accomplishment. TB case notification increased from 161/100,000 in FY2020/21 to 185/100,000 in FY2023/24, while the treatment success rate rose from 72% to 92.3% respectively. TB preventive treatment coverage reached 79% of eligible children under 5 years, 80% of eligible contacts over five years, and 94% of eligible People Living with HIV (PLHIV). Innovative case-finding approaches through the CAST+ campaign, active case investigations, and mobile TB clinics have strengthened the program's reach.

Additionally, leprosy remains a leading infectious cause of visible disability in Uganda. It is one of the neglected tropical diseases that continues to be endemic in close to 45% of the districts in the country. The proportion of leprosy patients with grade 2 disability reduced significantly from 19.5% in FY2022/23 to 11% in FY2023/24, while the proportion of child leprosy cases remained high at 15% by the close of the FY2023/24, above the target of less than 3%.

Despite this significant progress, Uganda's TB and Leprosy response faces challenges like insufficient funding, limited social protection, minimal private sector engagement, limited specialized care access, and limited efforts to address the social determinants of TB and Leprosy consequently threatening its sustainability.

TB notification rates for new and relapse TB patients increased from 2020 from 147 cases per 100,000 population reaching the highest in 2022 at 214 cases per 100,000 population. However, observed drop in 2023 with a slight increase in 2024. Men have higher TB notification rates over the years compared to the females and well above the national average of TB notification rates (see Figure 15).

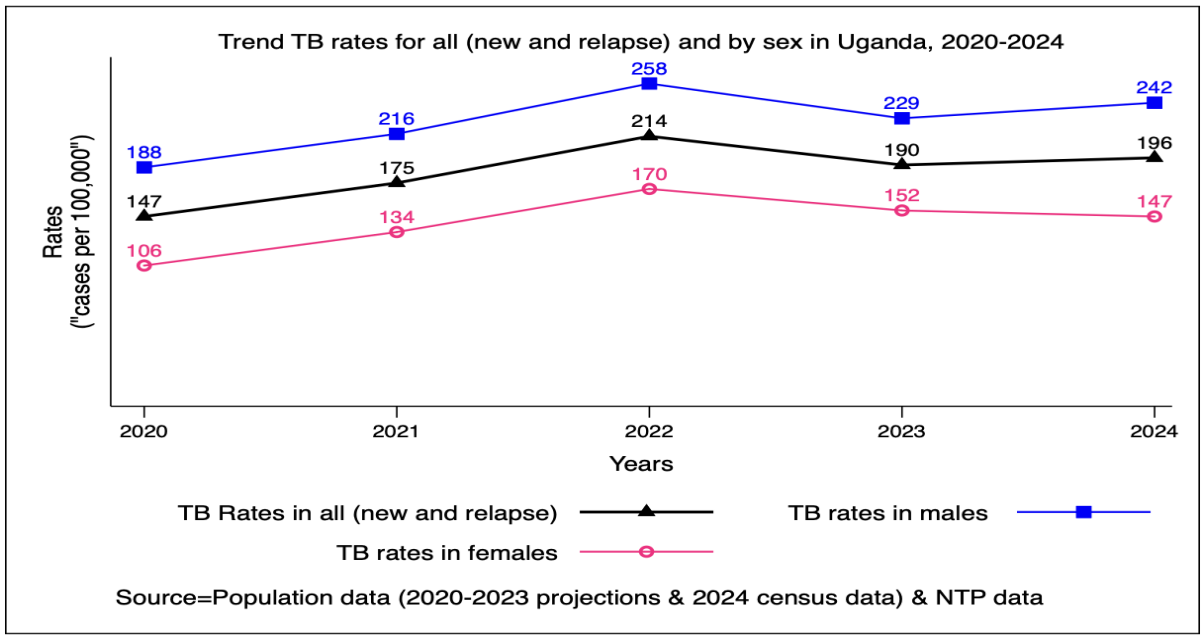

Figure 6: TB notification rates for new TB patients, males and females, 2020-2024

d) Malaria

Despite malaria upsurges experienced in many parts of the country between October 2021 and end of September 2022, the country registered remarkable progress in reversing both incidence and mortality due to malaria.

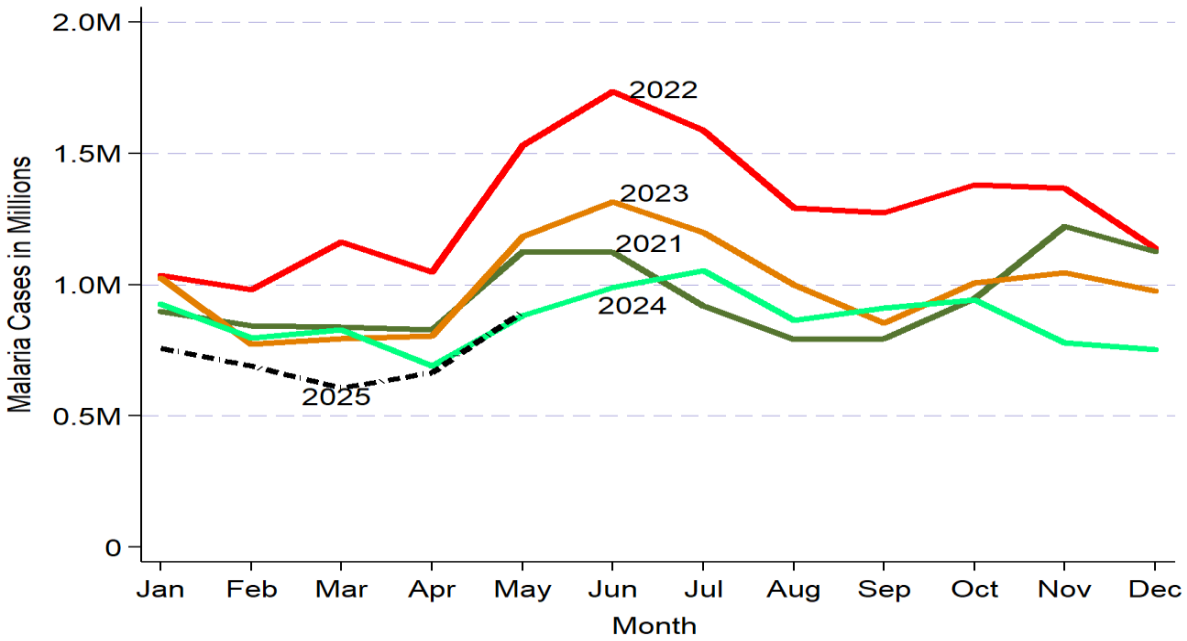

Figure 7: Malaria monthly case trends for Uganda, 2021, 2022, 2023, 2024 and 2025

The number of districts with incidence >750/1000 declined by 62% from 13 to 5 between 2022 and 2024 (Table below). Equally, the population in the areas with very high incidence (which was highest in 2022) reduced by 57% from 2,330,700 to 992,100

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by the end of 2023. High-impact interventions were deployed in selected high-burden regions.

These include mass ITN distribution across the country, IRS in Bukedi, Busoga, Teso, Lango and West Nile and Seasonal Malaria Chemoprevention (SMC) in Karamoja targeting Under 5s. Incidence categories and number/percentage of districts in Uganda per category, for the years 2021, 2022, 2023 and 2024.

The Ministry conducted a mass ITN campaign and distributed a total of 28,448,720 ITNs to 46,784,817 persons in all Districts in 2023; a total of 2,675,850 LLINs were distributed in 2024 out of the projected 3.5 million nets, targeting pregnant women, children under five years of age, and beneficiaries of the SMART Discharge program; conducted IRS in high malaria burden districts protecting the populations at risk of malaria; Seasonal Malaria chemoprevention (SMC) was conducted in 9 districts in the Karamoja region, 287,245 out of the 282,357 (102%) children under 5 years covered for SMC.

Table 2: Malaria Incidence Categorization by Districts

	2021			2022			2023			2024		
Incidence category	# Districts	Population affected	Proportion of population affected	# Districts	Population affected	Proportion of population affected	# Districts	Population affected	Proportion of population affected	# Districts	Population affected	Proportion of population affected
<100 (Very low)	21	9,057,000	21.1	11	5,271,900	11.9	17	7,525,600	16.5	26	11,807,900	25.2
101 <250 (Low)	54	16,136,000	37.6	39	12,429,000	28.1	60	20,586,300	45.2	56	18,246,000	38.9
251 <450 (Moderate)	37	10,258,700	23.9	41	13,068,500	29.1	48	13,188,200	28.9	39	10,924,100	23.3
451 <750 (High)	27	6,377,000	14.9	42	11,111,800	25.1	15	3,275,100	7.2	20	4,898,000	10.4
>750 (Very High)	7	1,056,900	2.5	13	2,330,700	5.3	6	986,900	2.2	5	992,100	2.1
Population		42,885,600			44,211,900			45,562,100			46,868,100	

*Incidence categorization: <100 Very low | 100 <250 Low | 250 <450 Moderate | 450 <750 High | >750 Very high

Diagnosis and treatment of malaria have improved; at public sector health facilities, in 2024, 99% of suspected malaria cases had a parasitological test, while 98% of confirmed malaria cases received first-line antimalarial treatment. Similarly, malaria case management has improved. iCCM was implemented in 81 Districts with 91% confirmed malaria cases that received first-line antimalarial treatment in the community being parasitologically confirmed. These interventions shall be continued during the next 5-year period.

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e) Triple Elimination

From the UPHIA Survey, 6.0% of adults 15+ years have ever had syphilis (6.1% among women and 5.8% among men), while 2.1% have active syphilis infection (2.2% among women and 2.0% among men). The survey also found that about 4.1% of the adults and 0.6% of the children had a Hepatitis B virus (HBV), and the HBV prevalence varied geographically from 0.8% in South-West to 4.6% in the Mid-North region.

By June 2024, Uganda had a sustained HIV testing and maternal ART coverage above 95% respectively and scaled up syphilis testing from 57% to 94% and treatment to 83% but also made progress in mainstreaming Hepatitis B programming into Maternal and Child services including testing (63% pregnant women tested), treatment (42% of those tested positive). Additionally, innovative point of care testing for EID and viral load for mothers was introduced and scaled up to 323 health facilities, leading to improvement in timely EID testing within 2 months for HIV exposed infants from less than 50% in 2019 to 85% by the end of 2024.

The multiple entry points for maternal, newborn and child health services provide a unique opportunity for coordination and integration of HIV, Syphilis, and HBV services. The country will continue to strengthen and utilize these platforms to deliver interventions including prevention, immunization, testing, and treatment to achieve triple elimination of vertical transmission by 2030.

f) Immunization

The introduction of new vaccines and schedules (IPV2, MR2, Hep B birth dose, Yellow Fever, and Malaria) has successfully increased access to immunization services against childhood diseases. In addition to the Measles Rubella campaign and polio supplementary immunization activities (SIAs), vaccination campaigns against yellow fever were conducted in six high-risk areas. MR1 data shows a consistent upward trend, indicating successful efforts to increase immunization coverage rates over the last three years of 2021, 2022, 2023 from 86% to 91% to 94% respectively and this has contributed to reduction in death of children before celebrating their first birthdays. DPT3 coverage remained relatively stable at 87% for two years, indicating a baseline level of immunization efforts. The increase to 91% in the second year suggests successful interventions. The program has maintained high immunization coverage rates despite the Covid-19 pandemic. There has also been improved vaccine preventable disease surveillance, and collaboration with partners and MDAs. It has also improved community engagement, population identification, and data reporting, attributed to strong management and resource utilization.

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Challenges faced in immunization include missed children and communities (zero dose) because of irregular vaccination opportunities at both static, outreaches and hard-to-reach communities. Post Covid-19 pandemic amplified the notion of vaccine resistance due to the rise in new media spaces where misinformation, dis-information rapidly get disseminated. There has also been sub optimal data quality largely due to the manual data capture tools at operational level. These factors have led to re-surgence of Vaccine Preventable Disease outbreaks like measles. The changing global financial fiscal space has amplified the urgency of increased domestic financing for vaccine procurement.

It is recommended that the program embraces and implements the Learning and Performance Management model (QI), Reduce Missed Opportunities for Vaccination, Routine consistent messaging, targeted interventions using data to reach Zero Dose and Under Immunized Children, Strengthening Civil Society Organizations(CSOs), continuous support supervision to poor performing districts, support Periodic Intensification of Routine Immunization that includes Supplementary Immunization Activities(SIAs) including the Integrated Child Health Days(ICHDs) to improve catch-up strategies, strengthen regional level structures and last mile delivery of vaccines, support data use through use of dashboards and Geospatial technologies and digitization. The training in microplanning and Mid-Level Management to improve leadership and management capacities at sub-national levels, as well as re-strategize on immunization coverage improvement to reach every child and every targeted population with all the antigens using the life course approach in an integration approach thereby guarantee improving the overall health of the population. This notwithstanding, given the expanded menu of antigens, and the rapidly changing financial fiscal space, the program should develop a comprehensive investment case to support resource mobilization efforts and use the same for advocacy for increased domestic financing.

f) National Health Laboratory Services (NHLDS)

Over the course of the three years from 2020–2021 to 2022–2023, significant progress was made in several areas, including the development of the department's strategic plan, completing annual quantification, equipping about 89 hubs, completing ToT for SPARS in all 16 regions, and mentoring of 23 health facilities laboratories on ISO implementations.

These achievements have equipped laboratory personnel with the capacity to deliver high quality laboratory services required for universal health coverage. Nonetheless, persistent underperformance was noted over time in the national DQAs for national and subnational databases as well as the annual refresher training sessions on the use

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of Laboratory Web-based ordering systems. These activities have not been carried out in the last two years due to budgetary restrictions. To guarantee that all planned interventions are carried out according to schedule, the department is required to intensify resource mobilization.

g) Emergency Medical Services (EMS)

The Ministry of Health has made significant progress in improving the emergency medical service (EMS) in Uganda. The EMS Policy and Strategic Plan have been disseminated across all levels ensuring that communities are informed about the available EMS services and their role in improving health outcomes.

To enhance emergency response and coordination, 2 call and dispatch centers and ambulance hubs have been established in Naguru NRH and Masaka RRH. Construction of 4 additional centers in Arua, Lira, Mbale, and Mbarara began in FY 2022/23 and is currently underway. Furthermore, efforts are being made to digitize ambulance number plates, and the setup of an ambulance communication system is in advanced stages. These initiatives aim to streamline communication and improve the efficiency of emergency response.

The EMS program has demonstrated its effectiveness during various health emergencies, including the COVID-19 pandemic and Ebola outbreaks. Trained emergency medical teams have been deployed across the country to respond to these crises, highlighting the program's readiness and capacity to handle diverse health challenges. However, there are still challenges that need to be addressed. The country currently faces a significant shortage of ambulances, with only 276 (53.5%) available out of the 516 required. This shortage hampers the effective coordination and referral of EMS services as shown in table 7 below.

Table 3: Ambulance needs in Uganda

Ambulance Type	Required	Available	Gap	Gap Percentage
Emergency ambulances (type B) at Constituency level	353	181	172	48.7%
National and Regional level	52	40	12	23.1%
Marine	20	14	6	30%
Specialized	66	35	31	47%
Aeromedical	5	0	5	100%
Medical Command	20	6	14	70%
Total	**516**	**276**	**240**	**46.5%**

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The main challenge has been the ever-increasing number of injuries and insufficient EMS human resources across all levels which hinder implementation of the policy and strategic plan objectives. Adequate staffing is crucial for the smooth functioning of the EMS and the provision of timely and quality emergency care.

The Road traffic injuries have increased by over 300% in the last 10 years from 50,000 cases in 2016/17 to 150000 cases in FY 2023/25. In the year 2023/24, the Ministry of public service approved new staffing norms for the EMS providing staff positions for EMS at all levels. The remaining issue now is resources to recruit the staff to take up these positions. In the next 5 years under the NDPIV, Ministry of Finance has indicated that wage will be provided gradually to run the National EMS system.

h) Reproductive, Maternal, New-born, Child, and Adolescent Health

During the MoH SP period, Uganda made significant strides in implementing the five-year National Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy (2021-2026), also known as the Sharpened Plan II. This strategy aims to end preventable maternal, newborn, child, and adolescent deaths while promoting health and development throughout the life course. The Sharpened Plan II was aligned with a multi-sectoral approach, integrating enhanced accountability mechanisms to target districts and populations facing barriers to accessing care or experiencing high burdens of maternal and childhood deaths. This comprehensive strategy emphasized collaborative efforts across various sectors, including health, education, and community development, to address socio-economic determinants of RMNCAH outcomes.

Several key operational plans were developed under the Sharpened Plan II to ensure effective implementation of its goals. Notably, the Family Planning Costed Implementation Plan II (FP-CIP II) was launched, focusing on scaling up high-impact, evidence-based interventions to improve the quality of care in family planning. Additionally, new guidelines were introduced for pre- and inter-conception care, timely antenatal care initiation in the first trimester, essential care during birth and the first week of life, Integrated Management of Newborn and Childhood Illnesses (IMNCI), integrated Community Case Management (iCCM), nutrition, adolescent health, and social and behavioral change communication (SBCC). These guidelines were essential in ensuring comprehensive and continuous care for women, children, and adolescents across the country.

In terms of delivery service, significant progress was made at the national level. Eighty-one (81) Health Centre IIs (HC IIs) were upgraded, equipped, and staffed with

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midwives to provide Basic Emergency Obstetric and Newborn Care (BEmONC) services, improving maternal and newborn care in underserved areas. Moreover, 369 health facilities (HFs) were functionalized to offer adolescent-responsive antenatal care (ANC) and family planning services, a critical step toward addressing the specific reproductive health needs of young people. The referral system was also strengthened, with innovations such as the use of social media to coordinate emergency referrals and the enhancement of the national call-and-dispatch ambulance system. To further support emergency care, 68 additional ambulances were procured and deployed to improve the transportation of patients in need of urgent care. Efforts to build the capacity of health workers were also prioritized, with the development of an in-service training package for neonatal nurses, aimed at improving the quality of newborn care.

Additionally, a Quality Improvement (QI) collaborative was established in nine sub-regions to support the identification, management, and retention of high-risk pregnancies, contributing to better maternal and neonatal outcomes. In terms of medical supplies, advocacy efforts led to the inclusion of intravenous caffeine citrate in the management of preterm babies, with provision extended to Regional Referral Hospitals (RRHs). To improve comprehensive emergency obstetric and newborn care (CEmONC) services, 42 Health Centre IVs (HC IVs) were equipped with theatre equipment and blood transfusion services. These interventions played a pivotal role in reducing maternal and newborn mortality rates, contributing to improved health outcomes across the country.

The impact of these interventions is reflected in a reduction in institutional perinatal mortality rates, as outlined in the data presented below, showcasing the success of these efforts in improving the health and survival of mothers, newborns, and adolescents in Uganda.

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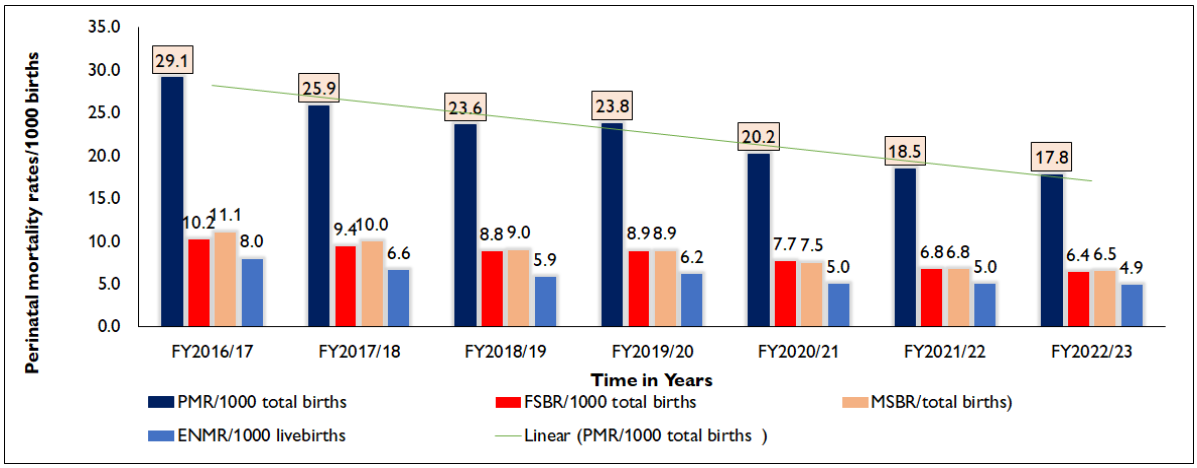

Figure 8: Trend for Perinatal Mortality Rates 2016/17 – 2022/23

Despite significant improvements in certain areas of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) during the review period, Uganda's institutional maternal mortality ratio (MMR) remains unacceptably high and above the national target as set in the MOH Strategic Plan I. This indicates that while progress has been made in other indicators, maternal deaths in health facilities continue to pose a major challenge to achieving Uganda's RMNCAH goals. Multiple factors contribute to this persistent issue, including limited access to timely emergency obstetric care, delays in seeking care, and infrastructural and logistical barriers in many health facilities.

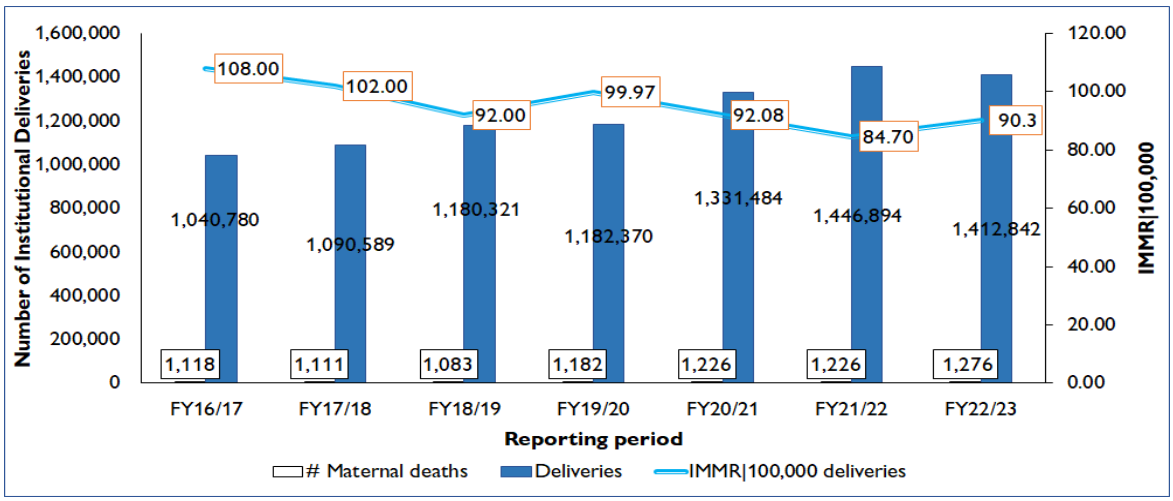

Figure 9: Trend for Institutional Deliveries 2016/17 – 2022/23

One positive trend was observed in modern contraception coverage, where Uganda saw an increase in the number of couples using modern methods of contraception in 2022/23, with a total of 5,189,035 couples protected, surpassing the national target of 4,361,361. This success can largely be attributed to the improved availability and

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distribution of contraceptive commodities at service delivery points. Consistent supply chains, effective logistics management, and ongoing community outreach programs contributed to this achievement.

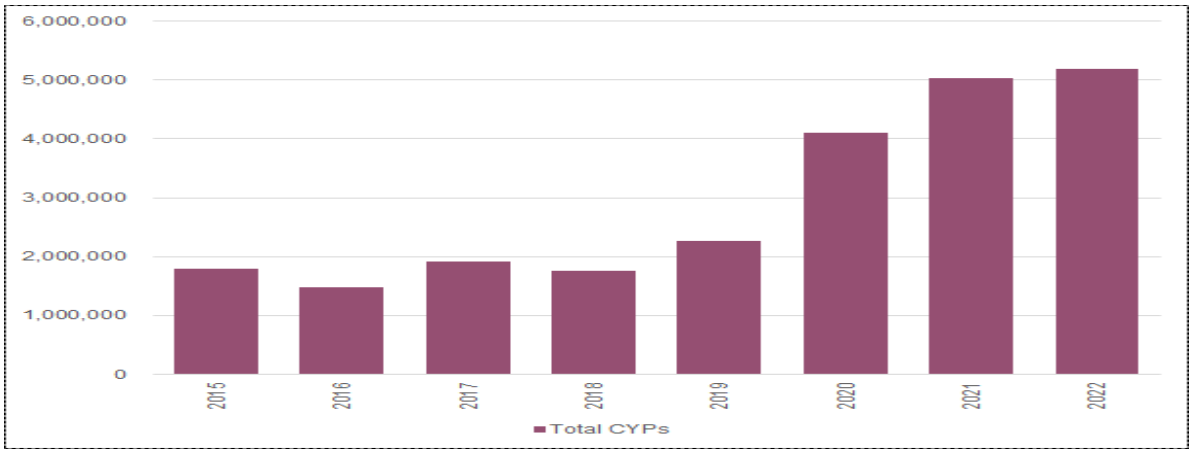

Figure 10: National CYP Trend

However, other critical RMNCAH indicators did not maintain the same momentum. For example, the coverage of antenatal care (ANC) 4 and health facility deliveries met targets in the first two years of the strategic plan but fell 6% short of the targets in the third year (2022/23). Similarly, the target for intermittent preventive treatment in pregnancy (IPTp) for malaria (IPT3) coverage was achieved in 2020/21 and 2021/22 but saw a decline in 2022/23. This drop was largely attributed to stock outs of key commodities, particularly malaria prevention supplies, caused by delayed deliveries at the points of care. Furthermore, laboratory screening for anemia among women attending ANC remains suboptimal, primarily due to the shortage of supplies for hemoglobin (Hb) estimation, further undermining maternal health outcomes. Efforts have been made to improve reporting on maternal and perinatal deaths, with concerted initiatives at all levels of the health system to increase accountability and improve data quality. Weekly Maternal and Perinatal Death Surveillance and Response (MPDSR) working group meetings have played a critical role in enhancing oversight, transparency, and follow-up at the health facility level. These meetings have contributed to a declining trend in deaths, although the reductions have not yet met national targets. Despite these challenges, the functionalization of Health Centre IVs (HC IVs) to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services has begun to show positive results, with incremental improvements in service delivery, particularly in high-burden regions.

The main challenges encountered include frequent stock stock-outs of essential medicines and health supplies for the different RMNAC components, inadequate health infrastructure, equipment, diagnostics and human resources for RMNCAH

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including opportunities for training and upgrading of RMNCAH staff as well as a weak referral system with inadequate communication between the different levels of facilities. It is however clear that strengthening the local maternity and newborn systems enables innovation and timely action which if coupled with a quality improvement collaborative on identifying high risk pregnancies, response and retention contributes towards the implementation of Goal oriented ANC. It is recommended that the sector should strive to ensure adequacy of RMNCAH related health infrastructure including equipment, EMHS and human resource, scale up in service training of RMNCAH health workers, strengthen MPDSR and foster community engagement for RMNCAH programs.

i) Non-Communicable Diseases

The burden of NCDs and their associated risk factors continues to grow as evidenced by the latest NCD risk factor survey 2023. The burden of Diabetes has more than doubled from previously 1.4% of the population to 2.7% of the population. The burden of high blood pressure has increased from 24.3% to 26% of the population. The prevalence of asthma among school going children has increased to between 10-20% of the children, Chronic obstructive pulmonary disease among rural adults stands at about 8-16% (Bruce Kirenga et al, 2019). The burden of sickle cell disease remains very high at 0.7% of the population and 13.3% being sickle cell carriers. The burden of preventable cancer of the cervix remains very high with the age standardized cervical cancer incidence of 56.2/100,000 population and very high age standardized cervical cancer mortality rate of 41.4 /100000, implying that many women are diagnosed late and less than 80% may not survive for more than 5 years after diagnosis a trajectory which needs to be changed with increased awareness, HIV vaccination and precancerous screening and treatment of precancerous lesions. There are also high rates of the breast and prostate cancers among others which need to be tackled. These are all high without mentioning the growing numbers with NCD related complications such as chronic kidney disease, stroke, other NCDs such as Type 1 Diabetes and Rheumatic disease which are also high with limited capacity to treat them which all lead to premature death. Mental Health and Neurological Disorders also remain a challenge. These NCDs are worsened by increasing NCD risk factors as elaborated below.

Smoking/tobacco use at 8.3%, current alcohol consumers at 31% and heavy drinkers at 7.7%, proportion not consuming adequate fruits 88.9%, physically inactive proportion at 3%, Overweight and obese proportions at 23.9% and 9.3% respectively which have almost doubled from the previous 14.5% and 4.5% respectively. There is still a high proportion of Ugandans who consume 11.3% high salty foods, exceeding WHO's recommended daily intake of 4g, leading to major NCD risk factors and requiring significant reduction to prevent NCDs.

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Physical inactivity has reduced from previously 4.3% to currently 3% which is evidence that Ugandans are more physically active through there are serious disparities between the rural peasants and the urban dwellers who suffer from limited time, recreation spaces and walkways among others. The burden of diabetes type 2 has more than doubled from 1.4% in 2014 to 2.7% in 2023.

Despite this seemingly gloomy picture, the government has weathered the storm with the following interventions have been accomplished in during the MoH SP I period; elevation of the NCD program into a functional department, creation of centres of excellence for specialized NCD service (UHI, UCI under ministry of health and Makerere Lung Institute (MLI) under Makerere University college of Health sciences/ Mulago hospital) decentralization and integration of NCD screening into Primary health care services, legislation on mental health (mental health act) and establishment of the mental health advisory board, alcohol control policy, tobacco control and regulations, adopted the WHO SAFER strategy for alcohol control, NCD and Mental health investment cases developed, these await approval, dissemination, and implementation, integration of NCD intervention especially DM, HTN and cervical Cancer screening into HIV care, revision of EML and UCG integrating revised molecules of NCDs, adaptation of WHO strategies such as WHO – PEN, PEN Plus and initiating implementation, revision of cervical cancer screening, prevention and pre-cancerous management guidelines and rollout of cervical cancer screening and mobilized and rallied the public on the importance of NCD prevention – such as promotion of physical activity, dangers of tobacco use and exposure, avoidance of unhealthy foods, avoidance of excessive alcohol consumption, environmental preservation. Limited financing, limited treatment and diagnostic supplies, limited awareness and limited health worker skills in managing NCD coupled with the multisectoral nature of roles to combat NCDs not being fully embraced remain the main challenges.

There is a need to prioritize and dedicate resources for NCD care from PHC level to tertiary level covering NCD health supplies, capacity building, NCD awareness for prevention and behavioural change and build robust real-time NCD data systems at all levels. Deliberate integration of NCD care into existing chronic and acute care services as well as strengthening NCD Multisectoral collaboration and prioritization by all government agencies. These will go a long way in ensuring that NCD risk factors are address by all contributing agencies since they are multisectoral in nature are all key. There is also need for continuous awareness amongst the general public to avoid the preventable risk factors for NCDs and seek health care early.

j) Community Health Services

During the NDP III implementation period, the first National Community Health strategy was introduced in 2023, outlining important areas for funding and encouraging partner alignment with Ministry of Health priorities. Moreover, the implementation manual for the social service pillar offered a way to link community health programs to the parish development model.

There has been a deliberate drive to digitize community health service delivery with the electronic community health information system, revision of community reporting tools, launch of the integrated community health service package and new approaches to community health financing. There was improvement in coordination with the strengthening of the technical working grouping coupled with mapping and engaging Civil Society networks to deepen service delivery.

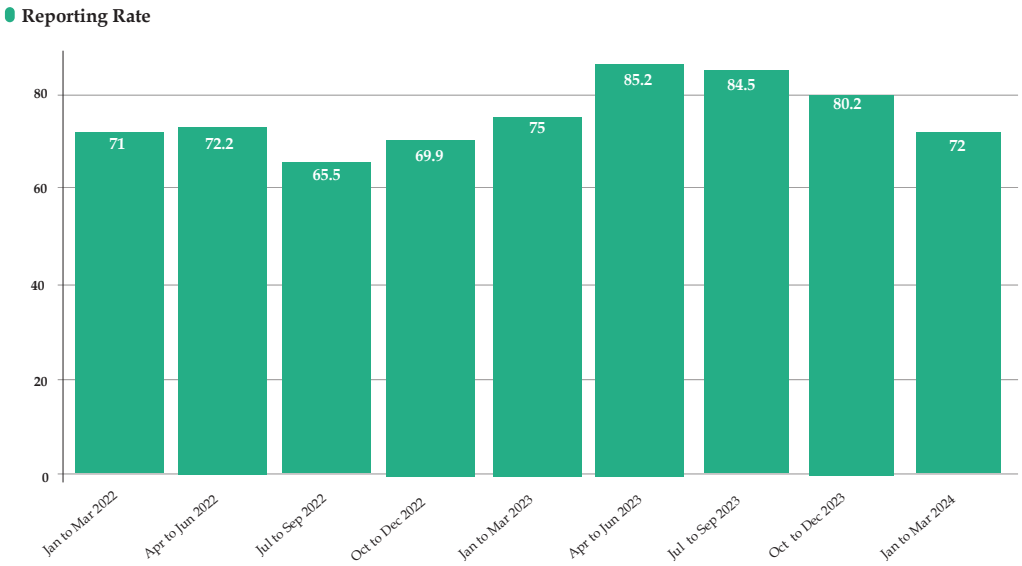

Figure 11: Progress on reporting of community Health workers (VHTs/CHEWs)

Community health services face challenges like poor infrastructure, limited health workforce, and medical supplies. To ensure equitable access, increased investment and coordination are needed. Key lessons include building resilient community-based systems, improving coordination between health authorities and local governments, and defining urban health community programming. It is recommended that the sector should improve financing and logistical support for community health programs, strengthen VHT capacity, scale up CHEWs, define urban health programming, and enhance government-partner collaboration.

During the implementation of the National Industrial Food Fortification Strategy 2017–2022, 95% of households used iodized salt, food industries fortified wheat, and vegetable cooking oil fortified with vitamin A. Low customer awareness, operational difficulties, and the high cost of industrial premixes are some of the difficulties. No laws pertaining to sweetened beverages exist.

The Integrated Package of Nutrition Interventions, including Deworming, Growth Monitoring & Promotion, and Micronutrient Supplementation (Vitamin A, IFA), was delivered to selected schools in specific districts. The MoGLSD collaborated with NSSF, NMS, Parliament of Uganda, UNICEF, WFP, WHO, and World Vision Uganda to establish breastfeeding and childcare facilities in workplaces, but MDAs are slow in implementing the regulations.

k) Health Promotion and Disease Prevention

MoH piloted the CHEWs strategy, and now it's under scale-up. High level Health Promotion and Disease Prevention advocacy convenings that have led to increased and streamlined funding for promotive and preventive interventions through CHW. Increased ownership, and participation of religious and cultural leaders in public health intervention design and roll out. MoH was able to engage and sign MoUs with most of these institutions.

The following achievements were registered:

a) Strengthened Public Health Risk Communication and Community Engagement (RCCE) before, during & post public health emergencies, including COVID-19, Ebola, Marburg, & Cholera among others.
b) Increased demand of immunization services, including successful national vaccine introduction campaigns (MR, HPV, Yellow Fever reactive campaigns, and now malaria). This has been mainly due to strong community mobilization and demand generation activities.
c) Piloting and scale-up of the Community Health Extension Workers (CHEWs) program, focusing on training, equipping, and deployment to improve community health promotion, population well-being, and service delivery. Over 30 districts have been reached between 2022-2025.
d) Enhanced use of digital and mass media platforms (radio, TV, social media, and experiential mobile vans) for health education, improving access to accurate and timely information.
e) Capacity building of District Health Educators and other health promotion officers in delivery of preventive and promotive services at community level.
f) Integration of health promotion into Non-Communicable Diseases (NCDs) prevention and control through advocacy, awareness, and behaviour change communication on lifestyle risks.
g) Improved partnerships with cultural and religious stakeholders for increased ownership and participation in public health undertakings for the sector. MoH has signed a number of MoUs in this regard.
h) Strengthened Monitoring and Evaluation systems for health promotion with harmonized tools for supervision, reporting, and documentation of progress and impact.

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i) Improved production and wide dissemination of information, education, and communication (IEC) and social and behaviour change m (SBC) materials tailored to diverse community needs.
j) Increased public engagement through social listening and community feedback mechanisms like community barazas, Increased use of the call centre, health talk shows among others
k) High level Health Promotion and Disease Prevention advocacy convenings that have led to increased and streamlined funding for promotive and preventive interventions through CHW.

The challenge remains lack of adequate resources to undertake nation-wide promotion activities and shortage of staff.

2.1.4 To strengthen disease surveillance, disaster response and epidemic control at national and sub-national levels

Uganda is prone to recurrent outbreaks and several public health incidents each year, therefore continued efforts to robust surveillance system, epidemic control, and disaster preparedness response. In the period 2020/2021 to 2024-2025, major outbreaks responded to included COVID-19, Sudan Ebola Virus Disease, Congo Crimean Hemorrhagic Fever, Rift Valley Fever, Anthrax, Monkey Pox, circulating Vaccine Derived Polio Virus type 2, Measles and Cholera. Several other public health emergency incidents were detected and responded to at subnational level. Key public health emergency incidents included Drought Situation in the Karamoja region, Floods/Mudslides in Rwenzori and Bugisu/Bukedi regions.

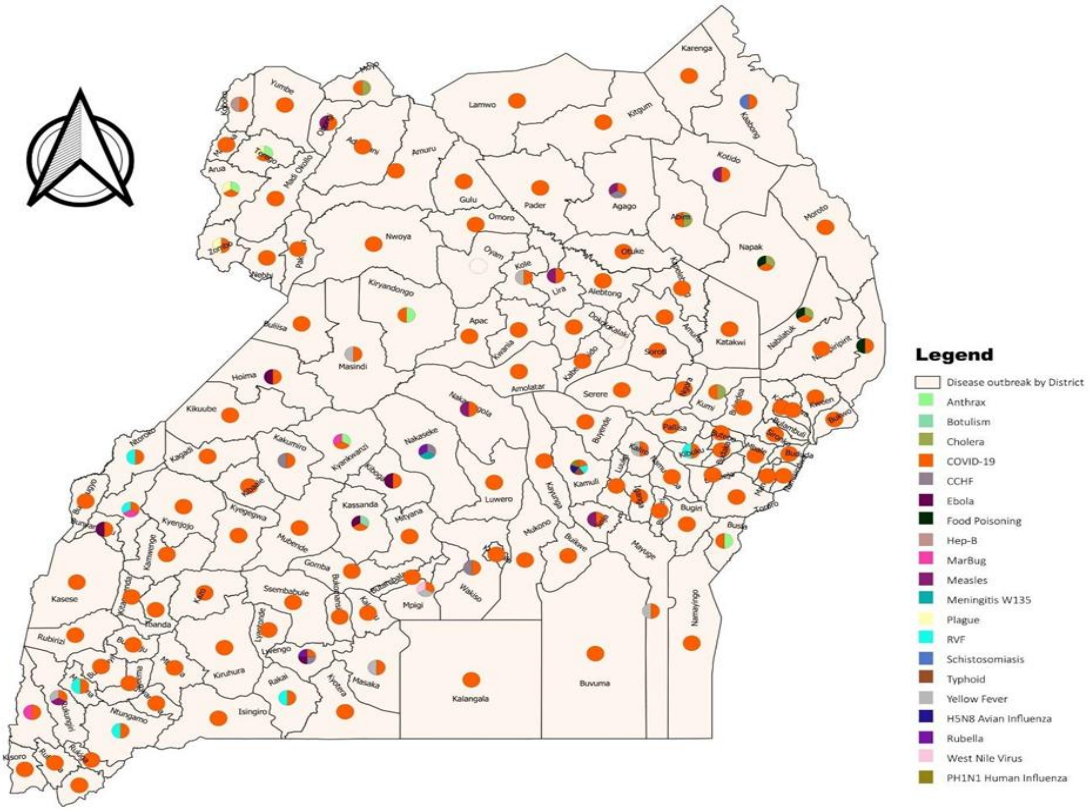

Figure 12: Map of outbreaks in the last 5 years

The national capacity for integrated disease surveillance and management of health risks continued to improve in the last 5 years as per the MoH Strategic Plan. This has been achieved through development of strategic guidelines, established structures for coordination, designation of more PoEs and Sentinel surveillance sites, One Health Approach, capacity building for health work force across levels, eIDSR/IDSR 3rd edition roll out and enhanced capacity for sample collection and management. The National Action Plan for Health security 2019 -2023 implemented over the past 5 years consolidated these efforts.

a) Strengthening Disease Surveillance

Disease surveillance is coordinated through Established Public Health Emergency Operation Centers at national and regional levels. There are 12 functional EOCs i.e., the Arua, Moroto, Soroti, Mbale, Masaka, FortPortal, Hoima, Kampala, Mubende, Lira and the national EOC. The EOCs monitor and verify signals, coordinate the IMT once instituted at national and regional levels. Notably the EOCs were pivotal in the coordination of COVID-19 response, Ebola outbreak and preparedness activities in 2022, floods/landslides in the Rwenzori and Elgon/Bukedi region.

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The revision of IDSR and subsequent roll out of the 3rd edition of the IDSR has streamlined disease surveillance and reporting in all the districts of Uganda, although 100% district coverage remains to be achieved. The IDSR secretariat instituted at the Surveillance Division convened different stakeholders for collaborative efforts to roll out of the technical guidelines.

Monitoring and evaluation actions for surveillance through the quarterly performance review meetings and the revision of the IDSR support supervision has set stage for results monitoring dissemination and quality improvements at all levels of supervision. Partner mapping and resource tracking using 4W matrix was completed in quarter 3 of FY1 2023/2024. Adoption of digital tools for surveillance and reporting i.e., DHIS2/eIDSR, MTRAC, ODK, and GoData is transforming surveillance through timely and more accurate data collected. Capacity building of health force and different actors at all levels were conducted for newly developed and revised surveillance strategies and protocols i.e. School Based Surveillance and Community Based Surveillance.

b) Strengthening Epidemic Control

Through NTF/DTFs and IMT meetings, epidemics were easier controlled due to the streamlining of response activities and adoption of guidelines, institution of public health and social measures. This was manifested in the control of COVID-19 outbreak through quarantine, lock down, vaccination, community engagement and social behavioral change communication; and in the Ebola outbreak with a lock down instituted for Mubende and Kassanda districts.

Designation of more points of entry i.e. Mpondwe, Mutukula, Malaba, Katuna, Mirama Hills improved port health and capacity to detect cross border public health events.

c) Strengthening disaster preparedness and response

Uganda trained the RRTs at National level (NRRT) and cascaded the training to 40% of districts and formulated the DRRTs. This aimed at reinforcing the capacity and skills of multidisciplinary Rapid Response Teams (RRT) and their individual members to early detect and effectively respond to public health events, irrespective of origin or source, that present or could present significant harm to humans. A national RRT manual has been drafted as a guiding tool for the establishment of RRTs and their deployment.

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One health approach: There is a constant interaction between humans, animals, and environment and this affects health, more than 60% of infections that affect man come from animals and over 90% of all infectious agents are affected by environment there has been a collaborative effort of multiple disciplines working locally, nationally, internationally for optimum health of humans, animals and environment. This led to the formation of National One Health Platform that encompasses different MDA's such as MoH, MAAIF, MWE & UWA. The country has also adopted a one health strategy and instituted a one health secretariat. There have also been efforts to formulate and establish the DOHT at districts level and 29% (42 districts) of the districts have been covered by the end of 2023. Looking forward to establishing more DOHTs in the coming FYs 2023/2024 & 2024/2024 as targeted in the MoH strategic plan to achieve 80%.

Developed and disseminated 14 different strategies at national and sub national levels by the midterm year 2022/2023 to support Disaster Preparedness and Response achieving 93% of the targeted. These include; National Emergency Preparedness plan, Contingency plans for Anthrax, Pandemic Influenza, Monkey pox and yellow fever developed, The Public Health Act of 1935 was amended and Rules and Regulations for notifiable diseases, Multi-Hazard plan for PHEs, NAPHS, PoE specific Public Health Emergency Plan , RRT operational manual, IDSR 3rd Edition, Cholera response, National, Disaster Preparedness and Response plan, One Health Strategy, One Health Communication Strategy, Draft National Strategy for coordinated surveillance of zoonotic diseases. Looking forward to developing 10 more strategies in the coming years as planned by the MoH strategic plan.

The issue is that districts lack the funding necessary for proactive monitoring and response efforts, so they must rely on requests made at the national level and lack personnel for Emergency Operations Centers and PoEs. Community awareness is hampered by the absence of IEC materials in the local language. It is recommended that GoU should advocate for more funds for districts to conduct active surveillance and respond to disease outbreaks and other public health threats, for wages to implement the approved staff structure for PoE and support to NPHEOC & REOCs in terms of HR and develop and disseminate enough IEC materials in the local language to facilitate community awareness on zoonotic diseases

In conclusion, there are 5 key outputs and 15 performance indicators under objective 4. The MoH achieved 67% (10/15) and little progress or no achievement for 33% (5/15) of the performance indicators as per midterm evaluation. This has been attributed to Support from GoU, Development Partners and Implementing partners especially in responding to disease outbreaks and other public health threats. Pending or partially implemented outputs include finalization and approval of the IES&PHE Strategic

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Plan, establishment of Integrated sentinel surveillance sites in all RRH's, and those related to prevention, control, and response to zoonotic diseases as well as formulation and functionalization of the district One Health Teams (DOHTs).

2.1.5 To ensure availability of quality and safe medicines, vaccines and technologies

The performance in terms of availability of the basket of 41 Essential Medicines & Health Supplies (EMHS) at health facilities has been declining over the period under review 81%, 78%, 58% against annual targets of 90%. There are various reasons contributing to this trend, including; Inadequate funding for supplies, with funding gaps of USD 47.1m annually, discrepancies between what is ordered by the Health Facilities and what is delivered by the warehouse specifically National Medical stores, delayed delivery of commodities from the National Medical Stores and from the Joint Medical Stores to the districts, bundling of cycle deliveries plus stock outs and delivery of commodities with short, dated expiries.

Notably however, the performance of availability of essential medicines for management of NCDs was good and annual targets were surpassed over the review period 81/31; 79/35, 68/40. The good performance was possibly due to increased advocacy, integration of NCDs management into routine care and increased partner funding

However, it must be noted that we still have a funding gap for the NCD commodities as government has maintained the same funding level for NCD commodities at 2bn. Challenges still exist in the form of significant funding gaps for commodity categories, delays in responding to emergency orders due to fixed order schedules, and the health facilities' use of out-of-date procurement plans and limited capacity of health facilities to generate procurement plans and carry out forecasting. It should however be noted that QAT has improved efficiency in the quantification process, the involvement of Stakeholders (Program Technical Officers, Development Partners, District Officials) has helped to improve accuracy in the procurement needs for commodities and real time stock status of ARVs has guided redistribution and should be scaled up countrywide.

It is strongly recommended that GOU to allocate more funding to EMHS, capacity of Health Facilities and Districts in forecasting, procurement planning and quantification is built, NMS & JMS delivery schedules are reviewed to address causes of delays, systems for real time commodity stock status monitoring are expanded and strengthened, dissemination and implementation of the National Medical counter measures (MCM) plan is fast tracked, AMS guidelines are finalized, disseminated and

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implemented, RBF principles are applied to the procurement of medicines and the logistics supply chain is strengthened at all levels.

The e-LMIS was rolled out to all the public and private not for profit health facilities across the country. All health facilities are now making orders electronically but should be extended to more users. Uganda currently has 52 local pharmaceutical manufacturing industries. The challenge they are facing is high cost of equipment and active pharmaceutical ingredients (APIs), which are imported. The formulary was due for review in 2025; however, the funding was from USAID, which was cut off as a result of the stop work order. We are in the process of submitting the curriculum vitae (CVs) of the officers to be appointed by the Minister of Health as stipulated by the Traditional and complementary medicines act.

2.1.6 To improve functionality and adequacy of health infrastructure and logistics

The GoU through the Ministry of health has continued to invest in health infrastructure with some notable results.

a) The number of hospitals and high-volume HC IVs with functional NICU rooms equipped with basic equipment such as infant incubators, radiant warmer, phototherapy units and oxygen concentrators was on average 58% against a target of 55%. The functionality varies with the levels of care as below: NRH (5/5) – 100%; RRHs (16/16) – 100%; GH (51/51) – 100%; HC IVs (High volume) (74/181) – 59%. Most HC IV s have NICU rooms with basic equipment, but the NICUs are non – functional because of lack of the trained staff. Only a few of the NICU equipment (infant radiant warmer) is under full utilization, the rest of the NICU equipment is redundant.
b) All targeted 14 RRHs (100%), have been equipped with CT scanners, representing 100% performance against the planned target. However, two others additional RRHs were established after setting the strategic plan targets (Kayuga and Yumbe) and these are scheduled to get their CT Scanners in FY 2023-24:
c) An average of 58 % of Hospitals against a target of 62% have functional X – Rays. The functionality varies with the different levels of care as below: NRH 5/5 (100%); NSH 5/5 (100%); RRH 15/16 (90%) (Moroto RRH X -Ray in non – functional). GH 20/51 (39%). Achievement of the planned target was affected due to two reasons; (1) The manufacturer (Philips) changed their local authorized maintenance service provider, as such maintenance of Philips X – Rays has not been done for 3 years (2) Some Philips X -Rays (non -digital) have been declared by the manufacturer as Obsolete and Philips shall no longer

provide spare parts for them. The Ministry plans to procure 20 new X-Ray machines in the FY 2023/24.

d) Only 34% (62 out of the 181 Public HC IVs) out of a target of 60%, have functional ultrasound machines and those that have the machines, have the challenge of the Human Resource (sonographers).
e) The Process of Development of a National master plan for establishment, expansion and maintenance of infrastructure is at 75% completion level. So far 80% data/inventory on infrastructure (equipment and buildings) in terms of both availability and condition has been collected and captured in NOMAD.
f) Two centers of excellence are being established (Uganda Heart Institute and Uganda Cancer Institute). Construction of UCI (Mulago) is nearly complete. Construction of UHI has not started. The land was secured, financing agreement, project was launched in 2023, and procurement for construction is ongoing. Additionally, Regional Cancer Centers are being established, with Gulu completed and commissioned, Mbale under construction and Mbarara not started although land has been secured. Other centers of Excellence established by GoU include Entebbe Children's Surgical Hospital, commissioned in November 2021.
g) Only 3 GHs out of the planned target of 12, have been established through upgrade of HC IV s and these are Koboko and Rukoki, and Kyegegwa. Additionally, 3 HC IVs are being upgraded to community Hospitals, Kabwohe in sheema, Mitooma in Mitooma , Muko in Rubanda, at 30% average progress of construction.
h) Due to inadequate funding, only 6 Hospitals out of the planned 9 hospitals have been partially rehabilitated during the period under review: Gombe, Kawolo, Busolwe, Kambuga, Buwenge, Kapchorwa.
i) 32 out of planned 68 new HC IIIs were constructed across the country and were expected to be completed and functional before end of FY 2023-24.
j) Additionally, 14 HC IIIs are being established in refuge hosting District under UCREPP, and these are: Koro, Lyete, Twajiji, Kikuruma, Kabazane, Ruhoko, Kyangwali, Morobi, Luru, Idiwa, Uriama, Bolomoni, Igarama, Luzira.
k) 26 HC IVs out of the planned 14 have been established/ renovated; 11 HC IIIs are being upgraded to HCIVs; 09 HCIVs renovated/ infrastructure improvements; 4 HC Ivs have been renovated by Enabel in Acholi sub region; 1 HC IV in Kween renovated by UNRA.
l) 3 HC Ivs are being renovated by USAID. 195 HC IIs out of the planned 159, have been upgraded to HC IIIs under the programs of UgIFT (154 facilities) and URMCHIP (41 facilities). 69 HC IIIs out of the planned 40 facilities were renovated. 40 HC III renovated under URMCHIP. 22 HC IIIs renovated under

KIDP (Karamoja sub region). 3 HC IIIs renovated partially under Enabel in Acholi sub region. 4 HC IIIs are being rehabilitated by USAID.

m) 5 out of the 5 planned high-capacity incinerators with combustion capacity of 500Kg/hr at max operating temperature of 1200^0C, are under construction, with progress of construction as follows; KCCA (75%), Lira RRH (95%), Gulu RRH (70%) and Mbarara RRH (90%) and Fort portal RRH (45%)

n) Small sized incinerators have been installed in Jinja, Lira, Hoima, and Fort Portal Mubende RRHs.

o) 3 out of the planned 4 regional blood banks have been established. Hoima and Arua Blood banks are substantially complete in terms of construction and equipping- ready for commissioning. Soroti blood bank is at 80% completion in terms of construction.

p) There is a plan to establish a regional blood bank in Jinja RRH under KOICA funding and another in Lira RRH by UCREPP.

q) A total of 976 staff housing units out of the planned 150, have been constructed during the period under review; UgIFT – (554 units); URMCHIP- (242 units); KIDP – (60 units); GoU – (116 units); Enabel- (4 units). These housing units were completed and commissioned. Additionally, (114) have been comprehensively renovated in Busolwe – 72 and Kawolo-42 under GoU funding.

r) The National Medical Equipment list and specifications as well as Medical Equipment Maintenance guidelines have been developed and are at the final stage of approval.

s) Medical equipment inventory is continuously maintained/updated using a computer online application/system (NOMAD). The total amount of equipment so far captured in the system is 51,465 (representing an estimated 75% of the total equipment). Of these 42,887 (83%) are functional.

t) 81% as compared to the 50% planned target for functional equipment maintenance workshops was achieved.

u) 14 RRHs /workshops out of the 16 RRH are equipped and functional. Mbarara, Kayunga, Yumbe, and Entebbe have no maintenance workshop. There has been no funding for establishment of new workshops which require construction, equipment and human resources.

v) There still remains the challenge of underfunding to the workshops to facilitate them to fully undertake comprehensive equipment maintenance in their regions and construction of standard Workshop blocks.

w) Selected medical staff at all levels of healthcare are trained in the use and handling of equipment on a quarterly basis across the country by the Regional Workshop Engineers and technicians.

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x) 90% of basic equipment is available at the lower-level facilities. Over performance 90% compared to the planned target of 60% is attributed to UgIFT and URMCHIP projects that equipped the lower facilities. Under these projects, all the upgraded and improved facilities (452 facilities), were provided with basic equipment. Additionally, Districts are also provided with development grant (for small equipment acquisition and maintenance).
y) Additionally, all HC IVs were provided with assorted oxygen therapy equipment (oxygen cylinders and concentrators, patient beds) as part of the COVID response.
z) Supported refurbishment, through the KOICA funding, of 28 health facilities in the Busoga region along with installation of rainwater harvesting and motorized borehole system, cold chain and medical equipment and, solar lighting system

2.1.7 To Accelerate health research, innovation and technology development

Health research and innovation are critical to strengthening the evidence base for healthcare decisions in Uganda. Despite slow initial progress, the rollout of the Electronic Medical Record (EMR) system has accelerated, with more health facilities being digitized. By the end of FY 2024/25, 21 public health facilities had fully implemented EMR systems, allowing for better patient data management and improving the efficiency of health service delivery. The system enables health workers to access real-time patient data, which is crucial for clinical decision-making, especially in maternal and child health services.

The ministry has also piloted several innovations, including the use of mobile health platforms for disease surveillance, and the development of the eCHIS (Electronic Community Health Information System), which has been deployed in eight districts, improving data reporting from community health workers. To ensure full coverage, more investment should be made in upgrading infrastructure, such as local area networks (LANs) and purchasing computers for health facilities that lack the necessary technology.

MoH plans to establish a National Health Research Knowledge Translation Platform, which would ensure that findings from research studies are promptly translated into policies and practices. This would support evidence-based health interventions, particularly in areas like maternal and newborn health. Training programs for health workers on the use of EMR systems and digital health tools should be scaled up, ensuring that users at all levels can effectively utilize these technologies.

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The Ministry of Health is focusing on strengthening health research, innovation, and technology development to address emerging health challenges and improve health outcomes. To date several national referral hospitals, including Kiruddu and Mulago Specialized Women's Hospital, have been fully digitized. The roll-out of the electronic medical records (EMR) system is gaining momentum, with 22 public health facilities using a comprehensive EMR by FY 2022/23. Although funding constraints delayed their development, efforts are underway to draft a new strategy that will guide research and innovation in the health sector. The electronic Community Health Information System (e-CHIS) was deployed in eight districts, improving data reporting and timeliness.

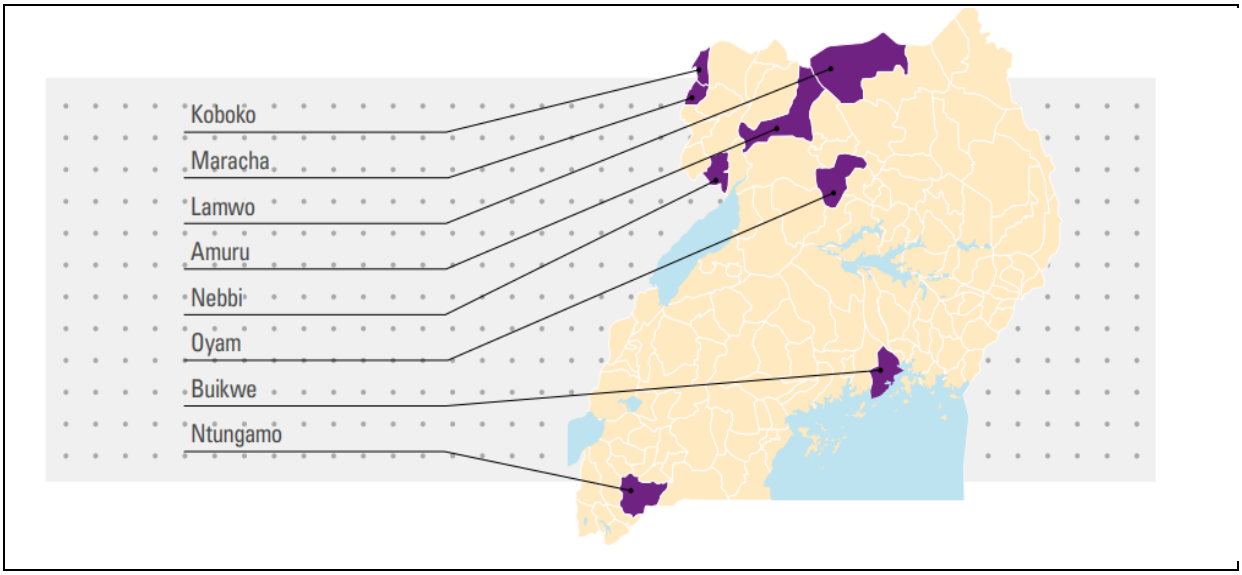

Figure 13: Map Showing coverage of the e-CHIS

The key challenges faced included limited funding for research and slow scaling up of EMR. It is recommended that adequate resources are allocated to expedite roll out of EMR.

2.1.8 Financing of the MoH SP 2020/21 – 2024/25

Uganda's government health budget has seen a steady increase, reflecting a commitment to enhancing health service delivery to meet the population's health needs. However, the GGHE- D per capita allocation estimated at 11.6 $ (NHA 2021) remains very low and inadequate to achieve UHC. The growth in the health sector budget has not increased in tandem with rising health care demands, high costs due to rapid population growth, the ever-rising disease burden, and a rapid epidemiological transition from communicable to NCDs.

The latest National Health Accounts (NHA) estimates that Out-of-pocket expenditure accounted for 28% of total health spending, putting a significant financial burden on households to pay for healthcare expenses. The NHA also reported that development

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assistance for health accounted for 50.3% of Total Health Expenditure (THE). However, development assistance for health has been on a downward trajectory and it is feared that this trend is likely to worsen. This complex health financing landscape has resulted into very high catastrophic health spending, estimated to be 13.6% at 10% household income threshold, which is very high compared to other countries in the region with similar UHC coverage index for instance Kenya at 5.2%, Tanzania at 4.3%, Rwanda at 1.2% and Zambia at 0.3%.

To improve financing of the health sector, the government has undertaken major reforms, including the shift from Input-Output budgeting to Programme Based Budgeting, the introduction and mainstreaming of Results Based Financing (RBF) mechanisms, needs adjusted resource Allocation Formula (RAF) to allocate Non-Wage Recurrent (NWR) budgets to Districts Local Governments aiming to improve equity and efficiency of resources allocation and an essential health care package. However, the latest health financing progress matrix for Uganda and a cross programmatic efficiency analysis for 5 key health programs highlighted that, critical weaknesses still exist that undermine the movement towards UHC while considering the limited fiscal space.

2.1.9 Analysis of the MOH Strategic Plan Financing

The government budget for health in Uganda has progressively increased, and in FY 2022/23 a 2.7% increase from the last year was registered. While the GOU per capita allocation increased from UGX 49,910 in FY 2016/17 to UGX 80,879 (USD 22) in FY 2022/23, it decreased thereafter to UGX 65,400/= in FY 2024/25 which remains very low and inadequate to achieve UHC especially with the rising health care demands, high costs due to rapid population growth, the ever-rising disease burden, and a rapid epidemiological transition from communicable to NCDs.

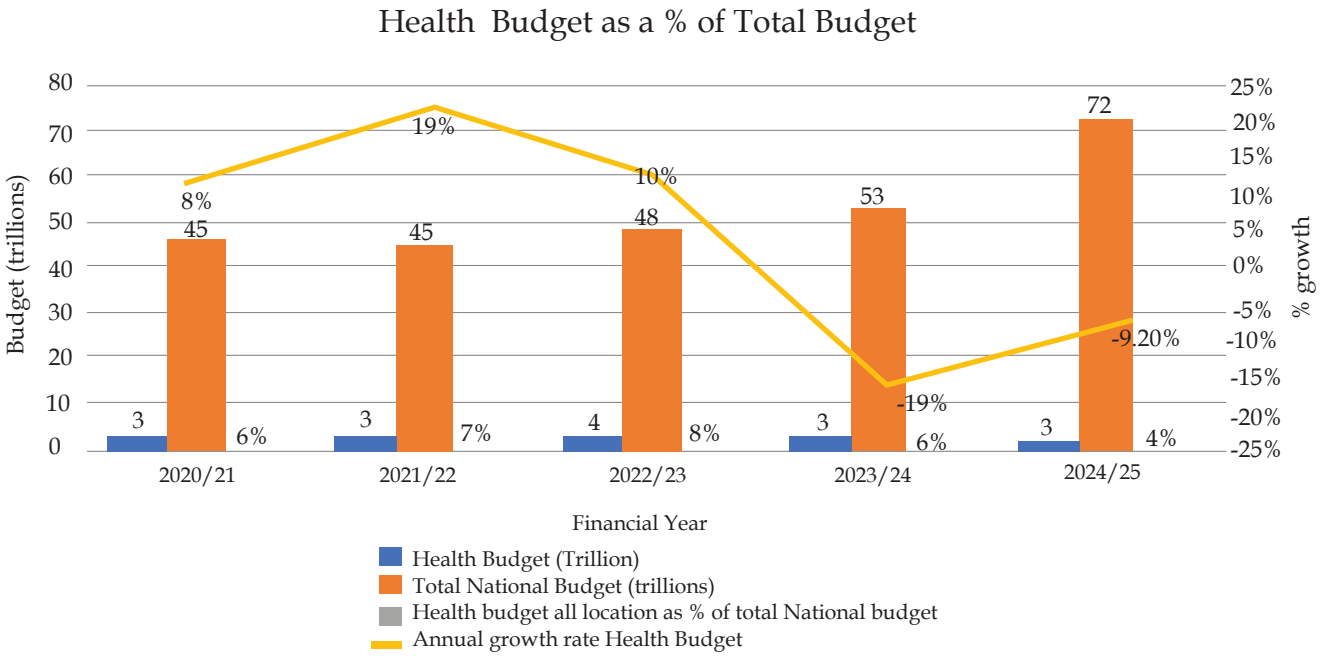

Figure 14: Health Budget Allocation as a % of the total National Budget

Regarding the budget performance over the last decade, the health sector has consistently registered a high budget absorption rate and budget release of over 80%. The budget spent, however, has consistently been between 76% - 78% which is quite low, and this is largely attributed to delays in implementation of donor projects and low releases.

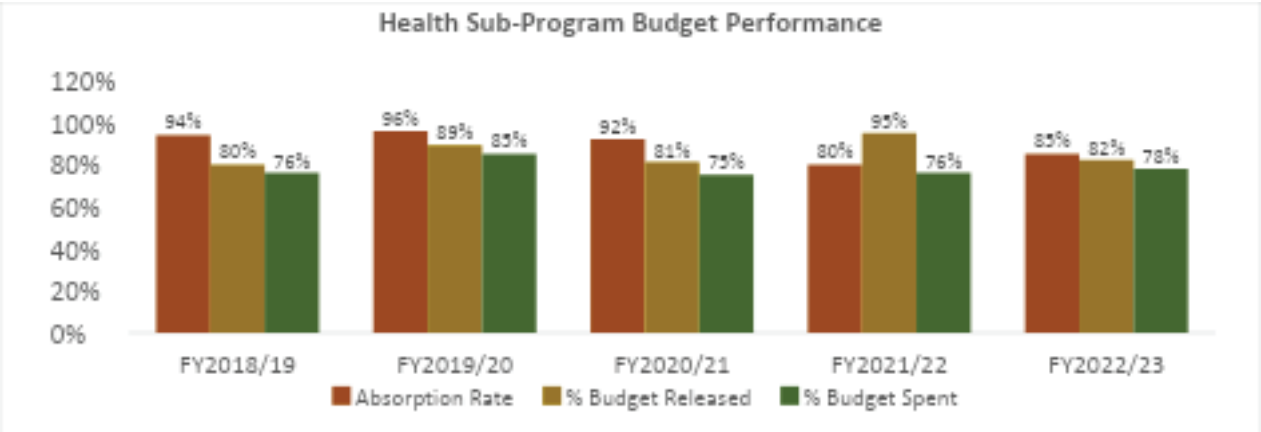

Figure 15: Budget Performance for the Health Sector

Source: MOH 2023: Annual Health Sector Performance Reports

For the FYs 2020/21 to 2022/23, budget allocation for both wages and non-wage recurrent had moderate increments. Similarly, an increment in the domestic development allocation was realized from FY 2020/21 to FY 2022/23. On the other

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hand, the donor component showed an initial increment with eventual reduction in the allocation from FY 2021/22 to FY 2023/23 from UGX year. The donors allocated UGX billions 100.5, 912.8 and 142.2 for the financials 2020/21, 2021/22 and 2022/23 respectively.

2.1.10 Implementation of the Health Financing Strategy (HFS) (2015 to 2025)

Uganda developed the Health Financing Strategy (HFS) (2015 to 2025) for the health sector to support the implementation of the National Health Strategies. The rationale for the HFS was "to provide a framework through which Uganda will finance its health sector to achieve its stated goals". The HFS proposes strategic interventions and reform areas in core health financing functions such as resource mobilization, pooling, and purchasing health services.

A summary of the progress made on the objectives of the health financing strategy is highlighted below:

a) **Revenue Raising:** This focuses on achieving Equity, efficiency, adequacy, and sustainability in resource mobilization for health. The minimal progress has been registered on this objective. While there was a notable increase (in absolute terms) in the health sector budget between 2015/15 (1.271 Tn) and 2022/2023 (3.6 Tn), the percentage share of health from the national budget has remained between 6.1% and 7.2% over the same period which falls short of the 15% Abuja declaration target. The per capita public expenditure on health ranged from 36 US $ in 2019 to 57 US$ in 2021, still below the WHO recommended minimum of 86 US $. A study on efficiency in Africa revealed that Uganda had an efficiency score of 68% compared to the mean average efficiency score of 80% for the African region (Ayiko et al., 2020). Existing evidence from studies done by Overseas Development Institute (ODI) has also shown that the allocation of Government of Uganda (GOU) funding and donor funding to the districts is inequitable.

b) **Strategic Pooling and Financial Risk Protection:** Emphasizing increasing effective pooling and strengthening strategic purchasing mechanisms that ensure the attainment of equitable and efficient resource allocation. Except for the Parliament's attempt to pass the National Health Insurance Scheme (NHIS) bill, all the proposed interventions for effective pooling are yet to be implemented. The NHIS bill was resubmitted to Cabinet for approval but has not been discussed. Similarly, Uganda's Health Financing Progress Matrix indicates that almost all the critical attributes for effectively pooling resources remain emerging as opposed to advanced. This means that most health financing functions, goals and objectives are not yet attained hence affecting financial risk protection for UHC. The

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government budget remains the most significant pool over which government has control. Donor support continues to be fragmented, declining and largely off-budget, while insurance scheme pools remain very low while catastrophic out of pocket expenditure is high. Resource tracking studies by MOH report that over 50% of the donor funding to the sector is channeled off-budget.

c) **Strategic Purchasing**: A lot of progress has been registered on this function, and the main achievement is the nationwide rollout of Results Based Financing (RBF) and the recent approval of the mainstreaming RBF into Primary Health Care (PHC) funding for lower-level health facilities. However, the incentivized indicators remain largely for Reproductive Maternal Neonatal, Child, and Adolescent Health (RMNCAH) services. Additional achievements included revising the Uganda Minimum Health Care Package and revising the resource allocation formula to make it more explicit. However, further revisions to make the formula more equitable and to further link provider performance to pay should be considered in the future. Furthermore, harmonization of provider payment and procurement across purchasers is also required. A cross-programmatic efficiency study in five key health program areas noted multiple and fragmented procurement and supply-chain streams and processes within the medicines, commodities, and supplies across health programs and sometimes within a particular health program (WHO, 2021).

d) **Institutional Arrangements:** for accountability and transparency in resource management and use. The new institutional arrangements linked to the joint funding mechanisms have not yet been realized. However, arrangements such as the Integrated Financial Management System (IFMS) and the Programme Budgeting System (PBS) have been established by the government to ensure transparency in resource use. Relatedly, some level of openness had been achieved within the health sector, with data on resource use largely available and accessible on public platforms, including the MoH website. Additionally, several fora for government and implementing partners, such as the Health Policy Advisory Committee (HPAC) and the Annual Joint Review Mission (JRM), were in place. They provided opportunities for joint planning and agreement on priorities. However, these forums are largely operational and functional at the central level and largely absent at the sub-national level.

e) **Partnerships:** Several partnerships exist in the country for financing and delivery of services (external agencies, public and private providers). The government continued to provide PHC grants to private-not-for-profit facilities to support the

delivery of services to its population during the review period. According to the Annual Health Sector Performance Report (AHSPR) 2020/2021, public facilities delivered about 75% of the services, Private-not-for Profit (PNFP) facilities 20% and private health providers (PHP) facilities about 5% of the services. Similarly, several partnerships with external agencies supported service delivery in the country at the national and subnational level. It was impossible to evaluate the specific progress made in each of the partnerships, given their large number and diversity and lack of clear indicators in the HFS.

2.1.11 Key Bottlenecks in the Implementation of the Health Financing Strategy

Table 4: Key Bottlenecks in the Implementation of the Health Financing Strategy

Pillar	Bottlenecks	Recommendations
Revenue Raising	• Competing government priorities amidst a constrained revenue base undermines increased allocations to health. • Slow adoption of innovative health financing models such as sin-taxation, earmarking, and motor third-party (MTP) insurance. • Macroeconomic challenges related to slow economic growth are a trajectory resulting in a low revenue base to expand support to virtually all sectors. • Global dynamics, including disruptions from the COVID-19 pandemic. • Inefficiencies in resource utilization within the sector result in leakages.	• Functionalize systems for reducing resource wastage (e.g., irrational prescribing, drug expiration, multiple (and disintegrated) procurement systems, poor adherence to the referral pathway) • Strengthening systems and structures for implementing a community health program that can enhance health promotion and prevention using a multisectoral approach to reduce the high recurrent costs associated with curative care in addition to scaling up implementation of high impact interventions with high rates of return. • Develop a regulatory and implementation framework and set up structures to support the growth of Community-Based Health Insurance (CBHI). • Ensure adequate stakeholder involvement during the drafting of the NHIS and ensure that the bill is mandatory. • MoH should continue lobbying for increased government allocation to the health sector.
Strategic Pooling and	• Fragmented resource pooling arrangements generally	• Encourage HDPs to provide earmarked on-budget support and

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Pillar	Bottlenecks	Recommendations
Financial Risk Protection	linked to limited trust in the government budget system. • Limited and highly conditional government funding. • Weak accountability systems. • Weak partner coordination systems. • Delays in establishing the NHIS by law.	to record all on and off-budget funding in the AMP or a virtual pool. • Establish joint planning (by government entities and HDPs) for implementing and funding sector priorities for both on-budget & off-budget funds at national and subnational levels.
Strategic health purchasing	• Limited fiscal and decision space, and financial autonomy, at the sub-national level. • Inadequate resources for the delivery of the benefits package. • Persistent system inefficiencies. • Lack of incentives to provide high-quality services. • RBF implementation challenges. • Performance data use challenges.	• MoH should continue the institutionalization of RBF through the Uganda Intergovernmental Fiscal Transfer (UgIFT) Programme while monitoring and evaluating its performance. • Advocate for donors to channel funds through RBF to support different high-priority interventions (non-communicable diseases (NCDs), new-born mortality, health promotion and prevention) through the UgIFT Programme. as well as scale up RBF to General Hospitals and Regional Referral Hospitals. • MoH should conduct a comprehensive review of health worker performance and provider payment and propose relevant strategies to incentivize health workers to promote the productivity of health workers and the delivery of quality services. • Ministry of Finance, Planning and Economic Development (MoFPED) should consolidate efforts to implement program-based budgeting more holistically.

2.2 OUTCOME PERFORMANCE INDICATORS

The performance of the health outcome performance indicators over the last five years of the strategic plan implementation is as follows:

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a) Life expectancy at birth has increased from 63.7 years in 2014 to 68.2 years in 2024 barely short of the NDP III target for the year of 68.7 years due to implementation of high impact interventions like immunization, integrated community case management of childhood illness, which have led to reduction in childhood mortality rates. The investments in HIV/AIDS prevention, control and treatment; and reproductive, maternal and neonatal health have also contributed to reduction in mortality.
b) Maternal mortality ratio reduced by 44% from 336/100,000 live births in 2016 to 189/100,000 live births in 2022.
c) Infant mortality rate reduced by 16.3% from 43/1,000 in 2016 to 36/1,000 live births in 2022 achieving the NDP III target of 35.6% by 2023/24.
d) Neonatal mortality rate reduced by 18.5% from 27/1,000 in 2016 to 22/1,000 live births in 2022 although short of the NDP III target of 20/1,000 live births by 2023/24.
e) The Total Fertility Rate has declined from 5.8 (Census 2014) to 5.4 (UDHS 2016), and from 5.2 (UDHS, 2022) to 4.5 (UBOS, Census Report 2024) thus achieving the NDP III target of 4.5.
f) Sanitation coverage (improved toilet) increased by 132% from 19% (National Household Survey 2019/20) to 44% (Census Report 2024)
g) Hygiene (Handwashing with soap and water) improved by 38% from 34% (National Household Survey 2019/20) to 47% (Census 2024).
h) Stunting in children under five reduced by 10% from 29% in 2016 to 26% in 2022, and there was 27.5% decline in wasting among children under five from 4% in 2016 to 2.9% in 2022 (UDHS).

2.3 CROSS CUTTING ISSUES

These are issues that can contribute to accelerating or derailing the progress of development across many sectors. Issues relevant to the health sector are gender and equity, HIV/AIDS, environment and climate and COVID-19. The strategic plan aims to ensure that health services are available for the people of Uganda based on need. The plan should address the community needs and reduce the proportion of the population spending out of pocket due to limited access. Due to the growing population and living longer, people increasingly need more medicines including treatments for chronic non-communicable diseases.

1) Gender and Equity

The health sector continued to observe significant disparities in access to services with males generally having low access and higher mortality rates. However, community surveys continue to indicate that diseases like HIV/AIDS were more prevalent among

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the females. Gender based violence especially among displaced communities also remains a major challenge. This calls for strengthening Gender Equity, Planning Budgeting at subnational levels and deepen integration of GBV interventions in health service delivery, and reporting frameworks.

2) AIDS

Uganda is running the multi-sectoral response with up-to-date and evidence informed policies, guidelines, protocols and related standards for HIV services to guide the priority HIV interventions.

According to the Uganda population HIV Impact Assessment Uganda's HIV prevalence declined from 6.2% in 2016/17 to 5.8% (UPHIA 2022) and 4.9% in 2024. The incidence rate among people aged 15+ years also significantly declined from 0.4% to 0.29% with the women still having a higher incidence rate at 0.38% compared to the men at 0.2%.

Although women have higher HIV prevalence and incidence compared to men, the proportion of women who are under care are much higher compared to men. The older population aged 50+ of both sexes continue to have a treatment gap and women showing treatment gaps in the younger age group 15-24, the male population have treatment gaps in all age groups but particularly in males aged 20 years and above. Key strategies have been put in place to address these gaps focusing on primary interventions to engage men in managing their own health: through developing and disseminating messages men can identify with; digitalized solutions for communicating messages, appointment reminders, and improving treatment literacy and establishing additional community based differentiated service delivery options, particularly for fishing communities.

According to the UPIA 2022 80.9% of people living with HIV knew their status, 96.1% of those who knew their status were on ART, while among those on ART 92.2% had achieved viral load suppression. Key strategies over the next 5 years to address the above issues include.

a) ***Prevention***: In line with Global HIV Prevention Coalition Roadmap, a package of combination HIV prevention interventions will be rolled out to achieve saturation levels. Age-specific interventions will be encouraged, recognizing that different prevention packages are needed for different age groups. The HIV/AIDS National Strategic Plan 2025-2030 thus provides for differentiated models of HIV prevention services delivery in order to appropriately reach different social-demographic and geographically differentiated groups. The key

priority interventions include HIV testing services, behavioral change interventions targeting young people, men, and high-risk populations, condom promotion and distribution, safe male circumcision, ARV-based prevention, and PMTCT.

b) ***Care and Treatment:*** The triple 95-95-95 will provide the cornerstone for further reduction of HIV infection and AIDS related deaths by 2025, with deliberate programmatic emphasis on achieving high (above 90%) coverage among sex workers and other key populations. There is need for Community empowerment to keep clients engaged in care and help them access treatment, adhere to their medications and prevent the transmission of HIV.

c) ***Social Support and Protection:*** Psychosocial, economic, legal and protection services are recognized as "social enablers" for HIV prevention, and uptake of care and treatment services. Despite the acknowledged role of social support and protection, there remain significant gaps in realizing meaning support and protection for PLHIV, PWDs, OVC, Key and priority populations and other vulnerable groups. This is predicated upon rampant stigma and discrimination, gender-based discrimination and violence, and significant structural challenges related to equity and human rights. Overall, HIV discrimination continues to fuel stigma for PLHIV and key populations. These categories of the population are also subject to human rights violations including structural legal and institutional barriers that affect access and utilization of HIV-related services. There are still cases of lack of knowledge of the laws protecting the rights of PLHIV among more than 50% PLHIV. The "know your rights interventions" being implemented under the Global Fund through UGANET and HRAPF and other implementers like UWONET, Plan Uganda, Uganda Law Society, Justice Centres, has limited coverage. There is need to Scale up interventions aimed at eliminating stigma and discrimination; Expand socio-economic interventions aimed at reducing social and economic vulnerability for PLHIV and other vulnerable groups; and scale up psychosocial support for PLHIV, PWDs, key and priority populations and other vulnerable people.

d) ***Systems Strengthening:*** Although a lot of gains have been made in strengthening systems for policy, planning and delivery of HIV services during the past decade, challenges cut across human resources, infrastructure, financing, information systems and laboratory services. There are human resource gaps too, as exemplified by over a quarter of staff positions for health in public sector not filled, contracted workers not yet absorbed, and HIV counsellors not yet included in the structure. While logistical and supply chain management system for HIV and AIDS goods and services has improved, work is still required to fill stock out gaps for ART drugs, other essential drugs and supplies.

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3) Environment and Climate Change

Climate change is a major health threat. It is characterized by rising temperatures and more extreme weather events like heavy rains, drought, windstorms, heat and cold waves that cost lives, disrupt health infrastructure, directly increase transmission and spread of diseases, and undermine the environmental determinants of health including clean air, sufficient food, safe water and secure shelter.

MoH using WHO guidelines conducted a climate change vulnerability and adaptation assessment (VAA) and used the findings to collaboratively develop a climate Health National Adaptation Plan (H-NAP 2025 – 2030). The H-NAP aims to enhance Uganda's health system resilience against climate by incorporating climate adaptation into health strategies and planning to ensure sustainable and continuous healthcare service during climate emergencies. The H-NAP calls for collaboration across sectors to address the climate change challenges. At sub national level there is need to support districts, cities and other LGs to conduct climate change vulnerability, capacity and adaptation assessments and to develop context-specific climate change adaptation plans. Guidelines will be developed to support this process.

4) Covid-19

The availability of vaccines for Covid 19 enabled the country to stem the Covid 19 spread and surveillance for other emergent diseases continued. Standard Operating Procedures (SOPs) and public awareness messages have been developed and widely disseminated. Capacity building of the health workforce and re-organization of service delivery points has been undertaken while ensuring continuity of essential services. Surveillance and laboratory services strengthening is very critical to effectively respond to the pandemic.

This plan will provide a framework under the disease surveillance and epidemic response interventions for coordination and control of COVID-19 by reduction of importation, transmission, morbidity and mortality in a bid to minimize the social economic disruption that might result from this pandemic.

2.4 INSTITUTIONAL CAPACITY

2.4.1 Health Financing

During the 5 years of the MoH SP, Uganda will be implementing the NDP IV which provides the national Medium-Term Planning and Expenditure Framework. A three-

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year rolling framework, the MTEF is used to streamline and guide the budget process and set out planned outputs and associated expenditures in the medium term.

In the past five years, health service delivery was financed by the government, private sources and development assistance under the SWAps. Development assistance continues to play a major role in financing health services but a bigger proportion of this is off budget. The MoH has information on general budget support and project support to the health sector but not sufficient information on off-budget support. Most of the funds from partners are directed towards the three areas of disease: HIV/AIDS, TB, and Malaria. There still exist many donor 'projects' – bilateral, multilateral and global health initiatives – which need to be integrated fully into strategic and operational planning and budgeting, even if the finances do not flow through the MoFPED.

The MoH implemented the major projects shown in Table 9 during the last 5 years and the majority are still ongoing.

Table 5: MoH Project Inventory and performance 2020/21 – 2024/25

Funding Agency	Project Title	Date of Effectiveness	Initial Closure Date	Amount Committed	Remarks
IDA	East African Public Health Laboratories Network Project	30-Mar-16	30-Mar-20	USD 15M	Completed
IDA/GFF/ SIDA	Uganda Reproductive Maternal and Child Health Services Improvement Project	26-May-17	30-Jun-21	USD 140M	Completed
Uganda-Spain Debt Swap Project for Health sector	Rehabilitation and Construction of General Hospitals-Kawolo and Busolwe General Hospital	Jan 17	Dec 19	USD 17.8M	Completed
Italy	Italian Support to HSSP and PRDP (Karamoja Region Staff Housing Project)	16-Jun-16	30-Jun-19	Ugx 5.62 bn	Ongoing
Italy	Italian Support to the Health Sector Development Plan *(Karamoja Infrastructure Development Project-Phase II)*	1-Jul-20	30-Jun-24	Ush 16.3 Bn GOU Counterpart: Ugx 700 m	Ongoing

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Funding Agency	Project Title	Date of Effectiveness	Initial Closure Date	Amount Committed	Remarks
GAVI	Gavi vaccines and health sector development plan	1-Jan-17	31-Dec-21	USD 2.6M Grant: USD 38.9	Ongoing
Global Fund	Global Fund for AIDS, TB and Malaria	1-Jan-18	31-Dec-20	USD 478 M	Ongoing
Emergency	Regional Hospital for Paediatric Surgery	Jun-17	April 2020	Ugx 117 bn	Completed
SPR-FINASI	Construction and Equipping of the International Specialized Hospital of Uganda		June 2020	249.9m USD	Ongoing

The MoH holds meetings with the different HDPs to discuss the different funding streams, proposals, projects and plans, for example GAVI, GFTAM, COAG, PEPFAR, JICA, UNFPA, World Bank, Enabel, SIDA, WHO Country Cooperation Strategy and UNICEF, among others. Uganda also participates in the IHP+ monitoring assessments of the 8 Effective Development Cooperation practices in health.

The monthly Financial Committee meetings were revitalized to monitor financial performance and ensure appropriate budget allocation. The Ministry is strengthening its internal measures to ensure timely submission of its operational plans and budgets to MoFPED as part of the overall strategy to get timely and adequate releases of Government Funds.

In the face of low funding, Uganda is also under considerable pressure to increase spending for health. This is driven primarily by the rapidly growing population and the need to adopt more effective and expensive—health technologies and service standards to combat the high disease burden. Besides, continuing resource mobilization and reducing waste, Uganda needs to take proactive steps to mitigate growing pressure to increase health spending.

There are two levels of resource allocation: inter-sectoral allocation across the ministries (which is done by MoFPED), and intra-sectoral allocation, which is performed by the MoH for the health sector, based on resource allocation formulas. Capital investment needs are assessed and paid for based on special technical appraisals. The MoH is responsible for reviewing the health resource allocation formula for the LGs and their health facilities and this was undertaken in FY 2019/20.

The MoH developed the Health Financing Strategy, 2016 which describes the key financing reforms, which once implemented, will together contribute to a health

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financing system considered desirable for Uganda. The MoH undertook extensive stakeholder consultations and finalized the Draft NHIS Bill, 2019 which was approved by Cabinet in June 2019 and is undergoing Parliamentary review and discussion. Draft NHIS provides for mandatory enrolment of all above 18 years old with a source of income and subsidies for the indigents in a phased manner. The private commercial health insurance schemes to provide complementary and supplementary packages not covered under the NHIS benefits package. In addition, government is continuing to continue funding services not covered under the benefits package.

Innovative health financing schemes exist to improve equity and access, including RBF initiatives. The MoH developed the National RBF Framework to enhance the utilization, efficiency and quality of health services delivered to the population of Uganda while improving equitable access to these services; and to increase the strategic purchasing of cost-effective services to contribute to significant reductions in morbidity and mortality.

The implementation of RBF was mainstreamed into sector conditional grant for health adopting the recommendations from the project mode to improve efficiency and effectiveness of the grant.

2.4.2 Human Resources Management (HRM)

The revised MoH macro structure was approved by Cabinet in May 2016 and revised in May 2023. Out of 668 approved posts 461(69%) were filled while 267 were vacant by the end of the previous strategic plan period as indicated in Annex III. Staffing levels are low in 3 out of 4 directorates, namely the Directorate of Governance and Regulation (51%), Directorate of Public Health (61%) and Directorate of Strategy, Policy and Development (62%). It is worth noting that by the end of the last strategic plan period the Health Service Commission had completed the recruitment of several health workers who were pending deployment bringing the staffing level to 74%.

The most critical role in HRH is managing the health workforce to assure continued responsive distribution, high motivation and retention, and maximum productivity of the workforce that is in place. The question of productivity is two-layered: how much time the staff spend on the job, and what portion of that time is spent on productive work.

The MoH employs an automated Attendance Machine that was deployed in 2016 in addition to the Integrated Human Resource Information for tracking duty attendance. Every department head, project manager, and principal level officer completes and signs a performance agreement with the permanent secretary, which will serve as the basis for evaluation. Additionally, in areas where the electronic medical records

system has been implemented, there is a chance to confirm the work completed by medical specialists and other staff members.

The HRH Working Group at the MoH is relatively active and oversees the development of HRH policies, strategies and guidelines. Some of the major challenges in HRH include wages, inadequate availability of pre-service health training, and poor training capacity and quality among health training institutions. Overall, implementation of the HRH strategy and policy has been slower than planned.

2.4.3 Monitoring and Evaluation

To ensure effective monitoring of the national health strategy, MoH developed the M&E plan for the HSDP with clear indicators and targets for assessing performance and ensure availability of accurate and timely information on health sector performance. This facilitates implementation of a country-led M&E Platform, especially in the use of harmonized data collection tools and reporting systems. All programs and projects are also expected to develop specific program/project M&E Plans which should include programme indicators to measure process, outputs and immediate outcomes. These should, however, be aligned with the goal, objectives and strategic interventions of HSDP to demonstrate the effects of health system strengthening to health outcomes. The new structure of the Ministry has provision for an M&E Unit under the Planning Department however, staff have not been recruited to functionalize it. The existing M&E Specialists are attached to specific programs or projects.

Quarterly performance review meetings are held, and annually, the Ministry compiles and disseminates Annual Health Sector Performance Reports (AHSPR). Annual joint health sector reviews are held. The central level in collaboration with partners also supports and participates in regional and district performance reviews. To the public, the MoH provides space for the participation of all districts and local authorities in the Annual JRM and Bi-annual Health Assemblies. At these fora, national and district level political leaders, national level CSOs working in the health sector, the media, and development partners receive performance feedback about sector performance, and generate priorities for the MoH in the subsequent fiscal year. In addition to this, specific programme reviews and evaluations are conducted.

Among the many innovations for feedback, the MoH uses the district league table to rank the performance of the districts using health-related indicators such as service coverage, staffing level, timeliness and completeness of reporting. Assessment of hospitals and HC IVs is also done using the Standard Unit of Output.

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The sector has registered improvements in most of the M&E system components, however, there are still several gaps. Weak linkages between MoH and UBOS lead to poor timing in provision of results for guiding sector planning. There is also lack of annual vital statistics on births and deaths.

With health information, research and evidence generation, the country utilizes the District Health Information System (DHIS)-2 software for routine data reporting. This was upgraded to DHIS2.3 version. The Ministry revised the HMIS tools to capture the data needs for all stakeholders. Capacity building in use of the new tools was undertaken in all districts with support from Partners. Quantification, procurement and distribution of the revised HMIS tools is ongoing with support from partners. The sector has made progress towards aligning the previously fragmented information systems within the health sector to ensure contribution to the one M&E system.

The inadequate supply of the revised HMIS tools in all facilities is still hampering data collection and reporting which compromises the data quality. There is still a challenge in the generation, compilation and submission of programmatic and departmental reports that are expected to feed into the overall sector performance reports. There are still irregular program and sub-national performance reviews due to inadequate funds. Evaluations for most programs not conducted due to inadequate funding and as a result impact of interventions is not well documented. The low reporting rates from the private sector limit the ability to appropriately monitor overall sector's outcome performance. Finally, the utilization of data for decision-making is still minimal and technical guidance and coordination needs to be given and enforced from the MoH to the lower levels and Partners.

A Data Quality Assessment (DQA) manual and harmonized DQA tools were developed and DQAs were conducted by the SCAPP department in a number of districts with support from GFTAM. A national DQA was undertaken during SARA 2018 and the findings showed that 40.2% of the facilities had matching reporting figures; 23.1% of the facilities were over reporting while 36.7% were under reporting; and 16.2% of the facilities were over reporting by over 10% and 9.4% under reporting by over 10% (MoH SARA, 2018). Surveys and facility assessments specific to some high burden conditions (HIV, TB prevalence, malaria, NCDs, etc.) were successfully initiated/conducted.

According to the SARA 2018, the general service readiness index (readiness or capacity of facilities to provide general services in Uganda was only 52%. Items of standard precautions for infection prevention and control were generally available (mean availability: 82%) and therefore contributed the most to the general service readiness index. This was followed by items of basic amenities (mean availability:

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56%) and items of diagnostic capacity (mean availability: 55%). Items of essential medicines (mean availability: 32%) and basic equipment (mean availability: 37%) were less available and therefore responsible for substantially pulling the general service readiness index down.

E-health has become a stronger area of focus, with the national e-health technology framework completed and draft e-Health policy and strategy developed. Several local innovation programs exist and can be leveraged to build country ownership and reduce the total cost of ownership. The Government has maintained strong stewardship over this developing area, to ensure the emerging e-health architecture is aligned to the pillars of e-health house of value and are contributing to the National Health Record Program.

2.5 SWOT Analysis

2.5.1 SWOT Analysis for Leadership and Governance

Table 6: SWOT Analysis for Leadership and Governance

Strengths	**Weaknesses**
- Existence of Guidelines for Governance and Management Structures. - Institutionalized planning and policy framework, monitoring and reporting system. - Uganda has relevant health policies and regulations in place, developed through a participatory multi-stakeholder process. - Decentralized service delivery allows decision-making to be close to the communities. - Strong functional MoH structure and senior-level leadership on health sector issues. - MOH developed and launched a Climate Change Health National Adaptation Plan (H-NAP 2025 -2030) to promote climate transformative leadership.	- The sector has not yet fully operationalized and implemented some strategies and guidelines including: The EMS Strategy; Referral Guidelines; CHEW strategy and Community engagement strategy. - Some of the newly created districts do not have the human, financial, and infrastructural capacity to operate effectively. - New staff structure unaffordable over the medium term
Opportunities	**Threats**
- High level political good-will for the health sector. - Global interest in the Health Sector - Bilateral and Unilateral support.	- Continuous creation of new districts and cities with no wage provision for recruitment of the DHTs, which affects leadership and governance at district level. - Inadequate funding and new LGs and Cities.

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- The program-based approach to planning and resource allocation under the NDP IV can enhance multi-sectoral collaboration.	- Uganda's health governance issues are deeply entrenched in its colonial past with a health care system based primarily on the medical model, which threatens the achievement of UHC. - Weak legislative function: Many proposed bills have not been enacted

2.5.2 SWOT Analysis for Health Sector Service Delivery

Table 7: SWOT Analysis for Health Sector Service Delivery

Strengths	**Weaknesses**
- Positive trends in coverage indicators (such as immunization coverage rate for 3 doses of DTP3 vaccine; ART coverage; and health facility deliveries). - Service delivery at all levels of the health system is based on the UNMHCP. - The decentralized health system and incorporation of both the public and private sectors increase access to health services. - HIV response is now mainstreamed at national and sub-national levels and HIV service provision is available at community level. - A high percentage (86%) of the population is within a 5 km radius of a health facility.	- Predominantly disease-oriented care system than health promotion and disease prevention. - Siloed, segmented sector specific interventions. - Inadequate access and poor quality of PHC services at lower level lead to influx of patients at the referral facilities. - Stocks-outs of key medicines, sundries and other consumables at facility level. - Poor or inadequate infrastructure includes staff accommodation. - Inadequate funding for public health emergencies

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	- Climate change related risks e.g., floods, landslides, drought, heatwaves that destroy health infrastructure and affect service delivery - A verticalized system of services delivery particularly for HIV and TB programs that will be difficult to maintain in the current scenario of markedly decreased donor funding.
Opportunities	**Threats**
- The integration agenda offers a shift to move away from siloed disease specific programmes towards a more people-centred service delivery approach - There are a number of active HDPs that support service provision. - Enhanced collaboration with WHO and other agencies helps in epidemic control and harmonized implementation. - Improved legal and policy environment for PPP supported by the PPP framework - The literacy rate has increased, which positively affects the population's health seeking behaviour.	- The emergency of COVID-19, Ebola virus disease M-POX and other diseases of epidemic potential - The sudden and drastic withdrawal of the support from development partners e.g. USAID that were support different regions.

2.5.3 SWOT Analysis for Health Workforce

Table 8: SWOT Analysis for Health Workforce

Strengths	**Weaknesses**

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- The strengthened regulatory capacity for HPCs to monitor registration and licensure of health workers - Existence of approved national guidelines for conducting training needs assessment and in-service training/CPD curriculum - MoH has established the iHRIS and Automated Attendance Analysis.	- Staffing gaps exist in the public sector across all health cadres, and vacancy rates are highest in districts, lower-level health units, and hard-to-reach areas. - Mismatch between the old staffing norms and the existing workload due to population growth, changes in disease burden and demand in health services. - Lack of career progression for some specialties. - Inadequate PPE for all health workers - Inadequate wage for recruitment - Health workforce not yet well sensitized about climate change and health - Lack of comprehensive data from public, private non for profit and private for-profit service providers.
Opportunities	**Threats**
- Increase in stock of qualified health professionals available for employment in the health sector. - Availability of bonded scholarships for medical specialists in the critical areas. - Development partners support in-service training and temporary contracting of critical health workers. - Digital tools and e-learning platform for health workforce training.	- "Brain drain" i.e. Specialists leaving the country for better opportunities is a big threat. - Emergency of new epidemics such as COVID 19 that has lead closing of training institutions, which affected the production of health professionals and re-assignment of health workers for COVID-19 response.

2.5.4 SWOT Analysis for Medicines, vaccines & other health supplies

Table 9: SWOT Analysis for Medicines, vaccines & other Health Supplies

Strengths	**Weaknesses**
- Active TWG for Medicines Procurement and Management. - A Medicines and Essential health supplies management system including financial and commodity tracking system (FACTS) designed and implemented at NMS and central ministerial levels has been put in place. - The supply chain system is harmonized, standardized and optimized to more accurately quantify needs, and in place order and delivery schedules, and a national quantification and procurement planning unit. - Clinical Guidelines and EMHS list in place to guide rational use of medicines	- Inadequate funding for EMHS Low at $6 per capita. - Limited supervision and distribution of pharmacies in the rural communities with an over concentration in urban centers. - Lack of price regulatory mechanisms - Antibiotics are widely available without prescription and there are currently no systems in place to control the use of antibiotics. - Indigenous and complementary medicines, though widely used in Uganda, are insufficiently regulated. - Un-harmonized current pharmaceutical sub-sector Acts of Parliament that provide conflicting roles by key actors: - Expiry of medicines with lack of pharmaceutical waste management facilities.
Opportunities	**Threats**
- Partnerships between the MoH and HDPs are contributing to improvements within the sector - Existence of incentives that include a 15% preferential rate in public procurement - Growing population is estimated at 41.6 million in 2020 which is a big market. - Increased pool of pharmaceutical professionals provides an opportunity for recruitment of the workforce.	- Over 80% of EMHS are imported - The domestic manufacturing industry is still low - Growing antimicrobial resistance

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- Availability of partner financial and technical support to strengthen the national drug authority	

2.5.5 SWOT Analysis for Health Financing

Table 10: Analysis for Health Financing

Strengths	**Weaknesses**
- There is an existing Health Financing Strategy which provides a road map for health financing functions in the sector - RBF mainstreamed into the sector conditional grant for health improving efficiency and effectiveness - Tools for planning and budget reporting in place	- The health sector is underfinanced, per capita expenditure stands at $57 compared with WHO recommendation of at least $80, which leads to inadequate HRH, inadequate health infrastructure development and lack of medicines, vaccines & other health supplies. - High catastrophic health expenditure with 13.6% - The health sector is heavily dependent on external, development partner resources and OOP payments from households to fund essential programs and is well below international targets for health sector financing. - Slow progress of the NHIS Bill, which would provide an opportunity to reduce high OOP payments and increase equity - High catastrophic health expenditure with 13.6%
Opportunities	**Threats**

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- The Ugandan government consistently reports financial performance and effectively disburses and executes allocated domestic funding to the health sector - There is high-level political commitment to increasing domestic funding for health. - The Uganda Partnership Policy (2013) helps to align donor funding with government priorities. - Availability of local and global evidence on national health insurance schemes that can be used to inform the Uganda NHIS - PPP act allowing for partnerships to enhance funding	- Limited fiscal space and significant donor funding provides little incentive for domestic contributions to health. - External funding remains difficult for the government to predict, plan for, and disburse. - High population growth rates combined with growing disease burden and declining tax revenues make this a challenge. - Medical Inflation: More expensive equipment and technology is coming on the market which increases the costs of treatment.

2.5.6 SWOT Analysis for Health Information System

Table 11: SWOT Analysis for Health Information System

Strengths	**Weaknesses**
- Availability of regular national health surveys - HMIS has progressively developed from completely paper-based system to electronic or computer-based system. - The MoH routinely monitors the disease burden in the country using the HMIS which captures data from both public and private health facilities - 100% of Districts report monthly through DHIS2. - Compliance with Timeliness for reporting (HMIS105) is 98% - The National eHealth Policy and Strategy in place	- Lack of data collection tools - Data quality gaps - Non-standardized coding of diseases - Low data use at all levels of the health system - Indicators for measuring sector performance and productivity are not yet well aligned with the UHC goal. - Limited qualitative indictors to measure interventions that address structural barriers - Low reporting rate from the PHP facilities

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	- There are still duplication and fragmentation of data across reporting systems that have been developed by different users, especially for HIV related data. - Irregular / delayed community surveys for impact evaluation
Opportunities	**Threats**
- There is opportunity to scale up the eHMIS to all the private sector and community level - (Linkage with the Parish Development Information System) - Window for multi-sectoral collaboration with Ministry of ICT, UCC, and National IT for data security and IT infrastructure maintenance - There are a number of active HDPs that support HIS. - New global ICT developments and innovations including mobile applications for contact tracing and early case detection for epidemics such as COVID-19. - Increase in local and global Knowledge Translation (KT) initiatives	- Inadequate information and communication technology facilities including limited and irregular electrical power supply and internet access - Rapid ICT advancement - Cyber threats of security breaches and hacking of health data

2.5.7 Issues from SWOT Analysis

Despite the notable progress in health system strengthening, there are still several gaps and challenges which may continue to slow down the country's progress towards the attainment of UHC. This is against the backdrop of rapid population growth, rising burden of preventable diseases amidst the increasing unpredictability of the external aid that has for long supported the health sector. Considering this, the current health system needs to be re-organized to address the growing challenges.

Leadership and Governance: There are relevant health policies and regulations in place, which have been developed through a participatory process. Although the structures for accountability are well-established at the national level, there are weak or non-existent performance management systems at sub-national levels. Further, the disease burden in Uganda is largely due to the social determinants of health requiring a multi-sectoral approach yet the current response is mainly focused on the health sector. The drivers of the high disease burden extend beyond the health sector service delivery system; they include access to safe water, sanitation and hygiene, air pollution, poor housing, occupational health, nutrition, lack of physical activity, alcohol intake, trauma and age and hereditary factors. Thus, this calls for a strong multi-sectoral collaboration as a pillar for health promotion and primary prevention and investing in primary health care to accelerate the attainment of UHC as well as, Vision 2040.

There are also significant gaps in the District Health Office staffing levels. Currently, 69% of approved positions are filled, which affects supervision of district health services and most of the newly created Local Governments, Cities and Municipalities do not have the human, financial, and infrastructural capacity to operate effectively.

Service Delivery: Uganda has significantly improved access to health services over the past 10 years. For example, most Ugandans (86%) now live within 5 Km of a health facility, ART coverage for both adults and children has significantly improved to 92.2% in 2022 with facility reports indicating it is 97% in 2023/24 and health facility deliveries have also significantly improved to 83% (UDHS 2022). Despite this progress in service availability, significant challenges remain to improve the quality-of-service delivery and address continuing health status issues such as high death rates from preventable diseases plus high infant and maternal mortality. The challenges include limited disease prevention actions at individual, household and community level, inadequacy of medicines, sundries and other consumables due to limited funding. Others include inadequate primary care services at lower levels; low staffing levels and poor maintenance of physical infrastructure for public health facilities including medical equipment. There are pertinent challenges to health infrastructure that

include spatial inequality in health facility population coverage, distance to health facilities, which poses a barrier to healthcare access to some segments of the population, and limited functionality and availability of necessary infrastructure at the health facility level. There is poor maintenance of the existing physical infrastructure for public health facilities including medical equipment. The situation has been complicated by the emergency of the Corona Virus Diseases-19 (COVID-19) and its interruption on health service delivery as well as socio-economic development, inadequate funding and creation of new districts and cities coupled with shrinking external funding. With decline in country's maternal and child mortality and relative change in conditions contributing to the biggest burden of mortality in the country, there will be need to adjust the investment. This includes focusing on increasing greater access to secondary and tertiary care including Level II nurseries for premature babies and HDU and ICU care for mothers with severe complications of delivery and strengthening and optimizing the quality of referral between service delivery levels.

Health Workforce: In the last 10 years, there has been a positive trend in staffing levels of health workers. The increase has partly contributed to the improvement in equitable distribution of health workers in the country with many rural districts having better staffing levels than urban districts. This trend is attributed to the increase in the production of health workers, strengthened regulatory capacity for Health Professional Councils to monitor registration and licensure of health workers. Also, there has been improvement in availability of data on the public sector health workforce. Opportunities for growth included the availability of bonded scholarships to support training of medical specialists in the critical areas and continued contracting of critical health workers on temporary basis by HDPs. The recent revision of the staff structure has reduced the staffing levels to 34%. However, the HRH shortage and distribution of health workers (doctors, pharmacists, and other cadres) continue to remain major obstacles to access to quality health care in remote and hard-to-reach areas. The wage bill limits the ability of the public sector to fill its vacant positions and to absorb the increasing numbers of health workers produced; it is thus a major bottleneck to the performance of the entire health system. Attracting and retaining health workers in the public sector continues to be a key challenge. Staffing levels in the private sector are not known and this is a gap to be addressed as the private sector contributes significantly to health care delivery. Further, the PNFP health facilities lack standard staffing norms.

There is increased stock of qualified health professionals available for employment in the health sector contributed by both public and private institutions and partly facilitated by availability of scholarships for medical specialists in the critical areas.

The HDPs support in-service training thus temporarily contracting critical health workers. Despite this, HRH shortage, inadequate skills (given emerging health care technologies) and poor distribution remain major obstacles to quality healthcare access. The wage bill continues to limit attraction and retention of health workers in the public sector. Staff absenteeism remains a challenge to health services delivery despite efforts, such as the establishment of the Integrated Human Resource Information System.

Medicines, Vaccines & other Health Supplies: Management of medicines and medical products has improved significantly in recent years due to strong leadership and regulation within MoH, and NDA, as well as strengthened supply chain management system by the NMS and JMS. However, the sector is still faced with challenges that include limited supervision and distribution of pharmacies in the rural communities with over-concentration in urban centers. The country still lacks price regulatory mechanisms. In addition, antibiotics are widely available without a prescription and there are currently no systems in place to control the use of antibiotics or for routine surveillance of antimicrobial drug resistance in either the public or private sector. Indigenous and complementary medicines, though widely used in Uganda, are insufficiently regulated. On a positive note, the long awaited Traditional and Complementary Medicines Act was enacted in 2020 to provide a regulatory framework for traditional herbalists and integrate indigenous and complimentary medicines in the healthcare system. Other challenges include the persistent stock-outs of medicines and other essential health supplies. The percentage of health facilities having over 95% availability of a basket of commodities is still low at 46%. More so, the pharmaceutical space is facing a significant human resources challenge, and the domestic manufacturing industry is still low despite incentives in place including preferential rate in public procurement.

However, there is a growing population that guarantees market for pharmaceutical products, the GoU put in place incentives that include a 15% preferential rate in public procurement over foreign pharmaceutical companies. The country's medicines and health supplies security is heavily dependent on donor funding. Further, the medical products regulatory system still has capacity gaps and as a result affects the development of the nascent domestic production capacity. Fortunately, there is an opportunity of partners being available to strengthen national drug authority and in turn support growth of domestic production.

Health Information System: There is a well-established and functional system for collection, processing, storage, retrieval and dissemination of health information for

decision-making despite some challenges. The system has progressively developed in Uganda from completely paper-based system to electronic or computer-based system, which is used to routinely to monitor the disease burden. A significant number of public health facilities (98%) use the system to make timely reports on monthly basis. Comparatively, reporting in the private sector is less than 25% despite the fact that all public and private health facilities are mandated to report health data through the national HMIS. This is attributed to fewer trained staff and lack of regular supervision of the private health facilities. The country has had regular national health surveys to inform policy and decision making. Despite this progress, the Uganda's HIS still has some internal gaps and limitations. The system is still faced with data in-put challenges including inaccurate and inadequate segregation of data at entry; reporting challenges such as limited access to real-time information and poor dissemination among the stakeholders. In addition, there is still poor utilization of information attributed to inadequate skills by decision makers and health workers to analyze and use health information. Another challenge is that the system does not capture adequately qualitative indicators on interventions that address structural and behavioral barriers on routine basis. The indicators for measuring sector performance and productivity are also not comprehensive to track progress with the Universal Health Coverage (UHC) goal. Lastly, there is a need to link the HMIS at community level with the parish development information system.

Health Financing: There is high-level political good-will and commitment to increase funding for health. A Health Financing Strategy 2015–2025 was developed to provide a road map for health financing functions in the sector. The sector also has introduced Results Based Financing (RBF) as a purchasing method that can promote more efficient use of resources and promote the strategic purchasing of cost-effective services. Despite this, the health sector is under-financed, which leads to inadequate HRH, inadequate health infrastructure development and lack of medicines, vaccines & other health supplies. The sector is heavily dependent on external, development partner resources and OOP payments from households to fund essential programs and is well below international targets for health sector financing. External aid to the sector is increasingly becoming unpredictable and is likely to significantly reduce in the coming years. Moreover, the in-country funding estimates indicate that a significant percentage of donor support to the health sector has been in the form of off-budget, which affects the intended equity and efficiency of the fiscal transfer allocations. The off-budget support to the health sector was estimated at 54% between 2008/09 and 2017/18 of the donor assistance. Thus, Uganda needs to take bold steps that will gradually transition MoH away from reliance on donor funding. Further, the progress in establishing a legal framework for health insurance through NHIS is still

slow; this would help to reduce high OOP payments and increase equity. Also, while the UNMHCP has been useful in prioritizing the available resource envelope. However, it has not been able to influence significantly an increase in overall financial resource allocation to the health sector. On the contrary, there is often re-prioritization with an explicit and implicit rationing process within the package of services and across population coverage due to the inadequacy of the resources to support the UNEHCP. Such re-prioritization affects quality, equity and utility of benefits to the users.

2.6 SUMMARY OF EMERGING ISSUES AND IMPLICATIONS

Several undertakings as highlighted below were started but not completed and will need to be brought forward into the Strategic Plan 2020/21-2024/25.

Table 12: Unfinished Strategic Actions

Health Leadership and Governance	**Health Workforce**
• Establishment of the National Institute of Public Health • Development of the institutional accreditation system • Approval of Policy and Strategy: Emergency Medical Services, CHEW, E-Health • Disseminate the H-NAP at all levels to promote climate transformative leadership and governance • Operationalise the 3 Acts that were passed and fast track all the pending legislation. • Advocate for improved staffing of the office of the DHO • Strengthen multi-sectoral collaboration to address other determinants of health towards UHC.	• Restructuring of the health workforce to conform to the revised expected standard of practice. • Institutionalization of a Regional Supervisory Structure • Production of super specialized cadres • Scaling up of strategies for monitoring and reducing absenteeism • Performance management training, coaching and mentorship • Orient health workers on climate change and health to create a climate-smart health workforce. • Lobby for more funding to tackle shortage and distribution of staff based on the revised staffing norms.
Health Financing	**Service Delivery Organization**
• Passing of the NHIS Bill and operationalization of the NHIS. • Implementation of the revised allocation formula for PHC. • Introduction of RBF financing for hospitals.	• Operationalization of the Emergency Medical Services Policy and Strategy. • Operationalization of the referral framework / guidelines.

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• Develop proposals to tap into global climate financing.	
Health Products	**Health infrastructure and equipment**
• Harmonization of the various e-LMIS (WAOS, RX Solution, RAS, IICS) and scale up to HC III level and linkage with the Enterprise Resource Planning (ERP) Platform. • Regulation of traditional and complementary medicine practitioners. • Tackle persistent stock outs. • Incentives for local pharmaceutical manufacturers to minimise high costs. • Tackle the anti-microbial resistance.	• Functionalization of Neonatal Intensive Care Units (NICUs) Intensive Care Units (ICUs) and High Dependency Units (HDUs) in all RRHs • Completion of renovation and equipping of selected general hospitals • Upgrading of HC IIs to HC IIIs (remaining 170) and HC IIIs to IVs (69 constituencies without) • Construction of 3 Regional Blood Banks (Arua, Moroto and Masaka) • Provision of 5,000 staff accommodation • Construction of National and 5 Regional Equipment Maintenance Workshops • Establishment of Regional Health Care Waste Management Centres • Creation of high-volume, specialized cancer and trauma centres.
Health Information	
• Improving operational capacity for birth and death notification and reporting • Implementation of the e-Health Strategy • Improve data use for decision making.	
Community Engagement and Feedback	
• Dissemination of the revised Health Unit Management Committee/Hospital Management Board guidelines • Communication Strategy	

3 THE STRATEGIC DIRECTION

The Uganda Demographic Health Survey 2022 and National Census 2024 reveal improved health outcomes, reduced mortality rates, and fertility rates; however, some challenges persist such as increasing prevalence of infectious diseases, non-communicable diseases, and rapid demand for health services due to changing epidemiological patterns, rapid population growth and climate change.

Malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis, and perinatal and neonatal conditions are the leading causes of morbidity and mortality yet 75% of Uganda's disease burden remain preventable. As a result, the Ministry plans to adopt some strategic shifts to tackle these challenges, and these are reflected in her strategic direction.

3.1 VISION

A healthy and productive population that contributes to socio-economic growth and national development.

3.2 MISSION

To provide high quality and accessible health services to all people in Uganda, including addressing broader determinants of health.

3.3 CORE VALUES AND PRINCIPLES

The Ministry of Health strives to coordinate the provision of user-friendly services by promoting the notion of putting all clients in the sector at the forefront with openness to dialogue and feedback for purposes of progressive improvement.

Our core values include:

i) Client Focus and Responsiveness

The Ministry of Health endeavours to ensure that the Country's health services meet the client needs and expectations, and their interests will be the priority of the health service. The health system shall attend to all its clients' needs, ideas, and feedback in a timely and professional manner.

ii) Quality

The Ministry of Health shall ensure that delivery of high-quality services is the primary objective and driving factor for our health system. The country prides itself

in the provision of high-quality services and products through the development and application of our medical, patient and customer service standards of care.

iii) Equity
The country's health services ensure every individual has access to health services that they need regardless of their social status, disability, gender or location.

iv) Respect
The country's health system respects promotive health aspects of cultures and traditions of the people of Uganda. The health system respects individual identity and autonomy of our partners in line with the professional code of conduct and national policies.

v) Professionalism, Integrity and Ethics
Work in the country's health system is to be performed with the highest level of professionalism, integrity, honesty, openness and trust as detailed in the ethics guidelines enforced by professional bodies to which the various actors are affiliated.

vi) Effective Communication
The Ministry of Health will promote effective communication in all aspects of health service delivery.

vii) Professional Development
We value learning, feedback, coaching and mentoring by taking responsibility to gain the required skills development to meet our clients' needs.

viii) Transparency and Accountability
We ensure a high level of efficiency and effectiveness in the development and management of the national health system. We believe in accountability for our performance, not only to the political and administrative system, but, above all, to the community.

3.3.1 Principles
The Ministry of Health guiding principles aim at providing the highest affordable quality services and these include:

i) Effective Leadership
We believe that effective leadership should be structured, present and accessible. Our leadership strategy is based on a practice and overall management level support

network which provides both personal and team motivation, direction and accountability.

ii) Teamwork

The health sector is composed of a team from different professions. Therefore, we believe in teamwork to reinforce the services from different disciplines all aiming at improving the overall care-giving experience.

iii) Decentralization

We acknowledge and shall support health services within the framework of decentralization and any future reforms therein.

iv) Partnerships

The private sector shall be complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided. The Ministry of Health will promote the Public-Private-Partnership-For-Health (PPPH) policy nationally and internationally.

v) Quality

We believe that consistency in standards, protocols and procedures is essential to maintaining and improving the quality of our services.

vi) Gender-Sensitive and Responsive Health Care

A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.

vii) Human Rights Approach

The Ministry of Health will ascertain that the rights to access quality health care and health information are respected by all categories of individuals of the society both within the public and private sector.

viii) Integration

Seamlessly integrate Primary Health Services and additional interventions to enhance the efficiency in delivering health services.

3.4 MOH STRATEGIC OBJECTIVES MAPPED TO THE NDP IV

The Human Capital Development Programme (HCDP), Digital Transformation, and Innovation, Technology Development & Transfer are the three main NDP IV programs in which MoH is positioned. MoH's main contribution, though, is to HCDP, which embodies her fundamental goal of offering all Ugandans access to high-quality healthcare.

Table 13: Mapping of MoH Strategic Objectives to HCDP Objectives, Intermediate Outcomes and Strategic Interventions

Vote Objective	NDP IV HCDP Programme Objectives	NDP IV Intermediate Outcomes
1. To accelerate integrated Health Promotion and Disease Prevention efforts at all levels	• Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.	• 3.1.1: Improved utilization of health services (health promotion and disease prevention).
2. To strengthen the health system for an effective healthcare service delivery and response.	• Objective 5: Reduce vulnerability, gender inequality and inequity along the lifecycle. • Objective 9: Strengthen the Policy, Legal, Institutional, and Coordination Frameworks.	• 3.1.1: Improved utilization of health services • 3.1.2: Improved adequacy of Human Resources for health, health infrastructure, medical equipment, vaccines, medicines, supplies and health technologies • 3.1.7: Improved financing for health
3. To enhance the accessibility and utilization of quality integrated communicable and non-communicable disease services.	• Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.	• 3.1.1: Improved utilization of health services • 3.1.6: Increased access to handwashing facilities
4. To promote optimal delivery of maternal, neonatal, infant, child, and adolescent health services at all levels.	• Objective 1: To improve the foundations of human capital development. • Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.	• 3.1.1: Improved utilization of health services
5. To strengthen health research, information, innovation, and technology in the provision of health services including emerging health threats.	• Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.	• 3.1.1: Improved utilization of health services

3.5 GOAL

The Goal of the MoH is to improve the overall health and wellbeing of all Ugandans by 2030.

The Strategic Plan Objectives include:

1. To accelerate integrated Health Promotion and Disease Prevention efforts at all levels.
2. To strengthen the health system for an effective healthcare service delivery and response.
3. To enhance the accessibility and utilization of quality integrated communicable and non-communicable disease services.
4. To promote optimal delivery of maternal, neonatal, infant, child, and adolescent health services at all levels.
5. To strengthen health research, information, innovation, and technology in the provision of health services including emerging health threats.

The SP Objectives of the MoH SP are aligned to the following NDP IV strategic objectives of the health sector which include:

- Objective 1: To improve the foundation of human capital development.
- Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.
- Objective 5: Reduce vulnerability, gender inequality and inequity along the lifecycle; and
- Objective 9: Strengthen the policy, legal, institutional, and coordination frameworks.

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3.5.1 GOAL OUTCOMES, INDICATORS AND TARGETS

The Table below shows the Goal outcomes, indicators and targets for the next 5 years period.

Table 14: Goal Outcomes, Indicators and Targets for the Next 5 Years Period

Result	Development Indicators	Baseline FY2023/24	Target FY25/26	Target FY26/27	Target FY27/28	Target FY28/29	Target FY29/30	Target Vison 2040	Data Source	Responsible Department
HCDP Objective 2: Enhance human capital development along the entire life cycle										
MOH Goal: To improve the overall health and wellbeing of all Ugandans by 2030										
Improved quality of life	Maternal Mortality Rate/ 100,000	207	182	156	131	105	80	15	Annual Health Sector Report, UDHS	MOH, UBOS
	Infant Mortality Rate/ 1000	34	30	27	23	19	16	4		
	U5 Mortality Rate/ 1000	46	42	38	34	30	26	8		
	Neo-natal mortality Rate (per 1000)	22	21.6	21.2	20.8	20.4	20			
	Total Fertility Rate-Total	5.2	4.96	4.72	4.48	4.24	4			
	Total Fertility Rate-Urban	4.3	4.3	4.2	4.2	4.1	4.1			
	Total Fertility Rate-Rural	5.6	5.38	5.16	4.94	4.72	4.5			
	Population growth rate	2.9	2.86	2.82	2.78	2.74	2.7	2	Census	UBOS
	Life expectancy at birth in year	68.2	69.7	71.3	72.8	74.4	75.9	85		UBOS
Improved access to service to social care, protection, safety, gender and Equity	Sanitation coverage	79.5	82.7	85.9	89	92.2	95.4		UNHS	UBOS
	Hygiene (Hand washing)	36	37.4	38.9	40.3	41.8	43.2			UBOS
	Universal Health insurance coverage	1.1	1.4	1.6	1.9	2.1	2.4		Annual Statistical Abstract	UBOS

3.6 MoH SP Interventions and Actions

This section provides a description of strategic interventions, outputs and actions under the MoH for the next five years.

Theory of Change: Given that 75% of illnesses are preventable, MoH intends to scale up effective service delivery methods over the next five years, concentrating on disease prevention and health promotion at all levels, with more focus at the community level. Through the development of an integrated community health system backed by CHEWS and VHTs, the community is being targeted as a major force for change. The strategy will include: first, integrating community health systems to strengthen the foundation of preventive healthcare service provision; strengthen integrated service delivery models for a comprehensive health service coverage; and focusing on young minds and multi-sectoral collaboration for long-lasting behavioural change. Figure 16 shows the sustainable health promotion and disease prevention model for Uganda.

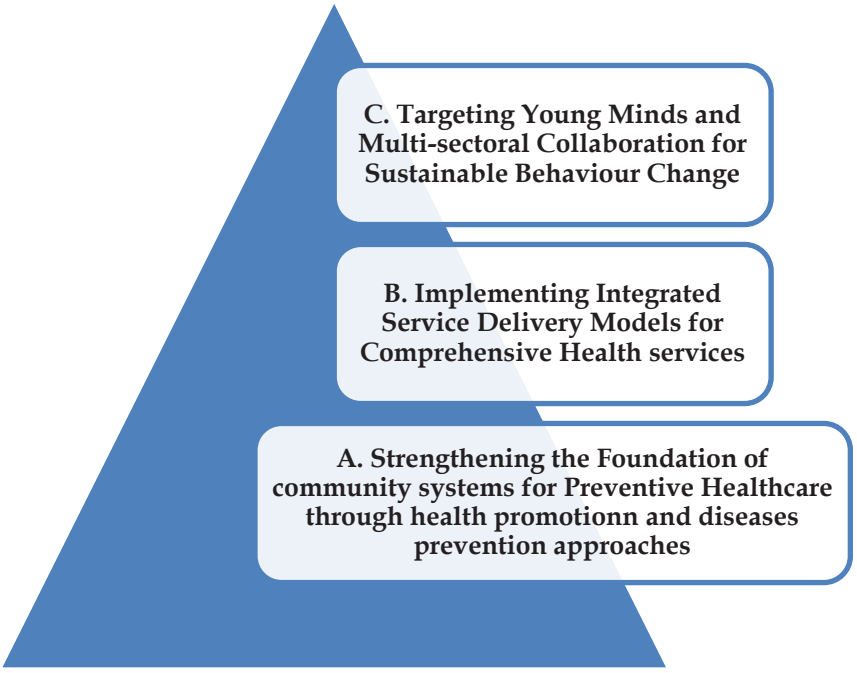

Figure 16: Uganda's Sustainable Health Promotion and Disease Prevention Model

Uganda's Sustainable health sustainable health promotion and disease prevention model is detailed below:

A. Integrated Community Systems as a Foundation for Preventive Healthcare service delivery

Uganda's preventive and promotive strategy will focus on the following aspects: promoting health-seeking behaviour and practices through self-awareness

promotion, and early screening; nutrition education and promotion, community based programs of routine early diagnosis for non-communicable diseases (NCDs) communicable diseases using wellness clinics in public health facilities;; institutionalizing community feedback mechanisms for increased demand creation of health services, community participation and ownership of health programs . This requires scaling up Community Health Extension Workers (CHEWs) and revitalizing Village Health Teams (VHTs) to deliver integrated service delivery packages at household and community levels.

B. Adopting an Integrated Service Delivery Model

Integrated service delivery models will be implemented to address multiple health needs simultaneously, reducing the burden on families and health systems while improving efficiency and coverage. This model will require robust support systems, standardized protocols, adequate supplies, and continuous technical supervision.

C. Sustaining Health Behaviours and Practices

Achieving sustainable health promotion and disease prevention requires a strategic focus on young minds using a settings approach like school-based health programs that influence lifelong practices and create generational change in health behaviours/practices. This multi-sectoral approach requires formal coordination mechanisms, shared accountability frameworks, and joint resource mobilization to ensure sustained impact on population health outcomes.

Additionally, MoH will keep using an integrated strategy that is guided by the Health System Integration Maturity Framework, strengthening performance management, replacing paper-based systems with sustainable digital platforms, and moving from a vulnerable to a proactive, adaptive, and resilient health system. Finally, the Ministry will assist efforts to move from a reactive and fragile health system to one that is proactive, adaptable, and shock-resistant considering the threats posed by climate change and public health catastrophes.

This inevitably calls for strategic shifts which will translate into action through strategic interventions, actions and the indicators that shall be used track progress of the strategy.

The strategic shifts include:

Table 15: Strategic Shifts

From	To
Curative Services	Community interventions (health promotion, disease prevention, and control)
Fragmentation, duplication and parallel planning and programming	Joint planning, budgeting, programming and monitoring (JPBF framework)
Individual disease-based service delivery models	Integrated and community-centred health service delivery [Service integration maturity framework (SIMF)]
Passive Participation	Effective multi-stakeholder engagement and community involvement for resilience
Manual or paper-based systems	Sustainable digital systems and Technologies
Routine Performance management cycle and appraisal tools	Effective human resources performance management with emphasis on staff engagement, support supervision for improved responsiveness, and HR optimization.
From vulnerable and reactive health system	Climate change, and health emergencies adaptation for resilient, sustainable health systems

To facilitate implementation, resource allocation and accountability, the lead departments in the MoH have been mapped against each of the key intervention areas. Below are the objectives, interventions and outputs over the 5 years.

Table 16: Summary of Objectives, Interventions and Outputs

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
MoH Objective 1: To accelerate Health promotion and Disease prevention efforts at all levels			
Strategic Intervention 3.1.1.1: Increase community ownership, access and utilization of health promotion, environmental health and community health services including persons with disabilities	Strategic Output 3.1.1.1.1: Integrated community health services package rolled out in all villages.	Training of CHEWs	HPE&C
		Renumeration of CHEWs	HPE&C
		Tooling of CHEWs	HPE&C
		Training and tooling of VHTs	CHD
		Support supervision on integrated community health services package implementation	CHD
		Support Establishment and orientation of Parish Social Services Committees	CHD
		Dissemination and orientation of health workers on the Integrated Community Health Services Package	CHD
		Review and disseminate the national community health strategy	CHD
		Develop and disseminate integrated Community engagement guidelines	CHD
		Train PHC and CHWs on the holistic community engagement model	CS
		Develop and disseminate the integrated health services delivery framework	
Strategic Intervention 1.2.1.3: Increase access to immunization against childhood	Strategic Output 1.2.1.3.1: Increase access to immunization against childhood diseases.	Procure and distribute Cold chain logistics (Fridges and cold boxes)	CDC&P
		Maintain and service EPI fridges.	CDC&P
		Roll out malaria vaccine in Under 5 children	CDC&P
		Support supervision and mentorship in EPI service delivery and cold chain maintenance	CDC&P
		Procurement of medical supplies (vaccines)	CDC&P
		Contribution to Gavi	CDC&P
		Subventions to LGs for Immunization	CDC&P
		Support supervision for Immunization Activities	CDC&P
		Conduct static and outreach immunization Sessions	CDC&P
		Capacity building for EPI service delivery	CDC&P
		Conduct paediatric deaths surveillance	RCH
		Implement Integrated Child Health Day activities	CDC&P

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
Strategic Intervention 1.2.1.2: Promote optimal Maternal, Infant, Young child, Adolescent and Elderly Nutrition Practices	Strategic intervention 1.3: Strengthen nutrition education and promotion at all levels.	Provide Vitamin A supplementation to U5s during routine immunization and Integrated Child Health Days	CHD
		Provide Iron and Folic Acid supplementation for pregnant women during ANC	CHD
		Promote micronutrient supplementation for the elderly (Calcium, Zinc, Vitamin D3, Magnesium, Vitamin B 12, B9 & B6, Iron)	CHD
		Build the capacity of health workers on the in-service training package (maternal, infant, young child, adolescent and elderly nutrition package/MMS/integrated management of acute malnutrition/ M&E for Nutrition, and supply chain management	CHD
		Build the capacity of community structures on Integrated community-based nutrition package	CHD
		Screen Food handlers for Typhoid & TB	EHD
		Nutrition health facility assessments conducted	CHD
		Conduct quality assurance of premix (food forticants) through testing at border points	EHD
		Scale up Nutrition promotion services at all levels of service delivery	CHD
		Promote local manufacturing of safe and quality nutrition commodities i.e. Therapeutic food, food supplements, and food fortificants.	CHD
		Develop and disseminate guidelines for micronutrient supplementation for pregnant women and the elderly	CHD
		Conduct Indicator survey on nutrition biomarkers	CHD
		Conduct awareness campaigns on nutrition with focus on dietary diversification and optimal breast feeding	CHD
Strategic intervention 3.1.1.5: Increase access to Sexual and Reproductive Health (SRH) information and services	Strategic Output 3.1.1.5.1: Increased demand and uptake of reproductive health services.	Develop Health promotion and SBC strategies, guidelines and innovative preventive interventions for all health programs.	HPE&C
		Develop, review and disseminate health educative, SBC/IEC/BCC and Health promoting materials and messages for all Health programs	HPE&C
		Organise and hold engagements and coalition in communities for different stake holders for advancement of public health.	HPE&C

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
		Support/train health facilities/health workers to offer adolescent and youth friendly, SRH/FP & CH services,	RCH
		Develop & disseminate Adolescent Health Services implementation plan 2025 - 2030	RCH
		Develop and disseminate the nurturing care framework for early childhood development	RCH
		Develop/review & disseminate SRH strategies and guidelines	RCH
		Support Establishment of District Committees on Adolescent Health (DICAH)	RCH
		Build capacity of the facilities and health workers to offer adolescent and youth friendly services	RCH
		Conduct adolescent and youth health campaigns	RCH
Strategic Intervention 3.1.1.2: Reduce the burden of communicable diseases with focus on high burden diseases (Malaria, HIV/AIDS, TB, Neglected Tropical diseases, Hepatitis), epidemic prone diseases across all age groups emphasizing Primary Health Care Approach	Strategic Output 3.1.1.2.1: Access to malaria prevention and treatment services improved.	Malaria vector control activities implemented (ITNs/LLINs)	CDC&P
		Mentorships and supervision of health facilities and community health workers in malaria management	CDC&P
		Malaria vector control activities implemented (IRS, larval source management)	CDC&P
		Seasonal malaria chemoprophylaxis for under-fives in target LGs	CDC&P
		Develop and disseminate a National Malaria elimination strategy & Guidelines	CDC&P
		Develop/review, disseminate and roll out malaria elimination strategy and guidelines	CDC&P
	Strategic Output 3.1.1.2.2: Access to quality HIV/AIDs and Syphilis prevention services improved.	Develop and disseminate HIV/AIDS and Syphilis Care and prevention strategies and guidelines	CDC&P
		Provision of HIV/AID, Syphilis, malaria, Hep B, etc Prevention Services	CDC&P
	Strategic Intervention 3.1.1.2.3: Access to quality prevention of TB and leprosy services improved.	Develop/evaluate and disseminate TB& Leprosy Control and prevention strategy	CDC&P
		Support to LGs & NGOs for TB, Malaria & HIV prevention & promotion Interventions	CDC&P

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
		Implement TB & Leprosy differentiated service delivery models incl. community support mechanisms, Training of health workers, community outreach & peer support groups in 250 DTUs	CDC&P
		Establish active surveillance system for Leprosy in 50 districts in (West Nile, Tooro, Busoga, North Buganda & Bunyoro sub regions)	CDC&P
		Develop, Disseminate and Evaluate TB & Leprosy Strategy	CDC&P
		Conduct integrated advocacy, communication, awareness, and social mobilization activities for TB and leprosy services in 80% (116) of the districts	CDC&P
	Strategic Intervention 3.1.1.2.4: Access to quality Hepatitis prevention services improved for elimination.	Scale up Hepatitis B testing services for the priority populations	CS
		Disseminate the National Viral Hepatitis Strategic Plan	CS
	Strategic Output 3.1.1.2.6: Public health emergencies prevented and/or detected.	Development of legislation, policies, strategies and guidelines in line with National Action Plan for Health Security (NAPHS)	IES&PHE
		Strengthen Routine implementation of Integrated Disease Surveillance & Response	IES&PHE
		Prepare, respond to and control Public Health Emergencies	IES&PHE
		Establish and functionalise Port Health services at the points of entry	IES&PHE
		Antimicrobial resistance monitoring system operationalised	IES&PHE
		Risk communication and community engagement on public health emergencies	HPE&C
		Conduct Risk assessments	IES&PHE
		National integrated sample transportation network operationalized	NPHLD
		Public Health laboratory services provided (CPHL)	NPHLD
Strategic Intervention 3.1.1.3: Prevent and control non-communicable diseases with specific	Strategic intervention 3.1.1.3.1: Centres of excellence in provision of oncology, cardiovascular and trauma services at both	Support supervision for Cancer & heart prevention services provided at all levels	NCD
		Roll out of community based mental health services	NCD

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
focus on cancer, cardiovascular, genetic, renal, endocrine, mental, trauma and malnutrition across all age groups.	National and Regional Levels and foster regional integration established.		
	Strategic Output 3.1.1.3.2: Strengthen multi-sectoral & health sector capacity in NCDs & injury prevention and control.	Develop workplace policies for NCD prevention and control	NCD
		Review & disseminate the National NCD prevention and control strategy	NCD
		Training of health workers in management of NCDs & injuries including medical emergencies	NCD
		Conduct NCD Indicator Surveys	NCD
		Community sensitization and awareness creation on prevention of NCDs & injuries	NCD
		Review and roll out the mental health strategy, substance abuse management guidelines	NCD
		Establish mental units in GHs and RRHs	NCD/HID
		Organise National Physical exercise day	NCD
		Support supervision on implementation of policy on institutional physical activity days	NCD
Strategic Intervention 3.1.5.1: Increase access to improved sanitation services in rural and urban areas	Strategic Output 3.1.5.1.1: Public sanitation facilities constructed.	Health inspection, monitoring and supervision of households, public and private facilities in urban and rural areas	EHD
		Support construction of resilient healthcare waste management infrastructure e (incinerators, placenta pits, storage shades, disinfection points, staff house, water source, generator house) constructed	EHD
		Support construction of inclusive and resilient sanitation infrastructure	EHD
		Procure and distribute equipment and supplies for healthcare waste, sanitation and hygiene	EHD
		Support Vector and vermin control interventions in communities and institutions	EHD
		Conduct monthly national cleaning days	EHD
Strategic Intervention 3.1.6.1: Increase	Strategic Output 3.1.6.1.1: Awareness	Conduct training and capacity building for improved WASH, healthcare waste management, climate change, vector & vermin control, and NTDs	EHD

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
access to hygiene facilities	creation campaigns on handwashing conducted.	Conduct public awareness campaigns on environmental health interventions across the country	EHD
		Roll out and implement the National Climate Change and Health Adaptation Plan.	EHD
		Conduct NTD prevention interventions in high endemic districts	EHD
		Develop & disseminate policies, regulations, strategies and guidelines/SOPs for environmental health	EHD
MoH Objective 2: To strengthen the health system and its functionality towards universal health coverage			
Strategic Intervention 3.1.2.1: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.	Strategic Output 3.1.2.1.8: Health service and service delivery standards developed, implemented and monitored.	Conduct client satisfaction surveys	SCAPP
		Scale up the use of self-regulatory quality improvement system (SQIS) in the private sector	SCAPP
		Develop/review and disseminate the service standards, guidelines, manuals, SOPs	SCAPP
		Strengthen the National, Regional & LG Supervisory mechanism	SCAPP
		Conduct harmonized health facility assessment (HHFA)	SCAPP
		Scale up implementation of the integrated Care system	SCAPP
	Strategic Output 3.1.2.1.11: Client charter and ethical code of conduct adhered to by health workers.	Develop & disseminate Client Charters	SCAPP
		Training of health workers in Human rights-based approach, client charter and ethical conduct.	SCAPP
		Roll out the performance management system for health workers under HCMS	SCAPP
	Strategic Output 3.1.2.1.12: Regulation and quality of Health Professionals Practise and Health Products strengthened.	Operationalise the Uganda Health Professionals Regulatory Council Act	CS
		Supervision of health professional councils	SCAPP
		Develop & disseminate the Traditional & Complementary Medicine Practitioners regulations	PNM
		Support the Dissemination of the National Drug and Health Products Act & Regulations	PNM
		Training TCMPs in quality and safety of products	PNM
		Rehabilitate /expand and equip National Referral Hospitals	HID
		Rehabilitate /expand and equip Regional Referral Hospitals	HID

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
	Strategic Output 3.1.2.1.3: Health Infrastructure improved.	Rehabilitate /expand and equip Community Hospitals (HC IVs)	HID
		Establish mental units in GHs and RRHs	HID/ NCD
		Establish emergence care units at hospitals and HCIVs	CS
		Operationalize NICUs at 55 GHs	HID
		Construct 4 regional blood banks and 1 national biosafety Laboratory	HID
		Transitional development funding (Health facility upgrades)	HID
		Establish community hospitals in constituencies without	HID
		Completion & Functionalization of unfinished structures at RRHs	HID
		Establish specialized hospitals (Katakwi & Lwengo)	HID
		Rehabilitation, Expansion and Equipping of Bugiri GH	HID
		Provide clean energy (solar) to health facilities	HID
		Repair and servicing of medical equipment	HID
		Service oxygen plants at Regional and National Referral hospitals	HID/CS
		Establish and retool Regional Equipment Maintenance workshops	HID
		Diagnostic & imaging equipment procured and installed	HID/NPHLD
		Radiology and diagnostic imaging equipment serviced and maintained	HID
Strategic Intervention 9.1.1.1: Develop and review policies and regulations related to HCD	Strategic Output 9.1.1.1.1: Policies for HCD reviewed and developed.	Develop and review laws, policies, strategies, guidelines and regulations for Health	F&A
Strategic Intervention 9.1.1.2: Capacitate institutions to deliver Human Capital Development Programme	Strategic Output 9.1.1.2.1: Improved Institutional capacity for HCD.	Pay staff salaries - MoH	F&A
		Pay Pension and gratuity	F&A
		Provide Human Resource Management Services	F&A
		Provide institutional, performance and human resource development services	IC&HRD, F&A
		Facilitate and supervise SHO and medical interns	CS
		Conduct monitoring and support supervision under Health	F&A
		Carry out project implementation monitoring	F&A

Result		Actions	Responsible Department
NDP IV Strategic Intervention	NDP IV Strategic Output		
		Map, establish and maintain a database	HSP&MSC
		Strengthening Private Health Service delivery through Public Private Partnerships for Health	HSP&MSC
		Support the scale-up of Private Healthcare facilities reporting into DHIS2	HSP&MSC
		Organise and attend national, regional and international meetings, consultative meetings and partner coordination	HSP&MSC
		Provide contributions to national, regional and international institutions (ILO, OPCW, ARLAC, WHO, GFTAM, ECSA, GAVI, UNFPA, APEPH)	HSP&MSC
		Disseminate Regional and international declarations, protocols and Memorandum of Cooperation	HSP&MSC
		Enhancing the coordination of the Health Development Partners and streamline off-budget tracking	HSP&MSC
		Coordinate and integrate Refugee Health programs into the GoU system (HSIRRP)	HSP&MSC
		Support transitioning of Health facilities in Refugee hosting districts into the GoU system.	HSP&MSC
		Strengthening healthcare-related service delivery by MDAs	HSP&MSC
		Support the development and implementation of MOUs between MOH and strategic partners	HSP&MSC
		Strengthening health service delivery by non-state actors such as NGOs and Faith-based organizations	HSP&MSC
		Organise monthly SMC meetings	SCAPP
		Organise monthly TMC meetings	F&A
		Organise monthly HPAC meetings	F&A
		Organise monthly TWG meetings	All Depts
		Provide support to MOH Subventions (JCRC, NCRI)	F&A
		Undertake planning, budget preparation and reporting (prepare BFP and MPS)	F&A / HISM&E
		Prepare, Print & Disseminate Health Sector Budgeting and Implementation Grant Guidelines	F&A / HISM&E

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
		Carry out Budgeting support supervision to LGs, RRHs & Health Insitutions	F&A / HISM&E
		Prepare, Print & Disseminate Ministry of Health Budget Execution guidelines	F&A
		Support/Prepare Ministry of Health Projects for implementation as per PIM Policy	F&A
		Equip, Upgrade and strengthen ICT system for MoH	F&A
		Preparing audited reports for Ministry of Health	F&A
		Carrying out communication and publicity (advertising and publications) for Health	F&A
		Conduct Health Policy research	F&A
		Prepare Policy briefs and position papers on topical sectoral public policy issues	F&A
		Prepare procurement plans for Health	F&A
		Pay overhead costs (rent, water, electricity, telecommunications, internet, cleaning services,) for Health	F&A
		Fleet and asset management for Health	F&A
		Project 3: Retooling of the MoH and its Institutions (ICT equipment, furniture, rehabilitation, stationery, etc)	F&A
Strategic Intervention 3.1.2.1: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.	Strategic Output 3.1.2.1.1: Adequate and well trained human resources for health at all levels in place.	Develop the HRH Development Plan 2025/26 to 2029/30 & review its implementation	IC&HRD
		Award scholarships / sponsor for training Super Specialists	IC&HRD
		Conduct Staff training and capacity building for Health	IC&HRD
		Develop and maintain a training data base	IC&HRD
		Continuous professional development and capacity building for in-service health workers undertaken	IC&HRD
		Develop an annual Capacity building plans for sector	IC&HRD
		Institutional capacity assessment for the health sector conducted	IC&HRD
Strategic Intervention 3.1.7.1: Increase financial risk	Strategic Output 3.1.7.1.1: Financial risk protection for health increased.	Community Health Insurance Guidelines disseminated	F&A, HIS&ME
		Develop, Review & Disseminate the Health Financing Strategy 2025-2035	F&A, HIS&ME
		Conduct National Health Accounts survey & findings disseminated	F&A, HIS&ME

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
protection for health with emphasis on implementing the national health insurance scheme and scaling up health cooperatives		Framework for costing health service delivery developed	F&A, HIS&ME
		Health Insurance Scheme regulations developed & disseminated	F&A, HIS&ME
		Capacity building for health insurance providers	F&A, HIS&ME
		National Health Insurance Scheme established and rolled out	F&A, HIS&ME
	Strategic Output 3.1.7.1.2: Financial diversification.	Hospital Private Wing services improved	F&A, HIS&ME
		Dissemination of guidelines for management of Private services in public facilities	F&A, HIS&ME
		Revenue Mobilisation Strategy for health Developed and disseminated	F&A, HIS&ME
		National Health Financing advocacy meetings and dialogues held	F&A, HIS&ME
Vote Objective 3: To enhance the accessibility and utilization of high-quality integrated services for both communicable and non-communicable prevention, control, and response			
Strategic Intervention 3.1.1.2: Reduce the burden of communicable diseases with focus on high burden diseases (Malaria, HIV/AIDS, TB, Neglected Tropical diseases, Hepatitis), epidemic prone diseases across all age groups emphasizing Primary Health Care Approach	Strategic Output 3.1.1.2.1: Access to malaria prevention and treatment services improved.	Regular supply of commodities to avert stock outs; Mentorship, supervision of health facilities and community health workers in malaria management; conduct clinical and mortality audits	CDC&P
	Strategic Output 3.1.1.2.2: Access to HIV/AIDs prevention, control and treatment services improved.	Capacity building for HIV/AIDS and Syphilis coordination and service delivery	CDC&P
		Mentorships and supervision of health facilities and Community Resource Persons	
		Provision of medical supplies for TB, Malaria and HIV	CDC&P
		Conduct UPHIA & other studies	
	Strategic Output 3.1.1.2.3: Access to prevention, treatment and control of TB and leprosy services improved.	Provision of TB/Leprosy care and treatment services	CDC&P
		Tuberculosis and Leprosy Cast Active case finding (community level)	CDC&P
		Training and mentorship of Health workers in Active TB/Leprosy Case Finding and management	CDC&P
		Scale up TB case finding and facility and community level using the standard of care approaches; ACF, and Digital Technologies, Portable X-rays, CAD4TB software, and mobile TB clinics across all the districts/ 2040 DTUs: (13.5M & 2.75M at Facility & Community Screening, yielding over 192,000 TB patients	CDC&P

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
		Undertake contact investigation and management for TB patients including TPT initiation among eligible individuals: 50,000 contacts annually are targeted for investigation & Management	CDC&P
		Expand and Equip Diagnostic and Treatment Units (DTUs) in 200 facilities (40 annually) including increasing access to mWRDs	CDC&P
		Implement the TSR improvement care package across all DTUs	CDC&P
		Scale-Up Digital Adherence Technologies (DATs) to 50% of DTUs	CDC&P
		Scale up electronic case-based surveillance system (eCBSS) in Health Facilities from 75% (1530) to 100% (2040) Diagnostic and Treatment Units (DTUs); 510 HFs targeted	CDC&P
		Conduct TB Burden estimation (Incidence/Prevalence): Based on Uganda's 2014 TB prevalence survey and updated WHO protocols for burden estimation	CDC&P
		Undertake Contact Investigation & management for Leprosy including initiation on Leprosy Preventive Treatment among eligible individuals	CDC&P
	Strategic Output 3.1.1.2.4: Access to NTDs Services improved.	Mass Drug Administration for NTDs	EHD
		Orientation and mentorship of health workers on NTD management	EHD
		Review & update the Uganda Neglected Tropical Diseases Master Plan 2023-2027	EHD
	Strategic Output 3.1.1.2.5: Hepatitis Prevention and control strategy implemented.	Strengthen capacity of health facilities to provide holistic care and treatment for people with viral hepatitis	CS
		Review the training curriculum for the CHEWs to cover viral Hepatitis, oral health prevention	CS, HPEC
Strategic Intervention 3.1.1.7: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative	Strategic Output 3.1.2.1.11: Improve patient-centred and integrated service delivery model.	Develop and disseminate the integrated health services delivery framework	CS
		Train health workers on implementation of integrated service delivery models	CS

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
and palliative healthcare services.			
Strategic Intervention 3.1.1.3: Prevent and control non-communicable diseases with specific focus on cancer, cardiovascular, genetic, renal, endocrine, mental, trauma and malnutrition across all age groups.	Strategic Output 3.1.1.3.1: Centres of excellence in provision of oncology, cardiovascular and trauma services at both National and Regional Levels and foster regional integration established.	Orientation of Health Workers in Community based Mental health rehabilitation	NCD
		Conduct National Mental Health Survey	NCD
		Support supervision on oncology and cardiovascular interventions	NCD
		Orientation of Health Workers in Community based Mental health rehabilitation	NCD
Strategic Intervention 3.1.1.6: Improve curative, palliative, rehabilitative and geriatric care services	Strategic Output 3.1.1.6.1: Quality curative, palliative, rehabilitative and geriatric care services provided.	Develop/review and disseminate curative, palliative, geriatric care, Fistula Care, Ophthalmology, Critical and Operative Care Services, IPC guidelines, SOPs	CS
		Support supervision for Curative, palliative, rehabilitative and geriatric care service provided (Primary, secondary & tertiary care) in health facilities	CS
		Strengthen infection prevention and control practices	CS
		Medical Board facilitated	CS
		Provide support to Entebbe Paediatric Hospital	CS
		Technical supervision and clinical mentorship of health workers	CS
		Operationalize Organ Donation and Transplant services	CS
		Support establishment of Oral Health Care services at health facilities	CS
		Establish palliative care services at all hospitals and HCIVs	CS
	Strategic Output 3.1.1.6.3: Medical Laboratory and	Diagnostic & imaging equipment procured and installed (X-ray & ultrasound at HCIV)	HID/ NHLDS

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
	diagnostic imaging services strengthened	Diagnostic & imaging equipment procured and installed (2CT at RRH, 10CT at GH) 3MRI at RRH	NHLDS
		National integrated sample transportation network operationalized	NHLDS
		Public Health laboratory services provided (CPHL)	NHLDS
		Accredited medical laboratories transitioned to the new ISO151892022	NHLDS
		Mentorships and audits of hospital laboratories	NHLDS
		Essential diagnostics list developed & disseminated	NHLDS
		Radiology and diagnostic imaging standards and guidelines reviewed / developed	NHLDS
		Expand infrastructure and Technologies at CPHL for provision of Integrated and Advanced Laboratory Services for Public Health Response, Specialized Clinical Care and Research	HID/NHLDS
		Procure 13 major pieces of equipment to functionalize the specialized Laboratories at CPHL	HID/NHLDS
		Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)	HID/ NHLDS
		Procure 8 pieces of Laboratory equipment for each of the Regional Six Regional Referral Hospitals with improved infrastructure	HID/ NHLDS
		Improve capacity for RRHs and GHs for bacterial culture and drug susceptibility testing	NHLDS
		Formulate and publish Health Region – specific antibiograms to guide antibiotic use	NHLDS
		Deploy Mobile Laboratories and X-rays in each of the four (4) tadeonal Regions to support disease outbreak investigations in the regions	NHLDS
		Perform disease outbreak simulation exercises in the regions at least once a quarter	NHLDS
		Implement Quality Management Systems for improved quality and accreditation of Laboratories and Imaging Services	NHLDS

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
		Expand the scope for local panel production of internationally accredited External Quality Assessment (EQA) schemes	NHLDS
		Increase the scope for equipment Calibration Centre to support equipment calibration and maintenance in the country	NHLDS
		Implement Biosafety and Biosecurity practices in all Laboratory and Imaging facilities	NHLDS
		Integrate Laboratory information management system with the electronic medical records in all the health facilities where they exist (e-afya, EMR, Clinic Master, etc)	NHLDS
		Consolidate Laboratory & Diagnostic for real time transmission into the national database	NHLDS
		Functionalize teleradiology services at all regional referral hospital and GH (internet and renumeration)	NHLDS
	Strategic Output 3.1.1.6.4: Nursing and midwifery practice strengthened.	Technical supervision and mentorship of nurses and midwives	N&M
		Standards and guidelines for nursing and midwifery practice developed	N&M
Strategic Intervention 3.1.2.1: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.	Strategic Output 3.1.2.1.4: Emergency Medical Services and the referral system improved.	Procure ambulances (15 per year)	EMS
		Construct and equip Regional Call and Dispatch Centers (5)	HID/ EMS
		Operation and maintenance of ambulances	EMS
		Procure ambulances (incl. aero medical ambulance, Type B ambulances & Equipment) under the EMS Acceleration Project	EMS
		Provide support to URCS	EMS
		Develop standards and guidelines for EMS & referral	EMS
		Training of EMS critical cadre (EMS Physicians, nurses, paramedics, aviation/marine, drivers)	EMS
	Strategic Output: 3.1.2.1.5: Expand geographical access of Health services.	Establish/upgrade new Community Hospitals (13)	HID/ CS
		Establish/upgrade new Health Centre IIIs (50)	HID/ CS
		National Paediatric Hospital constructed	HID/ CS

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
		Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)	HID/ NPHLD
		Regional anatomic pathology laboratories constructed and equipped (16)	HID/ NPHLD
		Construct and equip general hospitals in Kampala Metropolitan Area (2)	HID/ CS
		Upgrade General Hospitals to RRHs (2 GHs)	HID/ CS
	Strategic Output 3.1.2.1.6: Increase availability of affordable medicines, laboratory reagents and health supplies including promoting local production of medicines (including complementary medicine).	Procure and distribute EMHS to PNFPs through JMS	PNM
		Conduct regular facility assessment for medicines and health supplies management (SPARS)	PNM
		Capacity building for medicines management (Prescription, AMR, surveillance)	PNM
		Operation and maintenance of Regional Incinerators - (Proper management and disposal of pharmaceutical and medical waste)	PNM
	Strategic Output 3.1.2.1.7: Increase availability of safe blood and blood products.	Construct and equip five regional blood banks	CS, HID
Vote Objective 4: To promote optimal maternal, neonatal, infant, child, adolescent and older persons' health including increased access to improved health services and assistive technologies at all levels			
Strategic Intervention 1.2.1.2: Promote optimal Maternal, Infant, Young child, Adolescent and Elderly Nutrition Practices	Strategic Output 1.2.1.2.4: Dietary diversification promoted.	Train Health workers on maternal, infant, young child, adolescent and elderly nutrition package	CHD
		Orient Health Workers in micronutrient supplementation	CHD
		Nutrition health facility assessments conducted	CHD
		Scale up malnutrition rehabilitation services at all levels of service delivery	CHD
		Conduct Indicator survey on nutrition biomarkers	CHD
	Strategic Output 1.2.1.2.1: Enabling environment for	Scale up nutrition intervention across the country	CHD
		Accredit health facilities as mother-baby friendly	RCH
		Review the food fortification strategy	CHD

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
	scaling up nutrition at all levels strengthened.	Develop Nutrition regulations, guidelines and SOPs.	CHD
		Develop and implement a cost-effective school feeding programme linked to PDM and the local economy	CHD
Strategic Intervention 3.1.1.4: Improve maternal, neonatal, child and adolescent health services at all levels of care	Strategic Output 3.1.1.4.1: Maternal and child health services at all levels of care increased.	Revise & disseminate the RMNCAH sharpened plan, Family Planning Costed Implementation Plan & Guidelines	RCH
		Train and mentor staff at Community Hospitals to provide quality CEmONC services	RCH
		Conduct Maternal deaths surveillance	RCH
		Roll out Emergency Triage Assessment and Treatment (ETAT) in 10 regions	RCH
		Functionalise the Regional RMNCAH accountability and coordination structures	
		Supervision and mentorship of health workers for delivery of quality maternal & child health services	RCH
		Support provision of FP commodities	RCH
	Strategic Output 3.1.1.4.2: Appropriate neonatal care services at all levels enhanced.	Train and mentor health workers on provision of quality child survivor and thrival packages	RCH
	Strategic Output 3.1.1.4.2: Appropriate neonatal care services at all levels enhanced.	Develop guidelines and SOPs for neonatal care	RCH
		Perinatal death surveillance and review	RCH
		Construct and equip Neonatal intensive care units in RRHs	RCH/HID
		Construct and equip Level II newborn care units in General Hospitals	HID
Strategic intervention 3.1.1.5: Increase access to Sexual and Reproductive Health (SRH) information and services	Strategic Output 3.1.1.5.1: Increased demand and uptake of reproductive health services.	Support supervision on Sexual and Reproductive Health (SRH) information and services	RH
Strategic Intervention 3.1.7.3: Promote		Construct & equip regional assistive devices technology workshops	CHD
		Set up of rehabilitation units in 16 district hospitals	CHD

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
delivery of disability friendly health services including physical accessibility and appropriate equipment	Strategic Output 3.1.7.3.1: Disability health friendly services improved.	Procurement and distribution of disability inclusive medical equipment, devices and raw materials	CHD
		Procure and distribute assistive devices	CHD
		Procure and distribute delivery beds for PWDs	CHD
		Conduct awareness campaigns on disability prevention and rehabilitation services	CHD
		Specialist training of rehabilitation health professionals	CHD
		Access remodelling of available infrastructure to improve access for PWDs	CHD/HID
		Train/orient Health Workers on the basic rehabilitation service package	CHD
Vote Objective 5: To strengthen health research, innovation, technology, and information uptake in healthcare, complementary medicines, and emerging health threats			
Strategic Output 3.1.2.5: Increase availability of affordable medicines and health supplies including promoting local production of medicines (including complementary medicine)	Strategic Output 3.1.2.8: Promote digitalization of the health information system.	Expand and maintain the rollout of Electronic Medical Record Systems at GHs	HISM&E
		Expand and maintain the rollout of Electronic Medical Record Systems at HCIV	HISM&E
		Expand and maintain the rollout of Electronic Medical Record Systems at HCIII	HISM&E
		Expand and maintain the rollout of Electronic Community Health Systems at facility level	HISM&E
		Development of online self-paced learning platforms	HISM&E
		Capacity building for health workers in utilization of the Electronic Medical Record Systems	HISM&E
		Capacity building for community health workers on eCHIS	HISM&E
		Capacity building of health workers in telemedicine application	HISM&E
		Review & disseminate the Health Information and Digital Health Strategy, guidelines & SOPs	HISM&E
		Print and Distribute HMIS tools for non-digitized health facilities	HISM&E
		Undertake data cleaning, verification, supervision and mentorship	HISM&E
		Undertake data quality assessment and audits	HISM&E
	Strategic Output 3.1.2.1.10: Health facilities	Update health facilities geospatial attribute data framework and facilities databases	HISM&E
		Develop integrated health facilities geodatabases	HISM&E

Result		Actions	Responsible Department
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
	geodatabases developed and updated.	Conduct capacity building trainings on geodatabase management	HISM&E
Strategic Intervention 3.1.7.2: Promote health research, innovation and technology uptake including improvement of traditional medicines.	Strategic Output 3.1.7.2.1: Health research institutions strengthened.	Develop, review and disseminate the National Health Research Strategy and Health Technology Assessment Strategy	HISM&E
		Develop and disseminate traditional medicines list	HISM&E
		Develop the Health Research Agenda	HISM&E
		Develop the framework and guidelines for evidence-based priority setting and policy making for the health sector	HISM&E
		Conduct Health economic evaluations for evidence-based priority setting	HISM&E
		Organise annual National Health Research conference	HISM&E
	Strategic Output 3.1.7.2.2: Health innovations and technology uptake promoted.	Health innovations fund for middle career researchers	HISM&E
		Organise annual National Health Innovations conference	HISM&E
		Health Innovations Strategy developed/reviewed & disseminated	HISM&E
		Develop the framework for Health Technology Assessments	HISM&E
		Conduct Health Technology Assessments	HISM&E
		Develop evidence-based policy briefs on health innovations, programs and interventions	HISM&E
Strategic intervention 3.1.7.4: Strengthen population planning and development along the life cycle approach including civil registration, vital statistics and national population data bank	Strategic Output 3.1.7.4.1: Birth and death registration scale up.	Conduct health facility all-cause mortality audits	CS
		Deploy Medical Certification of cause of death for all health facility deaths	HISM&E
		Modification of EMR to Integrate MCCD form in all health facilities	HISM&E
Strategic Intervention 9.1.1.3: Undertake monitoring, and	Strategic Output 9.1.1.3.1: Monitoring, evaluation,	Produce statistical abstracts	HISM&E
		Compile and submit MOH performance reports	HISM&E
		Produce project monitoring and evaluation reports	HISM&E
Result		**Actions**	**Responsible Department**
NDP IV Strategic Intervention	**NDP IV Strategic Output**		
reporting of progress for HCD Programme during plan implementation	Coordination and reporting for HCD strengthened.	Organise and hold annual joint reviews at national and subnational level under Health	HISM&E
		Organise and hold quarterly review meetings at national and subnational level under Health	HISM&E
		Prepare & disseminate M&E Plan for MOH Strategic Plan	HISM&E
		Undertake MOH SP Mid-term and End-term evaluations	HISM&E
Strategic Intervention 3.1.2.1: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.	Strategic Output 3.1.2.1.1: Adequate and well-trained human resources for health at all levels in place.	Rollout performance management tools to all health workers (Dashboards, digital timesheets, HCMS)	HISM&E

3.7 KEY PRIORITY PROJECTS

The following projects have been identified for implementation in the next 5 years of the MoH SP period:

Table 17: MoH Projects for 2025 – 2030

#	Project Name	Code	Status	Project Cost (Ugx Bns)
1.	Rehabilitation and Construction of General Hospitals	1243	Implementation	358.76
2.	Emergency Medical Services Acceleration Project		Feasibility	77.83
3.	Uganda Health Services Transformation Project		Pre-feasibility	1,124.77
4.	Rehabilitation, Expansion and Equipping of Katakwi and Lwengo Specialized Hospitals		Concept	1,506.35
5.	Rehabilitation, Expansion and Equipping of Bugiri General Hospital		Pre-feasibility	81.76
6.	Expansion and Rehabilitation of Selected Regional Referral Hospitals		Concept	1015.45
7.	Establishment of Hospitals in Wakiso and Rubaga		Concept	588.59
8.	Establishment, Expansion, and Rehabilitation of HC IVs for Upgrade to Community Hospitals in Uganda		Concept	1,150.41
9.	Completion and Functionalization of Unfinished Structures in Regional Referral Hospitals		Concept	70.01
10.	Hospital Outcome Quality and Client Engagement Improvement Project		Concept	116.39
11.	Health Subprogram Disability Inclusion Project		Concept	113.28
12.	Global Fund for HIV/AIDS, TB and Malaria	0220	Implementation	3,809.08
13.	Global Alliance for Vaccines (GAVI)	1436	Implementation	1,221.69
14.	Italian Support to Karamoja Infrastructure Development Project - KIDP (Phase II)	1539	Implementation	44.98
15.	Digitization of Health Information in Uganda Health Sector		Feasibility	135.38
16.	Establishment of National Medical Equipment Service Centre		Concept	366.0

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#	Project Name	Code	Status	Project Cost (Ugx Bns)
17.	Construction of Regional medical Laboratories (Jinja, Gulu, Kabale, Hoima, Masaka & Soroti)		Concept	95.44
18.	Establishment of Standalone health data centre (Bank)		Concept	5.4
19.	Construction and Equipping of a Regional Blood bank in Jinja (KOICA)		Concept	10.0
20.	Rehabilitation and Construction of General Hospitals		Profile	1,530.0

4 FINANCING FRAMEWORK AND STRATEGY

This section presents the financing framework of the plan. It provides the overall and disaggregated costs of the plan and the strategies for mobilizing the required financing.

The financing cost was estimated based on the budgetary allocations in the budget framework papers of the MoH for the past 5 years and annual projections of 6% annual increments in budgetary allocations in the medium term at an ideal scenario. The external financing to support the strategic plan was based the donor numbers from MoFPED. The cost estimates assume risks of external shocks and government budgetary allocations, and these shall be mitigated by prudent macroeconomic policies and heavy institutional investment in good governance and compliancy to financing agreements.

The table below indicates the requirements for effectively and efficiently implementing the strategic plan interventions in the next 5 years.

4.1 SUMMARY OF THE STRATEGIC PLAN BUDGET

The total funding requirements for the 5 years is **Ugx. 16,938.99 billion.** The projected available budget is Ugx. 11,129.16 billion from both the MTEF (both domestic and donor/external funding) and off-budget sources translating into a shortfall of **Ugx. 5,809.87 billion**. The detailed breakdown for the budget required to finance the strategic plan is provided in the table below:

Table 18: Summary of the Strategic Plan Budget

Vote Strategic Objectives (Ugx Billions)	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**Total**	**% Share**
Strategic Objective No. 1	736.19	756.86	564.63	581.83	795.18	3,434.69	**20%**
Strategic Objective No. 2	660.80	649.13	2,264.48	1,601.41	1,373.48	6,549.30	**39%**
Strategic Objective No. 3	923.62	1,627.87	1,212.18	1,433.80	1,141.72	6,339.18	**37%**
Strategic Objective No. 4	62.10	61.49	62.14	59.10	54.17	299.01	**2%**
Strategic Objective No. 5	44.39	53.02	62.66	73.42	83.33	316.81	**2%**
Total Budget	**2,427.09**	**3,148.37**	**4,166.09**	**3,749.56**	**3,447.88**	**16,938.99**	**100%**

The major cost drivers over the strategic planning period are capital investments especially construction, rehabilitation and equipping of health facilities, health promotion and disease prevention, wage, and diagnostic services.

4.1.1 Source of Funding

The main sources of revenue for financing the strategic plan are highlighted in the Table below:

Table 19: Strategic Plan Budget by Source of Funding

Classification (Ugx Billions)	2025/26	2026/27	2027/28	2028/29	2029/30	Total
Wage	22.69	24.05	25.49	27.02	28.64	**127.90**
Non-Wage Recurrent	131.67	139.57	147.95	156.82	166.23	**742.25**
Total Recurrent	*154.36*	*163.62*	*173.44*	*183.85*	*194.88*	*870.15*
Domestic Development	148.18	157.07	166.49	176.48	187.07	835.29
External Financing	1,261.60	1,337.29	1,417.53	1,502.58	1,592.74	7,111.74
Total Development Budget	*1,409.78*	*1,494.36*	*1,584.02*	*1,679.06*	*1,779.81*	*7,947.03*
Total MTEF	**1,564.14**	**1,657.98**	**1,757.46**	**1,862.90**	**1,974.68**	**8,817.16**
Off-Budget Projections	**574.80**	**517.32**	**465.59**	**419.03**	**335.22**	**2,311.96**
Funding Gaps	**288.15**	**973.07**	**1,943.04**	**1,467.63**	**1,137.98**	**5,809.87**
Total Budget	**2,427.09**	**3,148.37**	**4,166.09**	**3,749.56**	**3,447.88**	**16,938.99**

4.2 RESOURCE MOBILIZATION STRATEGY

This section gives the appropriate strategies to mobilize additional resources to fill the financial gaps. Government budgetary allocation to the health sector has been on average about 7% of the national budget over the last strategic period. While the health development partners contribute significantly to the health sector, the overall resource envelope for the health sector is still inadequate to finance the delivery of the Uganda essential health care package for Uganda.

During the implementation of this plan, the MoH will work with MoFPED with support from HDPs, mobilise additional resources for implementation of this Plan. Priority will also be given to the broadening of the resource base for funding the health sector through innovative health financing mechanisms such as health taxes, debt for health swaps, and other nontraditional sources including implementation of the NHIS. The MoH shall also focus on capacity building of both finance and non-finance managers to ensure efficiency, effectiveness and transparency in the management of public finances at various levels (more health for the money).

For sustainability purposes, the sector will focus on increasing its fiscal space through strengthened domestic resource mobilization. The latest Fiscal Space analysis for Uganda shows that by the fiscal year 2029/30, Uganda could generate an additional US$1,626 million annually, equivalent to US$29.1 per capita per year. This can be generated from two sources: reprioritization of health in the national government budget enabled by sustainment economic growth, and from health sector-specific domestic resources. The additional US$29.1 per capita would increase domestic general government health expenditure (GGHE-D) per capita from US$10 in fiscal year 2021/22 to US$39.1 per year by fiscal year 2029/30. Assuming Development Assistance for Health (DAH) remains the same, the additional funds could increase

Uganda's total current health expenditure (CHE) per capita from US$44 in fiscal year 2021/22 to US$73.1 annually by fiscal year 2029/30. The estimated US$73.1 CHE per capita would be larger than the required US$58 per capita (moderate scenario) as stipulated in Uganda's National Essential Health Care Package but still lower than the target of US$106 per capita (optimistic scenario) for the fiscal years 2025/26-2029/30.

The potential approaches to increasing funding for health shall include:

1) Advocacy for increased government budget allocations including both domestic and external financing mechanisms.
2) Introduction of innovative health financing mechanisms such as earmarking of sin taxes on tobacco, alcohol and sugar-sweetened beverages, third-party insurance collections ring-fenced for health, promoting debt-to-health swaps, and health bonds.
3) Implementation of the National Health Insurance Scheme and improving the operations of community and private health insurance schemes.
4) Promotion of medical tourism through development of the centers of excellence in oncology, cardiovascular and virology. This will increase foreign exchange to the country and contribute to the ten-fold growth strategy.
5) Promote cost cutting measures such as service integration, joint planning, joint integrated support supervision and monitoring, use of utility prepaid meters, use of solar energy, and water harvesting techniques.
6) Promoting efficiency measures and increased accountability for use of public resources to minimize wastage. Furthermore, increase absorption of externally funded projects to over 90% by instituting measures to eliminate spending bottlenecks.
7) Strength the PPPH desk through collaboration with private sector entities to leverage private capital, expertise and innovations.
8) Innovative health financing mechanisms - sin taxes, debt for health swaps, strategic purchasing and pooling.
9) Strengthen private wings at RRHs and Specialised Hospitals.
10) Regular resource tracking of off budget financing to the sector to minimize duplications and wastages.
11) Partner with private sector companies and organizations to secure funding.

5 INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTING THE PLAN

The Ministry of Health will directly contribute primarily to the Human Capital Development Program but also has a role play under the following programs.

a) Natural resources, environment, climate change, land and water management.
b) Private Sector Development.
c) Digital Transformation.

The Human Capital Development Program Working Group will oversee the strategic plan's implementation. Under the general policy direction of the Permanent Secretary and the technical leadership of the Minister of Health, the Ministry of Health shall be represented and take part in accordance with the specified Terms of Reference.

The plan's successful execution will depend on a functional MoH structure, rules that are upheld, collaborative planning and budgeting, frequent performance evaluations, and dedication to accomplishing the MoH's goals and objectives. The individual departments will be responsible for implementation of interventions within their respective technical areas.

5.1 GOVERNANCE AND ORGANIZATIONAL STRUCTURE

The key oversight functions of the health sector will be managed through the Minister and the Ministers of State.

The Permanent Secretary provides technical leadership over the health sector and delivery of healthcare services across the country. The Office of the Director General Health Services (DGHS) reports to the PS and coordinates technical functions for healthcare service delivery. The work of the DGHS will be coordinated through the different departments and their respective heads, and other governance structures as appropriate.

The work of the Permanent Secretary will be supported through the following units: Administration, Public Relations, Internal Audit, Finance & Administration, and Procurement. MoH is implementing a sector-wide governance mechanism that promotes agreement on common procedures for consultation, decision-making, and information exchange in collaboration.

The key governance structures at MoH include the Top Management Committee (TMC), the Health Policy Advisory Committee (HPAC), the Senior Management Committee (SMC), Technical Working Groups (TWGs) and Heads of Departments as illustrated in Figure 2. These structures involved participation of multi stakeholders including other health MDAs & LG representatives, health development partners, CSOs, and other health service agencies and implementing partners. Inter-agency coordinating committees were also absorbed in the respective TWGs.

Table 20: Governance and Management Structure Coordination and Linkages

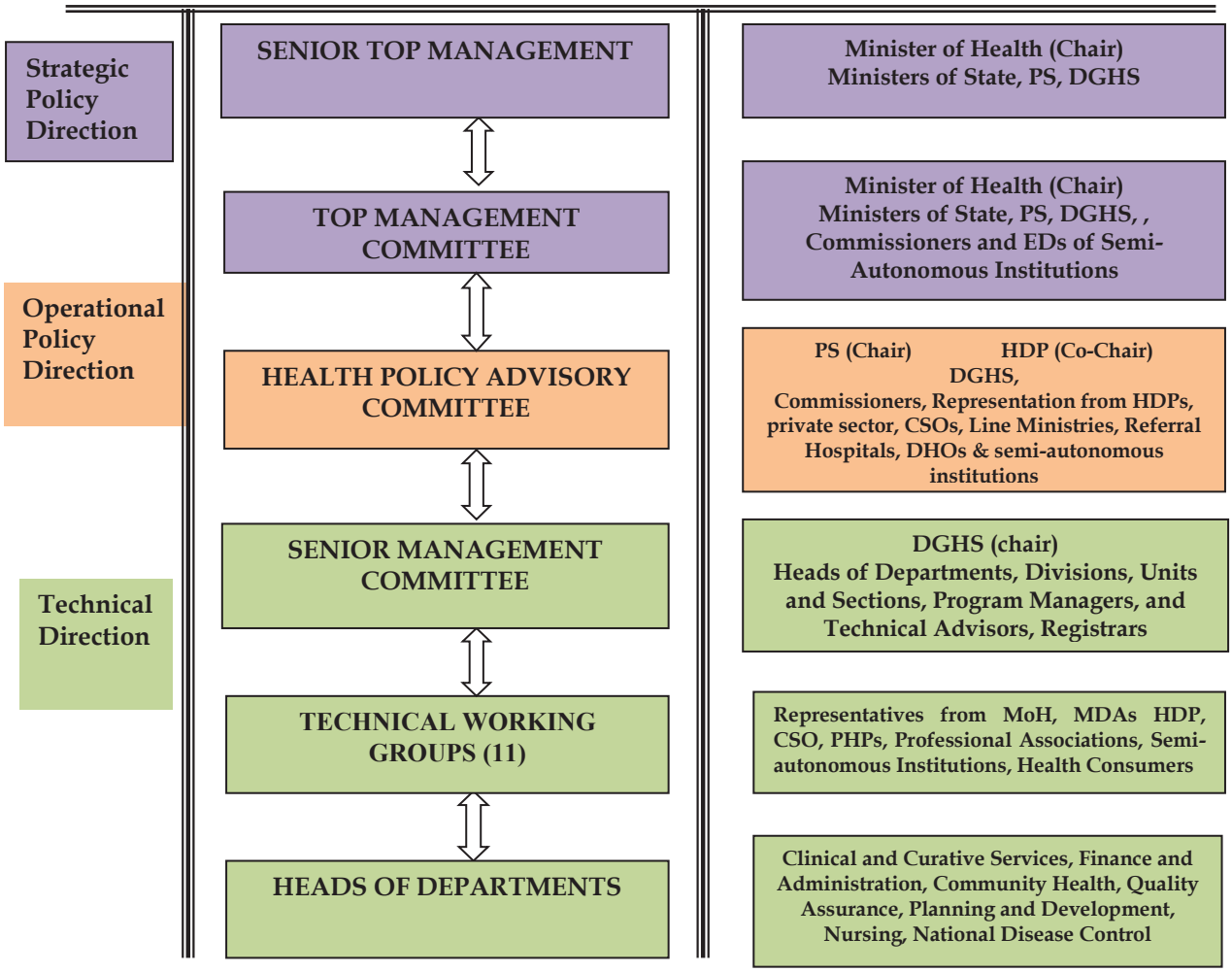
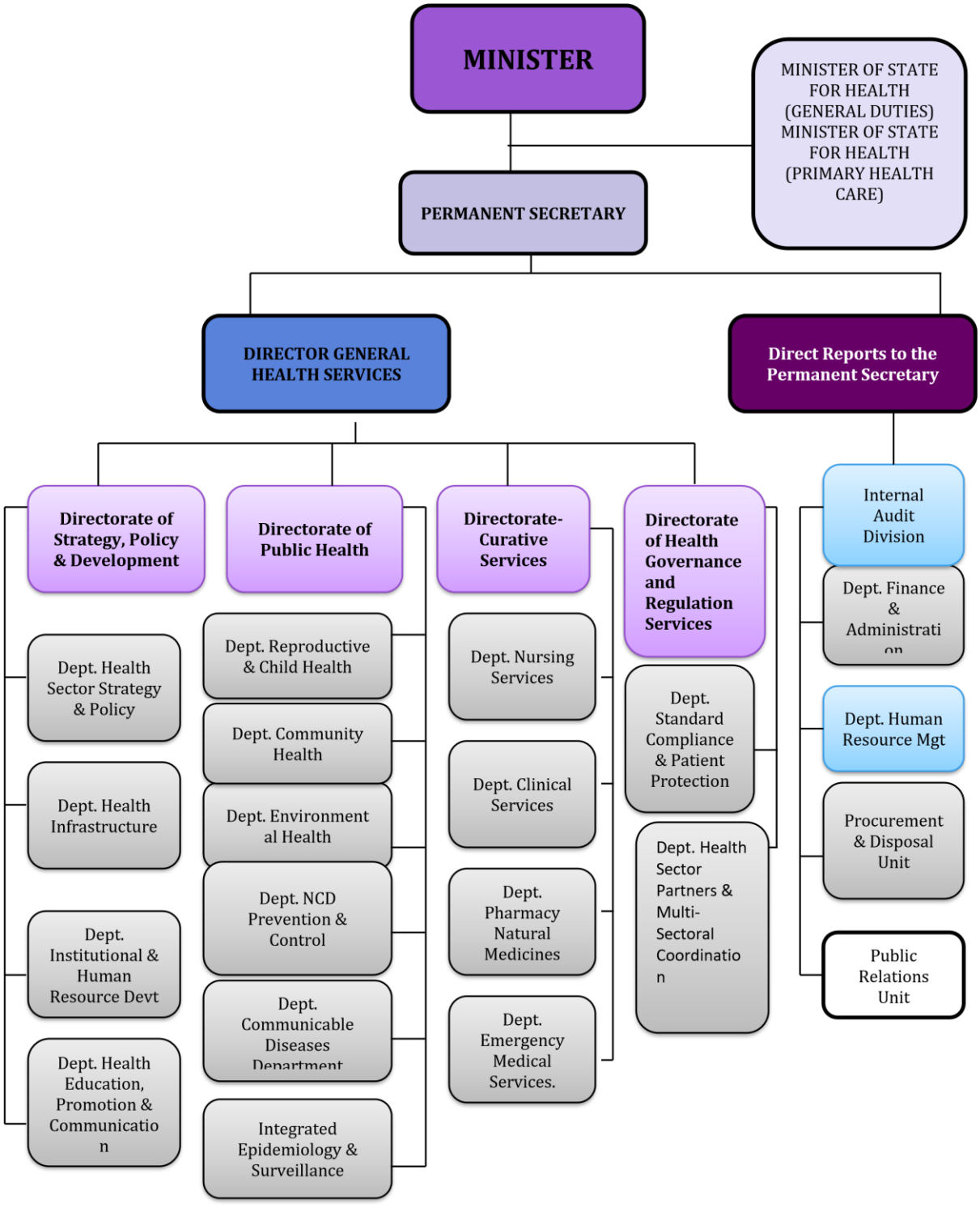


Table 21: Ministry of Health Approved Organisational Structure (May 2023)



1) Top Management Committee

TMC is chaired by the Minister and is responsible for providing policy direction, making decisions, approving proposals, and overseeing the health sector.

2) Health Policy Advisory Committee

HPAC is a monthly platform for discussing health policy and offering advice on the execution of the MoH strategic plan and policies, and any other issues submitted by the Senior Management Committee. HPAC brings together the government, HDPs, CSOs, and other stakeholders. It is chaired by the Permanent Secretary (PS) and co-chaired by the Head of the HDPs.

3) Senior Management Committee

SMC which is chaired by the DGHS provides strategic leadership in overseeing policy development and planning, as well as oversight of technical programs and assuring coordination of the activities and overall functioning of the Ministry. SMC makes intermediate management decisions and prepares position papers for referral to HPAC and TMC.

4) Technical Working Groups and (sub)committees

TWGs are each specialized in a certain technical field and responsible for actual technical coordination in their respective specialist areas. These forums are used to discuss and decide on technical matters, with specific recommendations and actions for implementation. The committees (and/or subcommittees) can be ad hoc or standing. While ad hoc committees are created to handle certain tasks and then disbanded after the assignment is finished, standing committees are always in place. Standing committees primarily relate to health services, while the ad hoc ones focus on different health system challenges.

All the TWGs and committees report through the SMC and reports from these are a standing HPAC agenda. Furthermore, HPAC and MoH Senior Management may task TWGs with specific issues to resolve. Two or more technical stakeholder committees can cooperate to address issues that cut across them. In such instances, they define the modalities of cooperation.

Technical stakeholder committees can collaborate to address specific issues that cross their boundaries, defining the modalities of cooperation. For example, the Global Fund Country Coordinating Mechanism is a crucial mechanism that unites technical stakeholders' committees to address issues related to malaria, TB, and HIV.

The TWGs include:

1) Strategic Planning, Financing and Development
2) Governance, Policy and Regulation
3) Human Resources for Health
4) Public-Private Partnerships in Health
5) Medicines Management and Procurement
6) Health Information, Innovation and Research
7) Clinical Care and Health Infrastructure
8) Nutrition
9) Communicable Diseases and Non-Communicable Diseases
10) Reproductive, Maternal Neonatal, Child and Adolescent Health
11) Community Health
12) Monitoring and Evaluation

5.1.1 Health Development Partner Coordination

a) HDP Group

The HDP Group meets monthly, with the overall purpose of coordinating development partners in Uganda. The group's aim is to strengthen the partnership between GoU and the HDPs to ensure more effective implementation of the national strategic plan and to reduce transaction costs for both agencies and Government. The HDP Group chooses one agency to be their coordinator for each GoU Financial Year (FY). The coordinator chairs the monthly meetings and acts as a contact point between group members and MoH.

b) Inter-Agency Coordination Committees

Inter-Agency Coordinating Committees are for those working disease or program areas to coordinate their activities. At MoH headquarters, the Public Private Partnership for Health (PPPH) Coordination Unit acts as secretariat and the coordinating arm of all resolutions from the PPPH TWG and HPAC that concern the public-private collaboration in health.

5.2 MoH Stakeholders

The MoH has multiple stakeholders to support the achievement of the Strategic plan objectives. These are:

a) Parliament of Uganda
b) The Health Service Commission
c) Health Facilities: National and Regional Referral Hospitals, General Hospitals and LLHFs (Public and Private)

d) Autonomous Institutions - National Medical Stores (NMS), National Drug Authority (NDA), Uganda Cancer Institute (UCI) and Uganda Heart Institute (UHI), Health Professional Councils and Associations.
e) Semi-autonomous institutions - Uganda Blood Transfusion Services (UBTS), Joint Clinical Research Centre (JCRC), Uganda National Health Research Organization (UNHRO), Uganda Virus Research Institute (UVRI) and Natural Chemotherapeutic Research Institute (NCRI).
f) Local Governments (Kampala City Council Authority (KCCA), Districts and Municipalities)
g) Ministries, Departments and Agencies (e.g. OPM, Ministry of Public Service, Ministry of Local Government, Ministry of Education and Sports, Ministry of Gender, Labour and Social Development, Ministry of Water and Environment, Ministry of Works, Uganda Bureau of Statistics, Population Secretariat, Uganda Aids Commission, etc.).
h) Medical Bureaus (Catholic, Protestant, Moslem, Pentecostal)
i) Health Development Partners (Bilateral, multinational or international NGOs)
j) CSOs involved in health
k) The Private Health Practitioners including Traditional Complementary Health Practitioners
l) Health Training Institutions
m) Researchers
n) Cultural Institutions affiliated to Health
o) Service Providers (suppliers, Consultants, Contractors) to the MoH
p) The Public Media
q) Community, Households and individuals

The respective roles and responsibilities are highlighted in the table below.

Table 22:Roles and responsibilities of key stakeholders for the MoH

Constituency	Stakeholders	Roles and Responsibilities
State Actors	Parliament of Uganda (Health Committee)	• Passing policies and laws • Resource allocation • Advocacy for health • Performance monitoring
	Health Service Commission	• Recruitment of staff
	Uganda AIDS Commission	• Stewardship of the HIV/AIDS prevention and Control agenda

Constituency	Stakeholders	Roles and Responsibilities
		• Participation in HIV/AIDS response policy and strategy formulation and review • Participation in health sector planning, monitoring and review
	National Drug Authority	• Oversight, regulation and management of health products • Participation in MoH planning, monitoring and review
	National Medical Stores	• Management of procurement, warehousing and distribution of all health products • Participation in MoH planning, monitoring and review
	Uganda Blood Transfusion Services	• Coordination of provision of blood and blood products • Participation in MoH planning, monitoring and review
	Uganda National Health Research Organization	• Development of a health research agenda • Participation in MoH planning, monitoring and review
	Natural Chemotherapeutics Research Institute	• Conduct research in natural products and traditional medicine in management and treatment of Human diseases • Participation in MoH planning, monitoring and review
	Uganda Virus Research Institute	• Coordination of evidence generation and knowledge management relating to viral conditions • Participation in MoH planning, monitoring and review
	National and RRHs hospitals	• Implementation of the MoH policies and guidelines • Participation in policy and strategy formulation and review • Participation in support supervision to LGs • Participation in performance reviews
	District Health Offices	• Participation in policy and strategy formulation and review • Participation in support supervision to LGs • Participation in performance reviews • Implementation of the MoH policies and guidelines

Constituency	Stakeholders	Roles and Responsibilities
	Health Facilities	• Implementation of the MoH policies and guidelines • Provision of feedback
	Ministry of Finance, Planning and Economic Development	• Provision of adequate financial resources for implementation of the Strategic Plan • Provide data that is required to inform health planning (e.g. UDHS, Household surveys, vital statistics) • Participation in development policies and strategies • Project appraisals • Joint planning, monitoring and review of sector performance
	Ministry of Public Service	• Maintenance of payroll • Restructure the HRH in line with changing tasks and new technologies • Performance based contracting of HRH • Inspection of health service delivery • Joint planning and review of sector performance
	Local Governments	• Participation in MoH policy development and review • Enforcement of the Public Health Act • Submission of reports • Supervision and monitoring of health service delivery • Supporting health infrastructure development • Passing of by-laws
	Ministry of Education and Sports	• Participation in MoH policy development and review • Promote sport and physical exercise • Implementation of the School Health Program • Ensure quality training of health workers.
	Ministry of Water and Environment	• Development of safe water sources (drilling bore holes, provision of piped water, protection of springs, rainwater harvesting) • Provision of sanitation services in rural growth centres & urban areas and communal toilets.

Constituency	Stakeholders	Roles and Responsibilities
		• Control and enforce sustainable use of the environment (EIA, avoid pollution, ensure sustainability use of wetlands) • Share climate data for integration into DHIS2 to enable model disease early warning systems • Coordinate the climate change agenda in MDAs and private sector
	Ministry of Agriculture, Animal Industries and Fisheries	• Ensure food (both plant and animal sources of food) security for the whole population • Control of zoonotic diseases • Participation in development policies and strategies • Joint planning and review of sector performance • Promote climate-smart agriculture for food safety and reduced greenhouse emissions
	Ministry of Internal Affairs (Directorate of Health Services)	• Participation in development policies and strategies • Joint planning and review of sector performance Ensure wellbeing of refugee populations • Ensure all visitors comply with regulation with respect to required vaccinations and sharing critical information concerning their health status under special circumstances e.g. bird flu
	Ministry of Defence (Directorate of Health Services)	• Participation in development policies and strategies • Joint planning and review of sector performance
	Ministry of Gender, Labour and Social Development	• Ensure youth and gender is mainstreamed in all sector policies • Advocacy and prevention of gender-based violence • Develop social policies for protection of vulnerable groups • Promote progressive workplace and safety policies that safeguard the workers
	Ministry of Works and Transport	• Construction and maintenance of roads for accessing health facilities and referral of patients • e.g., express lanes for ambulances. • Enforcing standards for all buildings

Constituency	Stakeholders	Roles and Responsibilities
		• Promote sustainable low-emission transport systems
	Ministry of Lands, Housing and Urban Development	• Promote urban and housing designs and infrastructure planning that consider health and wellbeing of the population • Strengthen access to land, and other culturally important resources, for women
	Ministry of Information Communication and Technology	• Facilitate data and voice communication
	Ministry of Energy	• Ensure access to affordable energy
	Ministry of Trade and Industry	• Ensure work and stable employment and entrepreneur opportunities for all people across different socio-economic groups • Ensure importation of goods that meet the quality standards
Non-state Actors	Development Partners	• Provision of demand driven technical assistance and inputs into implementation of the MoH priorities • Complement financing of the MoH priorities with earmarked or un earmarked funds • Actively participate in joint sector planning, monitoring and review
	Private Sector and CSOs (PHPs, PNFPs, CSOs)	• Contributing towards policies development, planning, monitoring and evaluation. • Resource mobilization for health care from households, organizations both local and international. • Providing or participating in research, community and social mobilization, advocacy, capacity building including human resources development, logistical support, technical assistance and other services at all levels. • Ensuring proper utilization of resources and accountability.

Constituency	Stakeholders	Roles and Responsibilities
	Community Health Workers	• Mobilize and link community with the formal health service • Provide community-based services approved by MoH • Reporting on community health data
Clients	Households/ Individuals	• Take care of their health, and practice appropriate health seeking behaviours

5.3 INSTITUTIONAL AND FINANCIAL SUSTAINABILITY

The following reforms will be promoted by the Ministry of Health to improve institutional and financial sustainable arrangements.

1) Adopt community-based preventive healthcare systems and service delivery model and sustain health behaviours and practices using young minds. This is critical since 75% of the Disease burden is preventable.
2) Integration of health care services which are patient centred.
3) Integrated programming and budgeting for effective delivery away from fragmented policies, vertical programmes, budgets and services.
4) Institutionalizing measurement and accountability by all stakeholders to strengthen health leadership and governance for multisectoral action on addressing the determinants of Health.
5) Mainstream off-budget financing into national budgets.
6) Resource mapping and tracking.
7) Institutionalisation of efficiency measures in the implementation of annual budgets.
8) Human Resource performance improvement, capacity building and motivation.

6 COMMUNICATION AND FEEDBACK ARRANGEMENTS

6.1 OVERVIEW

This Communication and Feedback Arrangements outline the steps the Ministry of Health will take to interact with and involve the many stakeholders to raise public awareness of the Ministry's mission. The communication and engagement strategy will be in line with MoH's basic values. This approach aims to prevent communication breakdowns inside the Ministry and maintain alignment with professional and efficient strategic agenda driving.

6.2 PURPOSE OF THIS COMMUNICATION STRATEGY

The objectives of this communication strategy:

a) Establish a clear understanding and awareness of MoH mandate amongst all key stakeholders
b) Encourage and attract strategic partners to reach out to the MoH, in delivering specific projects
c) Enable MoH adopt a proactive role to communicate with all stakeholders; and
d) Ensure that honest and accurate information is delivered in an open, effective and timely manner.

To ensure effective execution, it's critical that the Strategic Plan is widely disseminated and shared with key stakeholders.

6.3 DISSEMINATION STRATEGY

The dissemination strategy will include:

a) Use of the official MoH website: https//www.health.go.ug
b) Use of MoH Knowledge Management Portal: https//library.health.go.ug
c) Use of social media i.e., Facebook, WhatsApp's, Twitter among others.
d) Publishing program or policy briefs, education and awareness programs, newsletters.
e) Distribution of hard copies (main report/abridged version) to key stakeholders.
f) Presenting at national conferences and meetings.
g) Working with interest groups, peak bodies and citizen panels and using the media- distribution of brochures and advertising events or issues.

7 RISK MANAGEMENT

Risk management entailed determining the Ministry's potential susceptibility to external or internal causes that the sector might not be able to overcome. Potential risk contributing elements and risk reduction strategies are examined.

To put it into context the health sector faces the risk of failure to provide sustainable funding due increasing cost of health care services resulting from the rising population, the demographic shift and increasing burden of non-communicable diseases. This is further complicated by the country's dependency on development partners to fund critical components of health service delivery especially HIV, TB and Malaria. With the shrinking Global health financing space, limited resources will be available to finance health care.

Additionally, political and administrative decisions such as creation of new administrative units could result in escalation of costs to provide services, as well as MOH'S ability to adequately provide oversight. Further, Uganda is positioned in epidemic prone belt which together with influx of refugee increase the risk for outbreaks due to viral haemorrhagic fevers that disrupt health service delivery and poise a significant threat to trade and tourism. Climate change and changes in social determinants of health that are not directly controlled by MOH greatly affect health care outcomes.

The mitigation measures include prudent macroeconomic policies, compliance with financing acts, continuous engagement with stakeholders, enforcement of accountability, implementation of green growth policies, embracing of one health framework, improvement in surveillance and IT monitoring and massive education and stakeholder involvement using a multi-sectoral approach.

The Risk Management Strategy is detailed under Annex IV and outlines the risk profile, specific risks and the corresponding mitigation measures.

8 MONITORING & EVALUATION FRAMEWORK

Monitoring and evaluation (M&E) procedures are crucial to making sure that the MoH Strategic Plan's priority health actions are carried out as intended and that the intended outcomes are achieved. Progress toward the health-related national, SDG, and UHC commitments will be tracked using an integrated and thorough method to monitoring national health strategies. The M&E system will address the increasing need and interest in high-quality data for policy discussion, learning, assessment, decision-making, and accountability.

The M&E system will:

1) Provide guidance for the creation of sound policies, a better institutional setting, and stronger multi-stakeholder coordination systems.
2) Ensure well-functioning data sources (civil registration and vital statistics - CRVS) systems, population-based surveys, routine facility information systems, facility surveys, administrative data sources, disease and public health surveillance, research studies).
3) Ensure robust institutional capability for data gathering through a unified approach to data management, architecture, analysis, use, and distribution.
4) Ensure efficient multisectoral systems for performance and data evaluation.

8.1 DATA COLLECTION

Routine HMIS, administrative data, civil registration and statistics, surveys, censuses, and research are some of the several data sources. The Ministry of Health Strategic Plan's M&E will primarily rely on administrative data for the output indicators and the HMIS for the outcome indicators.

8.2 M&E GOVERNANCE, STRUCTURES, FUNCTIONS AND CAPABILITIES

The Ministry's M&E Unit will manage all M&E activities, including data analysis, utilization, and reporting, and will oversee designing and implementing the M&E frameworks. The unit will be supervised by the CHS HIS&ME. They also oversee and guide all M&E procedures, including maintaining a strong and comprehensive Monitoring, Evaluation, Learning, and Reporting system that prioritizes timely, accurate, and dependable reporting against predetermined targets and indicators.

8.3 DATA ANALYSIS, DISSEMINATION AND USE

The Division of Health Information will be responsible for production of quarterly and annual statistical reports using data from the DHIS2. There will be an Annual Performance Report every year which will be produced by the department of HIS&ME. This report will highlight progress and challenges in implementation of the MoH Strategic Plan and elaborated in the operational plan for the year. In order to

ensure that the MoH and submit these reports by August each year for compilation. The reports shall be incorporated in the Annual Performance Report which is presented at the JRM of each year.

The M&E Unit will develop a dissemination plan for sharing results. The plan will provide detailed information on how the results will be shared and discussed with key stakeholders and how progress results will be shared internally and externally. The dissemination frequency, dissemination avenues, and the person(s) responsible for dissemination will also be detailed in the plan. Prior to dissemination, data will be shared and discussed with the Planning department to ensure ownership. The M&E Unit will provide progress data for supporting evidence-based programmatic decision-making processes and improving the performance. Data collected will also be used to identify ongoing technical support needs.

8.4 REPORTING

HIS&ME Department will take lead in implementing reporting systems. The Ministry will document achievements, successes, lessons learned, best practices and challenges to build and contribute to the body of knowledge on Health Services Delivery in the Country. Progress report findings will be reviewed and discussed internally by the Planning unit team prior to dissemination. Monthly, quarterly, bi-annual and annual reports on activities implemented, progress against agreed-on targets and indicators, and narrative descriptions of achievements, challenges, and support needs will be compiled and submitted to MoH Senior Management and stakeholders.

8.5 DATA QUALITY ASSURANCE

The Division of Health Information together with the M&E Unit will develop a comprehensive data quality assurance plan detailing procedures and methods for managing and improving the quality of data collected most especially through the HMIS. Data verification will be based on a comprehensive system to review the collected data for completeness and accuracy. The actual method used will depend on the data source. Data Quality Audits and Data Quality Surveys will be regularly carried out to provide a picture of the level of accuracy of the data collected. Appropriate correction of the data will be applied, based on its expected accuracy to provide more realistic pictures of the state of the different indicators.

8.6 KNOWLEDGE MANAGEMENT

The MoH will ensure that all stakeholders are receiving guidance and evidence of the ministry actions in a manner that responds to their expectations. These stakeholders include the wider Government (OPM), parliament, citizens, and all other consumers

of health in line with the Access to Information Act. All M&E and research results users should be able to translate and use the data/information for decision making, policy dialogue, review and development.

8.7 PERFORMANCE REVIEWS AND EVALUATIONS

The Ministry will undertake joint quarterly and annual performance reviews, the output for which shall be the quarter and annual performance report. The quarterly reviews will take place every first month of a quarter, and the annual review will take place in August/ September of each year.

8.7.1 Mid-term Evaluation

A mid-term review of the MoH strategic plan will be conducted two-and-a-half years into the Plan's implementation. This review will address performance against the intended objectives and key outputs. It will recommend any changes required to achieve the objectives and targets.

8.7.2 End of Term Evaluation

A final evaluation of MoH strategic plan will be conducted a year after the Plan's implementation. The evaluation will assess the overall effectiveness of the MoH against its planned results, and where possible, it will look at impacts.

8.8 RESULTS FRAMEWORK

The Monitoring and Evaluation Framework is contained in Annex I.

9 ANNEX

ANNEX 1: VOTE IMPLEMENTATION ACTION PLAN (VIAP)

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Programme Objective 1: To improve the foundation of human capital development															
Programme Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services															
Goal: To improve the overall health and wellbeing of all Ugandans by 2030															
Vote Objective 1: To accelerate Health promotion and Disease prevention efforts at all levels															
Intermediate Outcome 3.1.1: Improved utilization of health services	Attempted Suicide Rate per 100,000 population	80	79	78	77	76	75								
	% of mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease between 30 - 70 years	21%	21%	20%	20%	19%	19%								
	Knowledge of HIV among the youth (%)	56%	56%	56%	56%	56%	75%								
	% of under 5 illnesses attributed to diarrhoeal diseases	12%	10%	8%	7%	6%	5%								
	Mortality rate from unsafe WASH (Diarrhoea, Typhoid, Dysentery & Cholera), per 100,000 population	28.1	28.1	26	26	26	24								
	TB case notification rate/100,0000	198	187	177	168	159	150								
	% of Population who slept under an ITN the night before the survey	62%	62%	62%	62%	65%	65%								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	HPV 2nd dose coverage for girls at 10 years	75%	78%	81%	84%	87%	90%								
	DPTHibHep 3rd dose coverage (%)	95%	95%	95%	96%	96%	97%								
	Intermittent Presumptive Treatment for Malaria in Pregnancy 3rd dose coverage (%)	55%	56%	59%	61%	63%	66%								
Strategic Intervention 1: Increase community ownership, access and utilization of health promotion, environmental health and community health services including persons with disabilities															
Strategic intervention 1.1: Implement an integrated health service delivery package at household/ community level through national-wide scale up of CHEWs and revitalisation of VHTs	% of Parishes with at least 2 functional Community Health Extension Workers	7%	10%	30%	35%	40%	45%		Training of CHEWs	0.50	0.53	0.55	0.58	0.61	**HPE&C**
	% of Villages with at least 2 VHTs offering integrated community health service package	0%	30%	40%	50%	55%	65%		Renumeration of CHEWs	6.30	6.30	6.30	6.30	6.30	**HPE&C**
	National Community Health Strategy reviewed and disseminated		1	1					Tooling of CHEWs	1.50	1.20	1.10	1.10	1.10	**HPE&C**
	Develop an integrated Community engagement guideline		1						Training and tooling of VHTs	1.60	0.81	0.00	0.00	0.00	**HPE&C**
	Number of PHC and CHWs oriented on the holistic community engagement model		500	500	500	300	200		Support supervision on integrated community health services package implementation	0.50	0.50	0.50	0.50	0.50	**CHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	% of facilities using integrated client follow-up systems in the community		40%	55%	70%	85%	90%		Support Establishment and orientation of Parish Social Services Committees	1.00	1.00	1.00	1.00	1.00	**CHD**
									Dissemination and orientation of health workers on the Integrated Community Health Services Package	0.50	0.30	0.30	0.30	0.30	**CHD**
									Review and disseminate the national community health strategy	0.30	0.20	-	-	-	**CHD**
									Develop and disseminate integrated Community engagement guidelines	0.30	0.20	-	-	-	**CHD**
									Train PHC and CHWs on the holistic community engagement model	1.00	0.30	0.30	0.20	0.10	**CHD**
									Develop and disseminate the integrated health services delivery framework	0.20	0.20	0.20	0.20	0.20	**CS**
Strategic Intervention 6: Increase access to immunization against childhood diseases															
Strategic intervention 1.2: Increase access to immunization against childhood diseases	% of under 5 children dewormed in last 6 months	29%	36%	46%	57%	72%	90%		Procure and distribute Cold chain logistics (Fridges and cold boxes)	5.00	5.00	5.00	5.00	5.00	**CDC&P**
	Measles-Rubella 2nd dose Coverage	41.00%	50%	70%	80%	90%	95%		Maintain and service EPI fridges.	1.00	1.00	1.00	1.00	1.00	**CDC&P**
	% of Children under one year fully immunized	86%	86%	87%	87%	88%	88%		Roll out malaria vaccine in Under 5 children	5.00	5.00	5.00	5.00	5.00	**CDC&P**
	% of children under 24 months immunized against malaria (malaria 4th dose coverage)	30%	35%	40%	45%	50%	55%		Support supervision and mentorship in EPI service delivery and cold chain maintenance	0.40	0.40	0.40	0.40	0.40	**CDC&P**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	% of sub counties with at least one health facility having a functional refrigerator for EPI	81%	85%	90%	95%	95%	100%		Procurement of medical supplies (vaccines)	26.54	31.85	38.22	45.86	55.03	**CDC&P**
									Contribution to Gavi	0.80	0.80	0.80	0.80	0.80	**CDC&P**
									Subventions to LGs for Immunization	36.45	40.32	44.35	48.79	53.67	**CDC&P**
									Support supervision for Immunization Activities	85.00	89.25	93.71	98.40	103.32	**CDC&P**
									Conduct static and outreach immunization Sessions	2.30	2.30	2.30	2.30	2.30	**CDC&P**
									Capacity building for EPI service delivery	1.00	1.00	1.00	1.00	1.00	**CDC&P**
									Conduct paediatric deaths surveillance	1.50	1.50	1.50	1.50	1.50	**RCH**
									Implement Integrated Child Health Day activities	16.00	16.00	16.00	16.00	16.00	**CDC&P**
Strategic Intervention 5: Promote optimal Maternal, Infant, Young child, Adolescent and Elderly Nutrition Practices															
Strategic intervention 1.3: Strengthen nutrition education and promotion at all levels	% of Health Facilities with a demonstration garden for nutrition	1%	5%	12%	17%	23%	31%		Provide Vitamin A supplementation to U5s during routine immunization and Integrated Child Health Days	6.00	6.50	7.00	7.50	7.50	**CHD**
	Vitamin A second dose coverage for U5s (%)	75%	76%	78%	79%	81%	82%		Provide Iron and Folic Acid supplementation for pregnant women during ANC	2.50	2.60	2.70	2.80	2.90	**CHD**
	% of Pregnant women receiving Iron and Folic Acid supplementation on 1st ANC visit	67%	69%	70%	72%	73%	75%		Promote micronutrient supplementation for the elderly (Calcium, Zinc, Vitamin D3, Magnesium, Vitamin B 12, B9 & B6, Iron)	0.05	0.05	0.05	0.05	0.05	**CHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	% of eligible premises inspected	NA	10%	15%	20%	25%	30%		Build the capacity of health workers on the in-service training package (maternal, infant, young child, adolescent and elderly nutrition package/MMS/integrated management of acute malnutrition/ M&E for Nutrition, and supply chain management	-	-	-	-	-	**CHD**
									Build the capacity of community structures on Integrated community-based nutrition package	0.40	0.60	0.80	1.00	1.20	**CHD**
									Screen Food handlers for Typhoid & TB	0.30	0.30	0.30	0.30	0.30	**EHD**
									Nutrition health facility assessments conducted	0.05	0.05	0.06	0.07	0.08	**CHD**
									Conduct quality assurance of premix (food forticants) through testing at border points	0.50	0.60	0.70	0.60	0.50	**EHD**
									Scale up Nutrition promotion services at all levels of service delivery	1.50	1.00	1.50	2.00	2.50	**CHD**
									Promote local manufacturing of safe and quality nutrition commodities i.e. Therapeutic food, food supplements, food fortificants.	2.00	3.00	4.00	4.00	4.00	**CHD**
									Develop and disseminate guidelines for micronutrient supplementation for	0.10	-	0.20	-	-	**CHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									pregnant women and the elderly						
									Conduct Indicator survey on nutrition biomarkers	-	-	0.50	-	-	**CHD**
									Conduct awareness campaigns on nutrition with focus on dietary diversification and optimal breast feeding	0.07	0.07	0.07	0.07	0.07	**CHD**
Strategic Intervention 4: Improve maternal, neonatal, child and adolescent health services at all levels of care															
Strategic intervention 5. : increase access to Sexual and Reproductive Health (SRH) information and services															
Strategic intervention 1.4: Health Promotion and Education scaled up through integrated Social Behaviour Change interventions	SBC Strategy Developed		1	1	1	1	1		Develop Health promotion and SBC strategies, guidelines and innovative preventive interventions for all health programs.	2.00	2.00	2.00	2.00	2.00	**HPE&C**
	Number of health program-based materials developed		5	5	5	5	5		Develop, review and disseminate health educative, SBC/IEC/BCC and Health promoting materials and messages for all Health programs	10.00	10.00	10.00	10.00	10.00	**HPE&C**
	Number of Engagements and Coalitions held in the Public		8	8	8	8	8		Organise and hold engagements and coalition in communities for different stake holders for advancement of public health.	3.00	3.00	3.00	3.00	3.00	**HPE&C**
	SBC guidelines developed		1	1	1	1	1		Support/train health facilities/health workers to offer adolescent and youth friendly, SRH/FP & CH services,	0.8	0.8	0.8	0.8	0.8	**RCH**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	SBC innovative preventive interventions developed and disseminated		20	20	20	20	20		Develop & disseminate Adolescent Health Services implementation plan 2025 - 2030	0.20	0.30				**RCH**
	SBC Calendar Developed		1						Develop and disseminate the nurturing care framework for early childhood development	0.20	0.30				**RCH**
	% of Health facilities providing adolescent friendly services	42%	60%	63%	66%	69%	72%		Develop/review & disseminate SRH strategies and guidelines	0.20	0.30				**RCH**
	% of LGs (Districts & Cities) with functional DICAH	39.4%	45.0%	54.0%	65.0%	72.0%	80%		Support Establishment of District Committees on Adolescent Health (DICAH)	0.05	0.05	0.02	0.02	0.02	**RCH**
	No. of health workers trained on provision of Adolescent and youth friendly health services	600	900	1,800	2,700	3,600	4,500		Build capacity of the facilities and health workers to offer adolescent and youth friendly services	0.12	0.12	0.12	0.12	0.12	**RCH**
	% of health facilities providing adolescent health services	42%	55%	68%	80%	90%	100%		Conduct adolescent and youth health campaigns	1.00	1.00	1.00	1.00	1.00	**RCH**
	AHS implementation framework 2025 - 2030 and guidelines developed and disseminated at all levels		AHS develo ped	Dissem inated											
	% of districts with trained health workers on the	0%	5%	10%	15%	20%	25%								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	ECD/nurturing care														
	No of SHRH and Self Care strategies and guidelines developed/reviewed		Strategy reviewed	Guidelines reviewed											
	No. of health workers trained in integrated SRH/HIV and selfcare packages	400	600	600	600	600	600								
	Proportion of women initiated on immediate postpartum FP services	2.5%	7.0%	15.0%	24.0%	32.0%	40.0%								
Strategic Intervention 2: Reduce the burden of communicable diseases with focus on high burden diseases (Malaria, HIV/AIDS, TB, Neglected Tropical diseases, Hepatitis), epidemic prone diseases across all age groups emphasizing Primary Health Care Approach															
Strategic intervention 1.5: Increase access to quality prevention services for Communicable & Non-communicable diseases	Malaria Elimination strategy & guidelines developed and disseminated		Strategy developed	Disseminated					Malaria vector control activities implemented (ITNs/LLINs)	1.00	200.00	1.00	1.00	200.00	**CDC&P**
	% of Target LGs implementing Indoor Residual Spraying	40%	50%	60%	65%	70%	75%		Mentorships and supervision of health facilities and community health workers in malaria management	1.00	1.00	1.00	1.00	1.00	**CDC&P**
	% of pregnant women who received ITNs at 1st ANC	70%	75%	80%	85%	90%	90%		Malaria vector control activities implemented (IRS, larval source management)	20.00	20.00	20.00	20.00	20.00	**CDC&P**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	% of Under five children in target districts received seasonal malaria chemoprophylaxis	85%	85%	90%	90%	95%	95%		Seasonal malaria chemoprophylaxis for under-fives in target LGs	1.80	1.80	1.80	1.80	1.80	**CDC&P**
	% of Population who know 3 methods of HIV prevention	91%	91%	91%	91%	93%	93%		Develop and disseminate a National Malaria elimination strategy & Guidelines	0.20	0.30				**CDC&P**
	% of HIV positive Pregnant women initiated on ART	95%	96%	97%	98%	99%	100%		Develop/review, disseminate and roll out malaria elimination strategy and guidelines	0.15	0.15				**CDC&P**
	% of HIV exposed infants with 2nd DNA/PCR within 9 months	81%	80%	87%	94%	100%	100%		Develop and disseminate HIV/AIDS and Syphilis Care and prevention strategies and guidelines	0.20	0.30				**CDC&P**
	Number of multimedia interventions for HIV/AIDS prevention and care conducted		12	12	12	12	12		Provision of HIV/AID, Syphilis, malaria, Hep B, etc Prevention Services	350.00	150.00	150.00	150.00	150.00	**CDC&P**
	TB& Leprosy Control and prevention strategy disseminated		1						Support supervision for Cancer & heart prevention services provided at all levels	0.50	0.50	0.50	0.50	0.50	**NCD**
	Number of multimedia interventions for TB/Leprosy prevention and care conducted		12	12	12	12	12		Develop/evaluate and disseminate TB& Leprosy Control and prevention strategy	0.20	0.30				**CDC&P**
	% of Health Facilities (HC IV and above) with	37%	51%	70%	76%	83%	90%		Support to LGs & NGOs for TB, Malaria & HIV prevention & promotion Interventions	71.00	74.55	78.28	82.19	86.30	**CDC&P**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	diagnostics for Hepatitis														
	Populations at risk Mapped (%)		20%	35%	50%	70%	85%		Scale up Hepatitis B testing services for the priority populations	0.20	0.20	0.20	0.20	0.20	**CS**
	% of Women 25 - 49 years screened for cervical cancer	23%	28%	28%	28%	33%	33%		Disseminate the National Viral Hepatitis Strategic Plan	0.20	0.20				**CS**
	% of Men 40+ years screened for prostate cancer	19%	20%	21%	22%	24%	25%		Roll out of community based mental health services	0.20	0.20	0.20			**NCD**
									Implement TB & Leprosy differentiated service delivery models incl. community support mechanisms, Training of health workers, community outreach & peer support groups in 250 DTUs	0.50	0.50	0.50	0.50	0.50	**CDC&P**
									Establish active surveillance system for Leprosy in 50 districts in (West Nile, Tooro, Busoga, North Buganda & Bunyoro sub regions)	1.10	1.10	1.10	1.10	1.10	**CDC&P**
									Develop, Disseminate and Evaluate TB & Leprosy Strategy	0.30	-	0.20		0.30	**CDC&P**
									Conduct integrated advocacy, communication, awareness, and social mobilization activities for TB and leprosy services in 80% (116) of the districts	2.00	2.00	2.00	2.00	2.00	**CDC&P**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic Intervention 1.6: Prevention and control of public health emergencies (surveillance, early detection through diagnostic services, RCCE, etc).	% of public health emergencies detected within 72 hours (7 days)	39%	50%	60%	70%	80%	90%		Development of legislation, policies, strategies and guidelines in line with National Action Plan for Health Security (NAPHS)	0.30	0.20	0.30	0.20	0.30	**IES&PHE**
	% of major PHE controlled/contained in timely manner as per guideline	30%	40%	50%	60%	70%	80%		Strengthen Routine implementation of Integrated Disease Surveillance & Response	3.30	9.30	4.90	0.94	0.64	**IES&PHE**
	Number of functional POEs	8	10	11	13	15	17		Prepare, respond to and control Public Health Emergencies	0.81	0.85	0.89	0.94	0.98	**IES&PHE**
	Number of strategies and guidelines developed	4	3	2	3	3	2		Establish and functionalise Port Health services at the points of entry	5.00	5.00	5.00	5.00		**IES&PHE**
	# of outbreaks confirmed within 7 days of alert	100%	100%	100%	100%	100%	100%		Antimicrobial resistance monitoring system operationalised	0.20	0.20				**IES&PHE**
									Risk communication and community engagement on public health emergencies	2.00	2.00	2.00	2.00	2.00	**HPE&C**
									Conduct Risk assessments	0.30	0.30	0.30	0.30	0.30	**IES&PHE**
									National integrated sample transportation network operationalized	2.50	2.50	2.50	2.50	2.50	**NPHLD**
									Public Health laboratory services provided (CPHL)	0.70	0.74	0.77	0.81	0.85	**NPHLD**
Strategic Intervention 7: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services															
Strategic intervention 1.7: Lifestyle	Alcohol Abuse Rate (%)	6.60%	6.60%	6%	6%	6%	5.50%		Develop workplace policies for NCD prevention and control	0.30	0.30				**NCD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
diseases prevention using a life course approach.	Total alcohol per capita (>15 years of age consumption) (litres of pure alcohol)	12.2	12.2	12.2	10	10	10		Review & disseminate the National NCD prevention and control strategy	0.00	0.15			0.20	**NCD**
	Road traffic injury mortality rate (per 100,000 population)	29.4	27.7	26.2	24.7	23.3	22		Training of health workers in management of NCDs & injuries including medical emergencies	0.20	0.20	0.20	0.20	0.20	**NCD**
	Number of substance abuse rehabilitation centres established	0	0	1	1	1	1		Conduct NCD Indicator Surveys		1.50				**NCD**
	% of LGs with designated spaces for Community physical exercise and sports (Stadia/community centres)	NA	5%	7%	10%	15%	20%		Community sensitization and awareness creation on prevention of NCDs & injuries	0.30	0.30	0.30	0.30	0.30	**NCD**
									Review and roll out the mental health strategy, substance abuse management guidelines	0.00	0.20	0.30	-	-	**NCD**
									Establish mental units in GHs and RRHs	0.00	8.30	8.30	8.30	8.30	**NCD/HID**
									Organise National Physical exercise day	0.20	0.20	0.20	0.20	0.20	**NCD**
									Support supervision on implementation of policy on institutional physical activity days	0.30	0.30	0.30	0.30	0.30	**NCD**
Intermediate Outcome 3.1.5:	% of population practicing open defecation	17	15	13	11	10	8								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Increased access to improved sanitation services.	% of population with access to basic sanitation (Improved toilet not shared with other households)	32	36	40	44	48	50								
	% of population with access to safely managed sanitation	18	23	28	32	36	40								
Intermediate Outcome 3.1.6: Increased access to handwashing facilities	% of the population with access to handwashing facilities in rural areas (handwashing with soap)	44.7	45	46	47	48	50								
	% of the population with access to handwashing facilities in urban areas (handwashing with soap)	53.1	56	57	58	59	60								
	% of the population with access to handwashing facilities in refugee settlements (handwashing with soap)	48	56	57	58	59	60								
Strategic Intervention 8d: Increase access to improved sanitation services in rural and urban areas															
Strategic Intervention 8e: Increase access to hygiene facilities															
Strategic intervention 1.8: Strengthen WASH and	% of Health facilities with inclusive sanitation facilities	214	279	363	472	613	797		Health inspection, monitoring and supervision of households, public and private facilities in urban and rural areas	2.00	2.20	2.42	2.66	2.93	**EHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
health inspection for disease prevention and well-being (including climate change & health)	No. of annual sanitation awareness campaigns conducted in LGs	135	135	135	135	135	135		Support construction of resilient healthcare waste management infrastructure (incinerators, placenta pits, storage shades, disinfection points, staff house, water source, generator house) constructed	29.00	17.40	11.60	11.60	5.80	**EHD**
	No. of sanitation awareness creation conducted in urban areas	20	20	20	20	20	20		Support construction of inclusive and resilient sanitation infrastructure	0.30	0.32	0.33	0.35	0.36	**EHD**
	% of Health facilities (HC IV and above) with functional incinerators	2,393	2,513	2,639	2,771	2,910	3,056		Procure and distribute equipment and supplies for healthcare waste, sanitation and hygiene	4.00	4.40	4.84	5.32	5.86	**EHD**
	No. of awareness campaigns on hand washing carried out in rural areas	135	135	135	135	135	135		Conduct training and capacity building for improved WASH, healthcare waste management, climate change, vector & vermin control, and NTDs	0.80	0.80	0.80	0.80	0.80	**EHD**
	No. of awareness campaigns on hand washing carried out in urban areas	80	80	80	80	80	80		Conduct public awareness campaigns on environmental health interventions across the country	0.50	0.50	0.50	0.50	0.50	**EHD**
	No. of awareness campaigns on hand washing carried out in refugee settlements	52	52	52	52	52	52		Roll out and implement the National Climate Change and Health Adaptation Plan.	2.00	2.00	2.00	2.00	2.00	**EHD**
	% health facilities with functional		85%	90%	95%	100%	100%		Conduct NTD prevention interventions in high endemic districts	4.00	4.00	4.00	4.00	4.00	**EHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	handwashing facilities														
	% of households/eligible premises that are inspected annually	2%	10%	28%	37%	42%	56%		Support Vector and vermin control interventions in communities and institutions	0.20	0.22	0.24	0.27	0.29	**EHD**
	% of Health facilities with climate resilient infrastructure (Solar Energy, incinerators, WASH)	15%	30%	33%	35%	37%	40%		Develop & disseminate policies, regulations, strategies and guidelines/SOPs for environmental health	0.20	0.30			0.20	**EHD**
	% Pre-primary, primary and secondary schools inspected	TBD	78%	84%	88%	90%	95%		Conduct monthly national cleaning days	0.50	0.50	0.50	0.50	0.50	**EHD**
Programme Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.															
Programme Objective 5: Reduce vulnerability, gender inequality and inequity along the lifecycle															
Programme Objective 9: Strengthen the Policy, Legal, Institutional, and Coordination Frameworks															
Goal: To improve the overall health and wellbeing of all Ugandans by 2030															
Vote Objective 2: To strengthen the health system and its functionality towards universal health coverage.															
Intermediate Outcome 3.1.1: Improved utilization of health services	Service availability and readiness index (%)	49%	51%	51%	53%	53%	56%								
Strategic Intervention 7: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.															
Strategic Intervention	Client satisfaction level (%)	73%	74%	74%	74%	76%	76%		Conduct client satisfaction surveys	0.25	0.25	0.25	0.26	0.26	**SCAPP**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
2.1: Develop and monitor implementation of the health service and service delivery standards	% of health workers expressing satisfaction with their jobs	N/A	50%	50%	50%	65%	65%		Scale up the use of self-regulatory quality improvement system (SQIS) in the private sector	0.40	0.40	0.40	0.40	0.40	**SCAPP**
	% of Private for-profit health facilities enrolled on the SQIS	1%	30%	50%	70%	90%	100%		Develop/review and disseminate the service standards, guidelines, manuals, SOPs	0.50	0.20	0.20	0.20	0.20	**SCAPP**
	No. of service standards, guidelines, manuals, SOPs developed and disseminated.		1						Strengthen the National, Regional & LG Supervisory mechanism	0.80	1.00	1.00			**SCAPP**
	GH and HUMCs Guidelines reviewed and disseminated		Reviewed	Disseminated	Disseminated				Conduct harmonized health facility assessment (HHFA)	-	0.80	-	-	0.80	**SCAPP**
	HHFA conducted			1			1		Scale up implementation of the integrated Care system	0.20	0.20	0.20	0.20	0.20	**SCAPP**
	Regional supervisory structure guidelines disseminated		1												
Strategic Intervention 2.2: Strengthen governance and management of the health sector at all levels	No. of SMC meetings held		12	12	12	12	12		Organise monthly SMC meetings	0.05	0.05	0.05	0.05	0.05	**SCAPP**
	No. of TMC meetings held		12	12	12	12	12		Organise monthly TMC meetings	0.01	0.01	0.01	0.01	0.01	**F&A**
	No. of HPAC meetings held		12	12	12	12	12		Organise monthly HPAC meetings	0.01	0.01	0.01	0.01	0.01	**F&A**
	% of TWG meetings held		83%	91%	91%	91%	91%		Organise monthly TWG meetings	0.04	0.04	0.04	0.04	0.04	**All Depts**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic Intervention 2.3: Promote adherence to client charter and ethical code of conduct by health workers	% of health institutions with Client Charters	NA	100%	100%	100%	100%	100%		Develop & disseminate Client Charters	0.05	0.05	0.05	0.05	0.05	**SCAPP**
	Performance Management system in use at all levels	NA	50%	55%	60%	65%	70%		Training of health workers in Human rights-based approach, client charter and ethical conduct.	0.40	0.40	0.40	0.40	0.40	**SCAPP**
									Roll out the performance management system for health workers under HCMS	0.20	0.20	0.20	0.20	0.20	**SCAPP**
Strategic Intervention 2.4: Health Partner and multi sectoral Coordination and engagement Strengthened	Health Partner Mapping database established and updated.		1	1	1	1	1		Map, establish and maintain a database	0.20	0.10	0.10	0.10	0.10	**HSP&MSC**
	% of LGs with functional PPPH desks	10%	50%	65%	75%	85%	95%		Strengthening Private Health Service delivery through Public Private Partnerships for Health	0.30	0.20	0.20	0.20	0.20	**HSP&MSC**
	No. of Regional and international engagements coordinated/ attended		16	16	16	16	16		Support the scale-up of Private Healthcare facilities reporting into DHIS2	0.50	0.50	0.50	0.50	0.50	**HSP&MSC**
	% of transfers/ obligations met		8	8	8	8	8		Organise and attend national, regional and international meetings, consultative meetings and partner coordination	0.30	0.30	0.30	0.30	0.30	**HSP&MSC**
	HSIRRP developed and disseminated	1	1						Provide contributions to national, regional and international institutions (ILO, OPCW, ARLAC, WHO, GFTAM, ECSA, GAVI, UNFPA, APEPH)	1.96	1.96	1.96	1.96	1.96	**HSP&MSC**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	No. of Health Facilities transitioned.	35	5	5	5	5	5		Disseminate Regional and international declarations, protocols and Memorandum of Cooperation	0.10	0.10	0.10	0.10	0.10	**HSP&MSC**
	No. of protocols and Memoranda of cooperation to key stakeholders disseminated		8	8	8	8	8		Enhancing the coordination of the Health Development Partners and streamline off-budget tracking	0.30	0.30	0.30	0.30	0.30	**HSP&MSC**
	The PPPH Strategy and guidelines reviewed and disseminated.		1						Coordinate and integrate Refugee Health programs into the GoU system (HSIRRP)	0.20	0.30				**HSP&MSC**
	Off-budget tracking report compiled and submitted		1	1	1	1	1		Support transitioning of Health facilities in Refugee hosting districts into the GoU system.	0.10	0.10	0.10	0.10	0.10	**HSP&MSC**
	% of MOUs between MOH and partners that are monitored for implementation		80%	100%	100%	100%	100%		Strengthening healthcare-related service delivery by MDAs	0.25	0.30				**HSP&MSC**
									Support the development and implementation of MOUs between MOH and strategic partners	0.20	0.20	0.20	0.20	0.20	**HSP&MSC**
									Strengthening health service delivery by non-state actors such as NGOs and Faith-based organizations	0.02	0.02	0.02	0.02	0.02	**HSP&MSC**
Strategic Intervention 2.5: Strengthen	% of private health facilities with an up-to-date licence (%)	TBD	100%	100%	100%	100%	100%		Operationalise the Uganda Health Professionals Regulatory Council Act	0.10	0.15				**CS**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
regulation and quality of Health Professionals Practise	% of Health Professionals with an annual practising licence	50%	100%	100%	100%	100%	100%		Supervision of health professional councils	0.10	0.10	0.10	0.10	0.10	**SCAPP**
Strategic Intervention 2.6: Strengthen accountability and availability of quality Health Products	% of TCMPs registered by Pharmacy Board	0	0%	5%	10%	15%	20%		Develop & disseminate the Traditional & Complementary Medicine Practitioners regulations	0.10	0.15	0.15	0.15	0.15	**PNM**
	number of TCM products licensed by NDA	0	1	2	3	4	5		Support the Dissemination of the National Drug and Health Products Act & Regulations	0.05	0.05	0.05	0.05	0.05	**PNM**
									Training TCMPs in quality and safety of products	0.20	0.20	0.20	0.20	0.20	**PNM**
Strategic intervention 2.7: Adequacy, functionality and quality of civil and sanitary infrastructure improved	Number of RRHs rehabilitated / expanded to increase scope of services 8 RRHs)			2	2	2	2		Rehabilitate /expand and equip National Referral Hospitals	0.00	0.00	480.00		480.00	**HID**
	Number of general hospitals rehabilitated / expanded to increase scope of services (16 GHs)			4	4	4	4		Rehabilitate /expand and equip Regional Referral Hospitals	240.00		480.00	480.00		**HID**
	Number of Community Hospitals (HC IVs) rehabilitated / expanded to increase scope of services (40			10	10	10	10		Rehabilitate /expand and equip Community Hospitals (HC IVs)	0.00	43.96	411.55	175.85	131.88	**HID**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	Community Hospitals)														
	% of General & referral hospitals with a functional mental health unit		10%	20%	30%	40%	50%		Establish mental units in GHs and RRHs	8.30	8.30	8.30	8.30	8.30	**HID/ NCD**
	% of hospitals and HCIVs with functional emergence care units		15%	40%	60%	80%	100%		Establish emergence care units at hospitals and HCIVs	26.25	26.25	26.25	26.25	26.25	**CS**
									Operationalize NICUs at 55 GHs	15.30	16.50	24.75	24.75	16.50	**HID**
	% of Health facilities with adequate clean energy (solar) source	TBD	1%	2%	6%	8%	9%		Construct 4 regional blood banks and 1 national biosafety Laboratory		15.45	15.45	10.30	10.30	**HID**
									Transitional development funding (Health facility upgrades)	36.00	38.00	41.80	45.98	50.58	**HID**
									Establish community hospitals in constituencies without	200.00	226.68	411.55	411.35	322.24	**HID**
									Completion & Functionalization of unfinished structures at RRHs	10.00	38.00	20.00	0.00	0.00	**HID**
									Establish specialized hospitals (Katakwi & Lwengo)		66.87	162.78	237.88	151.03	**HID**
									Rehabilitation, Expansion and Equipping of Bugiri GH	13.03	19.52	24.56	18.83	5.83	**HID**
									Provide clean energy (solar) to health facilities	5.00	5.00	5.00	5.00	5.00	**HID**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic intervention 2.8: Adequacy and functionality of medical equipment and other plant improved	% of Health Facilities whoose medical equipment were serviced in the previous qtr		20%	30%	40%	50%	60%		Repair and servicing of medical equipment	2.00	2.00	2.00	2.00	2.00	**HID**
	% of oxygen plants serviced and operational	80%	90%	90%	90%	90%	90%		Service oxygen plants at Regional and National Referral hospitals	1.40	26.47	27.79	29.18	30.64	**HID/CS**
	% regional medical workshops that are equipped	75%	81%	87%	94%	100%	100%		Establish and retool Regional Equipment Maintenance workshops	0.24	0.26	0.27	0.28	0.30	**HID**
									Diagnostic & imaging equipment procured and installed	3.00	5.00	5.00	5.00	5.00	**HID/NPHLD**
									Radiology and diagnostic imaging equipment serviced and maintained	2.00	2.00	2.00	2.00	2.00	**HID**
Strategic Intervention 1: Develop and review policies, laws, and regulations related to HCD															
Strategic Intervention 2.9: Policies, Laws and guidelines reviewed and developed	Number of Policies developed and reviewed for Health		10	10	10	10	10		Develop and review laws, policies, strategies, guidelines and regulations for Health	0.30	0.20	0.30	0.20	0.30	**F&A**
	Number of Laws for Health developed		2	2	2	2	2								
	Number of regulations for Health developed		4	4	4	4	4								
Strategic Intervention 2.10: Strength integrated	Number of health regions that have been supervised by the MOH Top management		8	8	8	8	8		Conduct monitoring and support supervision under Health	6.53	6.53	6.73	6.73	6.83	**F&A**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
support supervision and mentorships at national and subnational levels.	% of hospitals and HC IVs that have been reached for support supervision		20%	20%	20%	20%	20%		Carry out project implementation monitoring	2.00	2.00	2.00	2.00	2.00	**F&A**
	Number of community engagements/ barazas done to give feedback after support supervision		8	8	8	8	8								
Strategic Intervention 2: Capacitate institutions to deliver Human Capital Development Programme															
Strategic Intervention 2.11: Improve the capacity of the health sub-programme to deliver Human Capital Development	Subventions facilitated	1	1	1	1	1	1		Provide support to MOH Subventions (JCRC, NCRI)	0.48	0.48	0.48	0.48	0.48	**F&A**
	Number of Budget reports produced		6	6	6	6	6		Undertake planning, budget preparation and reporting (prepare BFP and MPS)	0.36	0.38	0.38	0.38	0.38	**F&A / HISM&E**
	Number of ICT systems Audited	0	3	3	3	3	3		Prepare, Print & Disseminate Health Sector Budgeting and Implementation Grant Guidelines	0.25	0.30	0.30	0.30	0.30	**F&A / HISM&E**
	Number of audit reports prepared and disseminated	8	8	8	8	8	8		Carry out Budgeting support supervision to LGs, RRHs & Health Institutions	0.50	0.50	0.50	0.50	0.50	**F&A / HISM&E**
	Communication Strategies developed and implemented		1	1	1	1	1		Prepare, Print & Disseminate Ministry of Health Budget Execution guidelines	0.05	0.05	0.05	0.05	0.05	**F&A**
	Number of research outputs produced		11	11	11	11	11		Support/Prepare Ministry of Health Projects for implementation as per PIM Policy	0.02	0.04	0.04	0.04	0.04	**F&A**
									Equip, Upgrade and strengthen ICT system for MoH	0.2	0.9	0.9	0.9	0.9	**F&A**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Preparing audited reports for Ministry of Health	0.6	0.6	0.6	0.6	0.6	**F&A**
									Carrying out communication and publicity (advertising and publications) for Health	0.2	0.2	0.2	0.2	0.2	**F&A**
									Conduct Health Policy research	0.1	0.1	0.1	0.1	0.1	**F&A**
									Prepare Policy briefs and position papers on topical sectoral public policy issues	0.05	0.05	0.05	0.05	0.05	**F&A**
									Prepare procurement plans for Health	0.1	0.1	0.1	0.1	0.1	**F&A**
									Pay overhead costs (rent, water, electricity, telecommunications, internet, cleaning services,) for Health	0.50	0.50	0.50	0.50	0.50	**F&A**
									Fleet and asset management for Health	-	1.85	0.20	0.20	0.20	**F&A**
									Project 3: Retooling of the MoH and its Institutions (ICT equipment, furniture, rehabilitation, stationery, etc)	0.29	0.30	0.31	0.33	0.35	**F&A**
Intermediate Outcome 3.1.2: Improved adequacy of Human Resources for health, health infrastructur	Health worker population ratio (Number of doctors, nurses and midwives per 10,000 population)	28	29	30	32	33	35								
	Number of physicians (doctors) per 10,000 population	2	2.1	2.2	2.3	2.4	2.5								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Preparing audited reports for Ministry of Health	0.6	0.6	0.6	0.6	0.6	**F&A**
									Carrying out communication and publicity (advertising and publications) for Health	0.2	0.2	0.2	0.2	0.2	**F&A**
									Conduct Health Policy research	0.1	0.1	0.1	0.1	0.1	**F&A**
									Prepare Policy briefs and position papers on topical sectoral public policy issues	0.05	0.05	0.05	0.05	0.05	**F&A**
									Prepare procurement plans for Health	0.1	0.1	0.1	0.1	0.1	**F&A**
									Pay overhead costs (rent, water, electricity, telecommunications, internet, cleaning services,) for Health	0.50	0.50	0.50	0.50	0.50	**F&A**
									Fleet and asset management for Health	-	1.85	0.20	0.20	0.20	**F&A**
									Project 3: Retooling of the MoH and its Institutions (ICT equipment, furniture, rehabilitation, stationery, etc)	0.29	0.30	0.31	0.33	0.35	**F&A**
Intermediate Outcome 3.1.2: Improved adequacy of Human Resources for health, health infrastructur	Health worker population ratio (Number of doctors, nurses and midwives per 10,000 population)	28	29	30	32	33	35								
	Number of physicians (doctors) per 10,000 population	2	2.1	2.2	2.3	2.4	2.5								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
e, medical equipment, vaccines, medicines, supplies and health technologies															
Strategic Intervention 7: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.															
Strategic Intervention 2.12: Adequate and well-trained human resources for health at all levels in place	% of approved posts filled (Public)	34%	38%	40%	45%	50%	55%		Pay staff salaries - MoH	22.35	23.46	24.64	25.87	27.16	**F&A**
	Wage, salaries, pension and gratuity for Health paid	1	1	1	1	1	1		Pay Pension and gratuity	10.95	10.95	10.95	10.95	10.95	**F&A**
	% of approved posts filled in public health facilities	34%	38%	40%	45%	50%	55%		Provide Human Resource Management Services	0.90	1.00	1.00	1.00	1.00	**F&A**
	% of MoH HoDs using the HCMS in performance management		50%	70%	90%	100%	100%		Provide institutional, performance and human resource development services	0.35	0.35	0.35	0.35	0.35	**IC&HRD, F&A**
	Human resource capacity building and management & records management conducted		1	1	1	1	1		Facilitate and supervise SHO and medical interns	39.27	43.20	47.52	52.27	57.50	**CS**
Strategic intervention 2.13: Undertake continuous training and capacity for	HRH Development Plan developed		1						Develop the HRH Development Plan 2025/26 to 2029/30 & review its implementation		0.20	0.05	0.00	0.00	**IC&HRD**
	No. of scholarships awarded		15	15	15	15	15		Award scholarships / sponsor for training Super Specialists	0.75	0.75	0.75	0.75	0.75	**IC&HRD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
health workers including use of digital technology.	Health Labour Market Analysis conducted		1				1		Conduct Staff training and capacity building for Health			0.15			**IC&HRD**
	HRH a training data base updated and maintained.		1	1	1	1	1		Develop and maintain a training data base	0.45	0.10	0.10	0.10	0.10	**IC&HRD**
	No. of staff trained under CPD		1500	1500	1500	1500	1500		Continuous professional development and capacity building for in-service health workers undertaken	1.00	2.00	2.20	2.42	2.66	**IC&HRD**
	Annual Capacity building plans for MoH developed		1	1	1	1	1		Develop an annual Capacity building plans for sector	0.10	0.10	0.10	0.10	0.10	**IC&HRD**
	Institutional capacity assessment for the health sector conducted			1					Institutional capacity assessment for the health sector conducted			0.50			**IC&HRD**
Intermediate Outcome 3.1.7: Improved financing for health	Government Health budget as % of Total Government budget	7.70%	7.90%	8.10%	8.40%	8.70%	9.00%								
	Incidence of catastrophic health expenditure at 10% of income (%)	13.6	12.9	12.9	12.9	12	12								
	Total Health Expenditure Per capita (USD)	57.2	57.2	57.2	59	59	59								
	Out of Pocket Health Expenditure as a proportion of Current Health Expenditure (%)	28%	26%	26%	25%	25%	24%								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	Population covered with health insurance	3.90%	3.90%	4.90%	6.20%	7.90%	10.00 %								
Strategic Intervention 11: Increase financial risk protection for health with emphasis on implementing the national health insurance scheme and scaling up health cooperatives															
Strategic intervention 2.14: Financial risk protection for health increased	% of sub counties with a functional health cooperative/community-based health insurance scheme	30	40	50	60	70	80		Community Health Insurance Guidelines disseminated		0.20	0.20	0.20	0.20	**F&A, HIS&ME**
	Health Financing Strategy 2025-2035 developed and disseminated		1						Develop, Review & Disseminate the Health Financing Strategy 2025-2035		0.10	0.50	0.50		**F&A, HIS&ME**
	National Health Accounts survey conducted, and findings disseminated		1			1			Conduct National Health Accounts survey & findings disseminated			1.30			**F&A, HIS&ME**
	Framework for costing health service delivery developed		1						Framework for costing health service delivery developed	0.20	0.20				**F&A, HIS&ME**
	National Health Insurance Scheme established			1					Health Insurance Scheme regulations developed & disseminated		0.30	0.20	0.10		**F&A, HIS&ME**
	No. of health insurance schemes developed and implemented		20	20	20	20	20		Capacity building for health insurance providers	0.50	0.50	0.50	0.50	0.50	**F&A, HIS&ME**
	Community Health Insurance Schemes guidelines developed and disseminated		1						National Health Insurance Scheme established and rolled out		1.00	3.00	3.00	3.00	**F&A, HIS&ME**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic intervention 2.15: Financial diversificatio n	% of public hospitals with functional private wings	5%	7%	9%	12%	14%	16%		Hospital Private Wing services improved	0.50	0.50	0.50	0.50	0.50	**F&A, HIS&ME**
	Non-tax revenue generated (UGX Billion)	26	27	28	29	30	31		Dissemination of guidelines for management of Private services in public facilities	0.40	0.10				**F&A, HIS&ME**
	Guidelines for management of Private services in public facilities disseminated			1					Revenue Mobilisation Strategy for health Developed and disseminated	0.10	0.10	0.05	0.05	0.05	**F&A, HIS&ME**
									National Health Financing advocacy meetings and dialogues held	0.05	0.05	0.05	0.05	0.05	**F&A, HIS&ME**
Programme Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.															
Goal: To improve the overall health and wellbeing of all Ugandans by 2030															
Vote Objective 3: To enhance the accessibility and utilization of high-quality integrated services for both communicable and non-communicable prevention, control, and response.															
Intermediate Outcome 3.1.1: Improved utilization of health services	Per Capita OPD attendance	0.99	0.98	0.97	0.91	0.85	0.8								
	Hospital (public & private) admission rate (per 1,000 population)	77.6	75	73	72	69	67								
	Bed Occupancy Rate (%)	62%	65%	69%	73%	77%	81%								
	Mortality attributed to communicable diseases (Malaria, TB & HIV/AIDS) (%)	40%	38%	36%	34%	32%	30%								
	Inpatient admission rate for mental, neurogical and	1%	2%	3%	4%	5%	6%								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	substance abuse cases														
	Number of new HIV infections per 1,000 susceptible population	1.23	1	0.9	0.6	0.3	0.1								
	Malaria Incidence (per 1,000 population at risk)	298	260	226	197	172	150								
	Tuberculosis incidence (per 100,000 population)	198	190	190	187	187	185								
	HIV Incidence rate	16%	14%	12%	10%	8%	6%								
	HIV Viral Load Suppression rate among PLHA	96%	97%	97%	98%	98%	99%								
	Per Capita OPD attendance for MNS (Mental Neurological & Substance abuse)	0%	0%	0%	0%	0%	0%								
Strategic Intervention 2: Reduce the burden of communicable diseases with focus on high burden diseases (Malaria, HIV/AIDS, TB, Neglected Tropical diseases, Hepatitis), epidemic prone diseases across all age groups emphasizing Primary Health Care Approach															
Strategic intervention 3.1: Access to quality Malaria treatment services improved for elimination	% LGs (Districts & Cities) with incidence below 10 cases per 1,000 per year	0	2	3	7	10	15		Regular supply of commodities to avert stock outs; Mentorship, supervision of health facilities and community health workers in malaria management; conduct clinical and mortality audits	108.00	113.40	119.07	125.02	131.27	**CDC&P**
	% of LGs (Districts & Cities) with no malaria deaths	8	15	20	25	30	35								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	% of malaria cases that are Laboratory confirmed	85%	90%	95%	97%	98%	99%								
	In patient malaria deaths (per 100,000 persons per year)	5.4	4.43	3.46	2.49	1.52	0.55								
	Percentage of confirmed malaria cases that received first-line antimalarial treatment according to national policy	90%	90%	95%	95%	95%	95%								
Strategic Intervention 3.2: Access to quality HIV/AIDs and Syphilis control and treatment services improved	ART Retention rate at 12 months (%)	82%	84%	87%	90%	92%	95%		Capacity building for HIV/AIDS and Syphilis coordination and service delivery	41.00	41.00	41.00	41.00	41.00	
	Proportion of MDAs & LGs with functional HIV/AIDS Coordination structures	83%	86%	90%	94%	96%	100%		Mentorships and supervision of health facilities and Community Resource Persons	0.20	0.20	0.20	0.20	0.20	
	Proportion of the domestic resource (fund) contribution to the overall HIV/AIDS annual budget	13%	20%	25%	30%	35%	40%		Provision of medical supplies for TB, Malaria and HIV	475.51	499.29	524.25	550.46	577.99	
	UPHIA conducted and findings disseminated		1						Conduct UPHIA & other studies				19.40		
	Number of HIV/AIDs operational research		2	2	2	2	2								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	and studies conducted														
Strategic Intervention 3.3: Access to quality treatment and control of TB and leprosy services improved.	TB treatment coverage rate (%)	90%	91%	92%	93%	94%	95%		Provision of TB/Leprosy care and treatment services	3.00	3.15	3.31	3.47	3.65	CDC&P
	TB treatment success rate (%)	85%	86%	86%	87%	87%	88%		Tuberculosis and Leprosy Cast Active case finding (community level)	3.00	3.00	3.00	3.00	3.00	CDC&P
	% of Leprosy cases with grade 2 disability	11%	9%	8%	7%	6%	5%		Training and mentorship of Health workers in Active TB/Leprosy Case Finding and management	2.50	3.00	3.20	3.80	3.80	CDC&P
	Number of health workers trained on TB/Leprosy case finding and management		300	300	300	300	300		Scale up TB case finding and facility and community level using the standard of care approaches; ACF, and Digital Technologies, Portable X-rays, CAD4TB software, and mobile TB clinics across all the districts/ 2040 DTUs: (13.5M & 2.75M at Facility & Community Screening, yielding over 192,000 TB patients	2.40	3.40	4.40	4.40	4.40	CDC&P
									Undertake contact investigation and management for TB patients including TPT initiation among eligible individuals: 50,000 contacts annually are targeted for investigation & Management	1.50	1.50	1.50	1.50	1.50	CDC&P

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Expand and Equip Diagnostic and Treatment Units (DTUs) in 200 facilities (40 annually) including increasing access to mWRDs	5.66	9.74	9.74	10.88	10.88	**CDC&P**
									Implement the TSR improvement care package across all DTUs	2.31	2.31	2.31	2.31	2.31	**CDC&P**
									Scale-Up Digital Adherence Technologies (DATs) to 50% of DTUs	1.90	2.28	2.28	2.66	2.28	**CDC&P**
									Scale up electronic case-based surveillance system (eCBSS) in Health Facilities from 75% (1530) to 100% (2040) Diagnostic and Treatment Units (DTUs); 510 HFs targeted	0.10	0.20	0.20			**CDC&P**
									Conduct TB Burden estimation (Incidence/Prevalence): Based on Uganda's 2014 TB prevalence survey and updated WHO protocols for burden estimation		3.80				**CDC&P**
									Undertake Contact Investigation & management for Leprosy including initiation on Leprosy Preventive Treatment among eligible individuals	0.50	0.50	0.50	0.50	0.50	**CDC&P**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic Intervention 3.4: Access to NTDs Services improved	Number of people (millions) requiring interventions against NTDs (leprosy, schistosomiasis, trachoma, sleeping sickness, Lymphatic Filariasis, soil transmitted helminths, taenia solium, onchocerciasis, Visceral Leishmaniasis, Buruli Ulcer, podoconiosis, rabies, tungaisis (jiggers), scabies)	26.79	25	23.21	21.42	19.63	17.85		Mass Drug Administration for NTDs	60.00	62.00	64.00	67.00	70.00	**EHD**
	Number of health workers oriented and mentored on NTD management		500	500	500	500	500		Orientation and mentorship of health workers on NTD management	0.20	0.20	0.20	0.20	0.20	**EHD**
	Number of people receiving drugs for NTD control		5,000,000	5,000,000	5,000,000	5,000,000	5,000,000		Review & update the Uganda Neglected Tropical Diseases Master Plan 2023-2027		0.20	0.10			**EHD**
	schistosomiasis control strategy reviewed/developed		1												
Strategic Intervention 3.5: Access to quality	Number of Health workers trained in provision VH care and treatment		500	500	500	500	500		Strengthen capacity of health facilities to provide holistic care and treatment	0.50	0.50	0.50	0.50	0.50	**CS**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Hepatitis prevention & treatment services improved for elimination									for people with viral hepatitis						
									Review the training curriculum for the CHEWs to cover viral Hepatitis, oral health prevention		0.05	0.05			**CS, HPEC**
Strategic Intervention 3.6: Improve patient-centered and integrated service delivery model	% of facilities implementing integrated service delivery models		40%	55%	70%	85%	90%		Develop and disseminate the integrated health services delivery framework	0.20	0.30				**CS**
	% of health facilities with established emergency care spaces		20%	40%	60%	70%	80%		Train health workers on implementation of integrated service delivery models	0.40					**CS**
Strategic Intervention 3: Prevent and control non-communicable diseases with specific focus on cancer, cardiovascular, genetic, renal, endocrine, mental, trauma and malnutrition across all age groups.															
Strategic intervention 3.7: Centres of excellence in provision of oncology, cardiovascular and trauma services at both National and Regional Levels and	Population aged 15 - 49 years diagnosed with diabetes who are on treatment (%)	31%	31%	31%	35%	35%	35%		Orientation of Health Workers in Community based Mental health rehabilitation	0.50	0.50	0.50	0.50	0.50	**NCD**
	Population aged 15 - 49 years diagnosed with heart/chronic disease who are on treatment (%)	40%	40%	40%	40%	45%	45%		Conduct National Mental Health Survey		1.00				**NCD**
	Average turnaround time for histopathology tests	14	12	10	8	6	4		Support supervision on oncology and cardiovascular interventions	0.30	0.40	0.40	0.40	0.40	**NCD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Technical supervision and clinical mentorship of health workers	0.30	0.30	0.30	0.30	0.30	**CS**
									Operationalize Organ Donation and Transplant services		5.00	1.00	1.00	1.00	**CS**
									Support establishment of Oral Health Care services at health facilities	0.20	0.20	0.20	0.20	0.20	**CS**
									Establish palliative care services at all hospitals and HCIVs	0.20	0.20	0.20	0.20	0.20	**CS**
Strategic intervention 3.9: Medical Laboratory and diagnostic imaging services strengthened	Average equipment downtime (days) for Radiology equipment	60	50	40	30	20	10		Diagnostic & imaging equipment procured and installed (X-ray & ultrasound at HCIV)	1.60	7.00	10.00	10.00	10.00	**HID/ NHLDS**
	Average equipment downtime (days) for laboratory equipment	90	80	70	60	50	40		Diagnostic & imaging equipment procured and installed (2CT at RRH, 10CT at GH) 3MRI at RRH		4.00	20.00	31.00	31.00	**NHLDS**
	% of radiological images requiring repeat examinations due to technical factors	10%	9%	8%	7%	6%	5%		National integrated sample transportation network operationalized	2.50	2.50	2.50	2.50	2.50	**NHLDS**
	% of Hospital laboratories that have been ISO accredited	43%	48%	59%	73%	86%	100%		Public Health laboratory services provided (CPHL)	0.70	0.74	0.77	0.81	0.85	**NHLDS**
	Radiology and imaging units accredited (ISO 151892022)	20%	30%	-	-	-	-		Accredited medical laboratories transitioned to the new ISO151892022	0.20	0.20	0.20	0.20	0.20	**NHLDS**
	% of laboratories providing 80% of	70%	80%	85%	90%	95%	95%		Mentorships and audits of hospital laboratories	0.80	0.80	0.80	0.80	0.80	**NHLDS**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	the defined test menu														
	# of policies, plans, and guidelines developed, approved & disseminated	100%	100%	100%	100%	100%	100%		Essential diagnostics list developed & disseminated	0.00	0.50	0.50	0.00	0.00	**NHLDS**
									Radiology and diagnostic imaging standards and guidelines reviewed / developed	0.00	0.10	0.10	0.00	0.20	**NHLDS**
									Expand infrastructure and Technologies at CPHL for provision of Integrated and Advanced Laboratory Services for Public Health Response, Specialized Clinical Care and Research	0.00	3.00	10.00	40.00	10.00	**HID/NHLDS**
									Procure 13 major pieces of equipment to functionalize the specialized Laboratories at CPHL		1.00	3.00	8.00	6.00	**HID/NHLDS**
									Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)	0.00	5.00	10.00	45.00	6.60	**HID/ NHLDS**
									Procure 8 pieces of Laboratory equipment for each of the Regional Six Regional Referreal Hospitals with improved infrastructure		0.00	4.00	7.00	2.00	**HID/ NHLDS**
									Improve capacity for RRHs and GHs for bacterial	0.50	0.50	0.50	0.50	0.50	**NHLDS**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									culture and drug susceptibility testing						
									Formulate and publish Health Region – specific antibiograms to guide antibiotic use	0.40	0.40	0.60	0.20	0.20	**NHLDS**
									Deploy Mobile Laboratories and X-rays in each of the four (4) tadeonal Regions to support disease outbreak investigations in the regions	0.30	0.30	0.30	0.30	0.30	**NHLDS**
									Perform disease outbreak simulation exercises in the regions at least once a quarter	0.25	0.25	0.25	0.25	0.25	**NHLDS**
									Implement Quality Management Systems for improved quality and accreditation of Laboratories and Imaging Services	0.80	0.80	0.80	0.80	0.80	**NHLDS**
									Expand the scope for local panel production of internationally accredited External Quality Assessment (EQA) schemes	0.50	0.50	0.50	0.50	0.50	**NHLDS**
									Increase the scope for equipment Calibration Centre to support equipment calibration and maintenance in the country	0.00	2.00	1.00	0.00	0.00	**NHLDS**
									Implement Biosafety and Biosecurity practices in all Laboratory and Imaging facilities	0.30	0.30	0.30	0.30	0.30	**NHLDS**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Integrate Laboratory information management system with the electronic medical records in all the health facilities where they exist (e-Afya, EMR, Clinic Master, etc)	1.50	2.00	1.00	0.50	0.50	**NHLDS**
									Consolidate Laboratory & Diagnostic for real time transmission into the national database	0.20	0.20	0.20	0.20	0.20	**NHLDS**
									Functionalize teleradiology services at all regional referral hospital and GH (internet and renumeration)	1.00	1.80	2.00	2.00	2.00	**NHLDS**
Strategic intervention 3.10: Nursing and midwifery practice strengthened	Ratio of Midwives to Total ANC Visits	890	832	774	716	658	600		Technical supervision and mentorship of nurses and midwives	0.36	0.36	0.36	0.36	0.36	**N&M**
	Ratio of Midwives to Total Deliveries	202	197	192	187	181	175		Standards and guidelines for nursing and midwifery practice developed	0.20	0.20	0.10	0.10	0.10	**N&M**
	Ratio of Nurses to Inpatients	304	298	292	284	278	272								
	Inpatient runaway rate	0.62%	0.50%	0.42%	0.36%	0.28%	0.20%								
Strategic Intervention 7: Improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative healthcare services.															
Strategic intervention 3.11: Emergency Medical Services and	Road traffic mortality rate (per 100,000 population)	29.4	27.7	26.2	24.7	23.3	22		Procure ambulances (15 per year)	14.80	14.80	14.80	14.80	14.80	**EMS**
	% of ambulance fleet that is functional	51%	56%	59%	63%	67%	71%		Construct and equip Regional Call and Dispatch Centers (5)	6.00	-	-	4.00	1.00	**HID/ EMS**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
the referral system improved	% of constituencies with a functional ambulance	52%	56%	60%	64%	68%	72%		Operation and maintenance of ambulances	4.00	4.40	4.84	5.32	5.86	**EMS**
	% of emergency cases that arrive at the hospital in an ambulance	7.4%	11%	15%	19%	23%	27%		Procure ambulances (incl aero medical ambulance, Type B ambulances & Equipment) under the EMS Acceleration Project	10.20	41.96	33.31	22.56	-	**EMS**
									Provide support to URCS	7.25	7.61	7.99	8.39	8.81	**EMS**
									Develop standards and guidelines for EMS & referral	0.10	0.05	0.05	-	-	**EMS**
									Training of EMS critical cadre (EMS Physicians, nurses, paramedics, aviation/marine, drivers)	3.00	3.00	3.00	3.00	3.00	**EMS**
Strategic intervention 3.12: Expand geographical access	Constituencies with a functional HC IV / Community Hospital	62%	65%	67%	70%	72%	75%		Establish/upgrade new Community Hospitals (13)	36.00	24.00	36.00	24.00	36.00	**HID/ CS**
	% of Sub counties/Divisions /TCs with a Public Health Facility (HC III and above)	75%	77%	79%	81%	83%	85%		Establish/upgrade new Health Centre IIIs (50)	60.00	60.00	60.00	60.00	60.00	**HID/ CS**
	National Paediatric Hospital constructed	0%					1		National Paediatric Hospital constructed				240.00		**HID/ CS**
	No. of Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)			2	2		2		Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)		18.50	18.50	-	18.50	**HID/ NPHLD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
the referral system improved	% of constituencies with a functional ambulance	52%	56%	60%	64%	68%	72%		Operation and maintenance of ambulances	4.00	4.40	4.84	5.32	5.86	**EMS**
	% of emergency cases that arrive at the hospital in an ambulance	7.4%	11%	15%	19%	23%	27%		Procure ambulances (incl aero medical ambulance, Type B ambulances & Equipment) under the EMS Acceleration Project	10.20	41.96	33.31	22.56	-	**EMS**
									Provide support to URCS	7.25	7.61	7.99	8.39	8.81	**EMS**
									Develop standards and guidelines for EMS & referral	0.10	0.05	0.05	-	-	**EMS**
									Training of EMS critical cadre (EMS Physicians, nurses, paramedics, aviation/marine, drivers)	3.00	3.00	3.00	3.00	3.00	**EMS**
Strategic intervention 3.12: Expand geographical access	Constituencies with a functional HC IV / Community Hospital	62%	65%	67%	70%	72%	75%		Establish/upgrade new Community Hospitals (13)	36.00	24.00	36.00	24.00	36.00	**HID/ CS**
	% of Sub counties/Divisions /TCs with a Public Health Facility (HC III and above)	75%	77%	79%	81%	83%	85%		Establish/upgrade new Health Centre IIIs (50)	60.00	60.00	60.00	60.00	60.00	**HID/ CS**
	National Paediatric Hospital constructed	0%					1		National Paediatric Hospital constructed				240.00		**HID/ CS**
	No. of Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)			2	2		2		Regional medical laboratories constructed and equipped (Jinja, Hoima, Soroti, Mubende, Masaka and Kabale)		18.50	18.50	-	18.50	**HID/ NPHLD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	No. of Regional anatomic pathology laboratories constructed and equipped (16)			4	4	4	4		Regional anatomic pathology laboratories constructed and equipped (16)		1.20	1.20	1.20	1.20	**HID/ NPHLD**
	No. of GHs constructed				1		1		Construct and equip general hospitals in Kampala Metropolitan Area (2)	-	120.00	120.00	-	-	**HID/ CS**
	No. of general hospitals upgrades to RRHs (Kapchorwa, Tororo)			1			1		Upgrade General Hospitals to RRHs (2 GHs)		480.00				**HID/ CS**
Strategic intervention 3.13: Increase availability of affordable essential medicines and health supplies including promoting local production of medicines. (including complement ary medicine)	Availability of the basket of tracer commodities (50) at Central Warehouses (%)	80%	90%	90%	95%	95%	95%		Procure and distribute EMHS to PNFPs through JMS	23.30	23.30	23.30	23.30	23.30	**PNM**
	% of health facilities with 95% availability of the 50 basket of EMHS	NA	22%	31%	44%	63%	90%		Conduct regular facility assessment for medicines and health supplies management (SPARS)	0.80	0.80	0.80	0.80	0.80	**PNM**
	Availability of the tracer public health emergency commodities - examination gloves, coveralls, surgical masks, 70% alcohol, vacutainer tubes, IV Ringer's lactate, sodium hypochlorite & aprons) (%)	NA	80%	85%	85%	85%	90%		Capacity building for medicines management (Prescription, AMR, surveillance)	0.80	0.80	0.80	0.80	0.80	**PNM**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	% of health facilities with a SPARS (Supervision, Performance, Assessment, Recognition, Strategy) score of 75% and above (%)	40%	55%	75%	85%	95%	95%		Operation and maintenance of Regional Incinerators - (Proper management and disposal of pharmaceutical and medical waste)	10.00	10.00	10.00	10.00	10.00	**PNM**
	% of health facilities (Hospitals, HC IVs & IIIs) with functional Logistics Management Information System	43%	50%	55%	57%	60%	65%								
Strategic intervention 3.14: Increase availability of safe blood and blood products	Blood collection rate - (%)	74%	80%	84%	85%	86%	88%		Construct and equip five regional blood banks	7.00	7.00	7.00	7.00	7.00	**CS, HID**
	% availability of safe blood and blood products at health facilities	80%	85%	85%	88%	88%	90%								
Programme Objective 1: To improve the foundation of human capital development															
Programme Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.															
Goal: To improve the overall health and wellbeing of all Ugandans by 2030															
Vote Objective 4: To promote optimal maternal, neonatal, infant, child, adolescent and older persons' health including increased access to improved health services and assistive technologies at all levels.															
Intermediate Outcome 3.1.1: Improved utilization of health services	Under 5-year Inpatient Admission rate for Malnutrition conditions	8%	7%	6%	5%	4%	3%								
	ANC 4th Visit Coverage (%)	54%	56%	58%	60%	62%	64%								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	Deliveries in health facilities (%)	67%	69%	70%	72%	73%	75%								
Strategic Intervention 5: Promote optimal Maternal, Infant, Young child, Adolescent and Elderly Nutrition Practices															
Strategic intervention 4.1: Malnutrition rehabilitation services strengthened	Number of Health workers trained in dietary diversification (Number)	NA	200	200	250	250	300		Train Health workers on maternal, infant, young child, adolescent and elderly nutrition package	0.40	0.60	0.80	1.00	1.20	**CHD**
									Orient Health Workers in micronutrient supplementation	0.20	0.20	0.20	0.20	0.20	**CHD**
									Nutrition health facility assessments conducted	0.05	0.05	0.06	0.07	0.08	**CHD**
									Scale up malnutrition rehabilitation services at all levels of service delivery	1.00	1.00	1.00	1.00	1.00	**CHD**
									Conduct Indicator survey on nutrition biomarkers	1.50	1.50	1.50	1.50	1.50	**CHD**
Strategic intervention 4.2: Enabling environment for scaling up nutrition at all levels strengthened	% of OPD attendance (Under 5) who are assessed for nutritional status	23%	27%	31%	35%	39%	43%		Scale up nutrition intervention across the country	1.00	1.00	1.00	1.00	1.00	**CHD**
	% of Health facilities designated as mother-baby friendly (Hospitals, HC IVs and IIIs)	2%	5%	8%	11%	14%	17%		Accredit health facilities as mother-baby friendly	0.05	0.05	0.05	0.05	0.05	**RCH**
	Food fortification Policy Direction reviewed/ developed (The national industrial food fortification strategy 2017-2022)		0	0	1	0	0		Review the food fortification strategy	-	0.30	0.40	-	-	**CHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Develop Nutrition regulations, guidelines and SOPs.	0.05	0.10	0.05	0.05	0.05	**CHD**
									Develop and implement a cost-effective school feeding programme linked to PDM and the local economy	0.50	0.10	0.10	0.10	0.10	**CHD**
Strategic Intervention 4: Improve maternal, neonatal, child and adolescent health services at all levels of care															
Strategic intervention 4.3: Investments in maternal and Newborn health services at all levels of care increased	Institutional/Facility Maternal Mortality Risk per 100,000 deliveries	82.6	78.1	73.6	69.1	64.6	60		Revise & disseminate the RMNCAH sharpened plan, Family Planning Costed Implementation Plan & Guidelines	-	0.30	0.10	0.10	0.10	**RCH**
	% of HC IVs that are fully functional (Offering blood Transfusion and Caesarean Section)	60%	64%	69%	74%	80%	85%		Train and mentor staff at Community Hospitals to provide quality CEmONC services	2.00	2.00	2.00	2.00	2.00	**RCH**
	% of maternal deaths notified	95.0%	96%	97%	98%	99%	100%		Conduct Maternal deaths surveillance	0.50	0.50	0.50	0.50	0.50	**RCH**
	% of maternal deaths reviewed	94.8%	96%	97%	98%	99%	100%		Roll out Emergency Triage Assessment and Treatment (ETAT) in 10 regions	0.10	0.10	0.10	0.10	0.10	
	% of Regional with functional RMNCAH accountability and coordination structures.	62%	68%	75%	81%	87%	100%		Functionalise the Regional RMNCAH accountability and coordination structures	0.40	0.40	0.40	0.40	0.40	**RCH**
	% of 1st ANC attendance in 1st trimester	35.0%	39.0%	43.0%	47.0%	51.0%	55.0%		Supervision and mentorship of health workers for delivery of quality maternal & child health services	1.00	1.00	1.00	1.00	1.00	**RCH**
									Support provision of FP commodities	1.80	1.89	1.98	2.08	2.19	**RCH**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic intervention 4.4: Access to quality Child Health services improved	% of Districts with Health Workers trained and mentored in ETAT – (Emergency Triage Assessment and treatment) / IMNCI packages	40%	47%	54%	61%	68%	75%		Train and mentor health workers on provision of quality child survivor and thrival packages	0.30	0.50	0.50	0.50	0.50	**RCH**
	% of districts implementing ICCM interventions	48%	50%	57%	58%	65%	72%								
Strategic intervention 4.5: Invest in appropriate neonatal care services at all levels	Institutional perinatal mortality rate per 1,000 births	17.8	16.5	15.2	14.1	13	12		Develop guidelines and SOPs for neonatal care	0.30	0.20	0.20	0.00	1.00	**RCH**
	% of Perinatal death notified	61.2%	69%	77%	85%	92%	100%		Perinatal death surveillance and review	0.10	0.10	0.10	0.10	0.10	**RCH**
	% of perinatal deaths reviewed	61.3%	66%	75%	82%	90%	100%		Construct and equip Neonatal intensive care units in RRHs	30.00	30.00	30.00	30.00	30.00	**RCH/HID**
	% of NRHs & RRHs with functional Neonatal Intensive care units (NICUs)	10%	20%	40%	60%	80%	100%		Construct and equip Level II newborn care units in General Hospitals	5.00	10.00	10.00	2.00	2.00	**HID**
	% of General hospitals & HCIVs with functional Level II newborn care units	0%	33%	38%	44%	52%	60%								
	Number of Health workers given specialized training in Neonatology at Regional and LG level	5	8	11	14	17	20								

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Strategic intervention 4.6: Increase access to Sexual and Reproductive Health (SRH) information and services	Couple years of protection	4,403,934	4,883,147	5,362,360	5,841,574	6,320,787	6,800,000		Support supervision on Sexual and Reproductive Health (SRH) information and services	0.60	0.60	0.60	0.60	0.60	**RH**
Strategic Intervention 13: Promote delivery of disability friendly health services including physical accessibility and appropriate equipment															
Strategic intervention 4.7: Disability friendly health services including physical accessibility and appropriate equipment promoted	% of RRHs with assistive devices technology workshops	20%	30%	40%	50%	60%	70%		Construct & equip regional assistive devices technology workshops	2.50	2.50	2.50	2.50	2.50	**CHD**
	% of general hospitals with functional Rehabilitation Care units	25%	30%	45%	60%	70%	80%		Set up of rehabilitation units in 16 district hospitals	1.50	1.50	1.50	1.50	1.50	**CHD**
	Number of Assistive devices distributed	NA	1,500	1,530	1,560	1,590	1,620		Procurement and distribution of disability inclusive medical equipment, devices and raw materials	2.50	0.00	0.00	2.50	0.00	**CHD**
	% of Hospitals with functional delivery beds for PWDs	2%	4%	8%	12%	16%	20%		Procure and distribute assistive devices	3.25	0.00	0.00	3.25	0.00	**CHD**
	Per capita OPD attendance for rehabilitative services	2%	3%	4%	5%	6%	7%		Procure and distribute delivery beds for PWDs	0.10	0.10	0.10	0.10	0.10	**CHD**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
	Number of PWDs provided with assistive and rehabilitative devices aggregated by age, gender, nationality and refugee status	202	100	120	150	180	220		Conduct awareness campaigns on disability prevention and rehabilitation services	0.10	0.10	0.10	0.10	0.10	**CHD**
	% Inclusive Equipment and raw materials Resources Provision	1%	3%	5%	8%	10%	15%		Specialist training of rehabilitation health professionals	2.00	1.50	2.00	1.50	1.00	**CHD**
	Number of rehabilitation health professionals trained on specialized rehabilitation health services	25	75	125	175	225	275		Access remodelling of available infrastructure to improve access for PWDs	3.00	3.00	3.00	3.00	3.00	**CHD/HID**
	%of Hospitals and Health Centre IVs that have undergone remodelling and/or have access for PWDs	0.25	0.33	0.41	0.49	0.57	0.65		Train/orient Health Workers on the basic rehabilitation service package	0.30	0.30	0.30	0.30	0.30	**CHD**
	Number of PHC and community health workers trained on basic rehabilitation service package.	300	600	900	1200	1500	1800								
Programme Objective 3: To improve population health, safety and management; Access to safe water sanitation and hygiene services.															
Goal: To improve the overall health and wellbeing of all Ugandans by 2030															

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
Vote Objective 5: To strengthen health research, innovation, technology, and information uptake in healthcare, complementary medicines, and emerging health threats.															
Strategic intervention 5.1: Promote digitalization of the health information system	% of hospitals and HC IVs with functional Electronic Medical Record System	15%	27%	39%	51%	63%	75%		Expand and maintain the rollout of Electronic Medical Record Systems at GHs	6.32	9.13	11.93	14.74	17.55	**HISM&E**
	% of LGs with functional Electronic Community Health Information System	15%	30%	45%	60%	75%	90%		Expand and maintain the rollout of Electronic Medical Record Systems at HCIV	5.40	2.40	2.40	2.40	2.40	**HISM&E**
	No. of Health workers trained in EMRS		12,000	12,000	12,000	12,000	12,000		Expand and maintain the rollout of Electronic Medical Record Systems at HCIII	6.00	12.00	18.00	24.00	30.00	**HISM&E**
	No. of CHWs trained in eCHIS		10,000	10,000	10,000	10,000	10,000		Expand and maintain the rollout of Electronic Community Health Systems at facility level	3.80	5.70	7.60	9.50	11.39	**HISM&E**
	No. of health workers trained in telemedicine application		0	50	100	150	250		Development of online self-paced learning platforms		1.00	1.00	1.00	1.00	**HISM&E**
	Electronic Document Management Information System (EDMIS) rolled out at MoH			1					Capacity building for health workers in utilization of the Electronic Medical Record Systems	10.32	10.32	10.32	10.32	10.32	**HISM&E**
									Capacity building for community health workers on eCHIS	2.70	2.70	2.70	2.70	2.70	**HISM&E**
									Capacity buidling of health workers in telemedicine application	0.20	0.20	0.20	0.20	0.20	**HISM&E**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
									Review & disseminate the Health Information and Digital Health Strategy, guidelines & SOPs	0.40	0.25				**HISM&E**
Strategic intervention 5.2: Health facilities geodatabases Developed and updated	Comprehensive health facilities geospatial attribute data framework developed	0	1						Update health facilities geospatial attribute data framework and facilities databases	0.30			0.30		**HISM&E**
									Develop integrated health facilities geodatabases		0.05	0.05			**HISM&E**
									Conduct capacity building trainings on geodatabase management		0.10	0.10	0.10		**HISM&E**
Strategic intervention 5.3: Strengthen routine Health Management Information Systems	Health facility Reporting rate	90%	91%	92%	93%	94%	95%		Print and Distribute HMIS tools for non-digitized health facilities	4.50	4.28	4.06	3.86	3.67	**HISM&E**
	Community health worker reporting rate	70%	75%	80%	85%	87%	80%		Undertake data cleaning, verification, supervision and mentorship	0.50	0.50	0.50	0.50	0.50	**HISM&E**
	% of lower-level non-digitized public facilities reporting no stock outs of HMIS tools	60%	60%	60%	60%	60%	60%		Undertake data quality assessment and audits	0.20	0.20	0.20	0.20	0.20	**HISM&E**
Strategic Intervention 12: Promote health research, innovation and technology uptake including improvement of traditional medicines.															
Strategic intervention 5.4: Health	Number of Research Papers published in peer reviewed journals		10	10	10	10	10		Develop, review and disseminate the National Health Research Strategy	0.10	0.10	0.10	0.10	0.10	**HISM&E**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
research strengthened									and Health Technology Assessment Strategy						
	Number of traditional medicines analysed		10	10	10	10	10		Develop and disseminate traditional medicines list	0.10	0.10	0.10	0.10	0.10	**HISM&E**
	MoH Research Agenda developed and disseminated		1	Dissem inated					Develop the Health Research Agenda	0.10	0.10				**HISM&E**
	No. of evidence-based priority setting guidelines developed.			1					Develop the framework and guidelines for evidence-based priority setting and policy making for the health sector	0.30	0.10	0.05	0.05	0.05	**HISM&E**
									Conduct Health economic evaluations for evidence-based priority setting	0.30	0.10	0.05	0.05	0.05	**HISM&E**
									Organise annual National Health Research conference	0.20	0.20	0.20	0.20	0.20	**HISM&E**
Strategic intervention 5.5: Health innovations and technology uptake promoted	% national health programs and interventions explicitly informed by research evidence from health research institutions		40%	50%	65%	75%	80%		Health innovations fund for middle career researchers	0.00	0.50	0.50	0.50	0.50	**HISM&E**
	No of Current and New medical technologies, programs and interventions assessed		10	10	10	10	10		Organise annual National Health Innovations conference	0.20	0.20	0.20	0.20	0.20	**HISM&E**
	Health Innovations Strategy developed and disseminated			Strateg y	Disse minat ed				Health Innovations Strategy developed/reviewed & disseminated		0.30	0.20	0.00	0.00	**HISM&E**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
				developed											
	Health Technology Assessments framework developed				HTA Framework developed				Develop the framework for Health Technology Assessments		0.40	0.00	0.00		**HISM&E**
									Conduct Health Technology Assessments			0.20	0.20	0.20	**HISM&E**
									Develop evidence-based policy briefs on health innovations, programs and interventions		0.05	0.05	0.05	0.05	**HISM&E**
Strategic intervention 14: Strengthen population planning and development along the life cycle approach including civil registration, vital statistics and national population data bank															
Strategic intervention 5.6: Birth and death registration scaled up	% of health facility births notified in DHIS2 and registered by NIRA	0%	10%	20%	30%	40%	50%		Conduct health facility all-cause mortality audits	0.10	0.10	0.10	0.10	0.10	**CS**
	% of health facility deaths notified in DHIS2 and registered by NIRA	15%	25%	35%	45%	50%	50%		Deploy Medical Certification of cause of death for all health facility deaths	0.15	0.15	0.15	0.15	0.15	**HISM&E**
	% of community deaths notified in the population data bank	0%	10%	20%	30%	40%	50%		Modification of EMR to Integrate MCCD form in all health facilities		0.10				**HISM&E**
	% of community births notified in the population data bank	0%	10%	20%	30%	40%	50%								
Strategic Intervention 3: Undertake monitoring, and reporting of progress for HCD Programme during plan implementation															
Strategic intervention	Statistical reports prepared	4	4	4	4	4	1		Produce statistical abstracts	0.1	0.1	0.1	0.1	0.1	**HISM&E**

Result	Development Indicators	Baseline 23/24	Target 25/26	Target 26/27	Target 27/28	Target 28/29	Target 29/30		Actions	Budget 25/26	Budget 26/27	Budget 27/28	Budget 28/29	Budget 29/30	Responsible Department
5.7: Monitoring, evaluation, and reporting strengthened	Report on implementation status of Cabinet decisions/ directives and Sectoral public policies in health monitored and evaluated produced.	4	4	4	4	4	4		Compile and submit MOH performance reports	0.20	0.20	0.20	0.20	0.20	**HISM&E**
	% of health facilities submitting HMIS reports.	55%	65%	70%	75%	80%	85%		Produce project monitoring and evaluation reports	0.20	0.20	0.20	0.20	0.20	**HISM&E**
	% of Private Health facilities submitting HMIS reports	30%	35%	40%	45%	50%	55%		Organise and hold annual joint reviews at national and subnational level under Health	0.80	0.80	0.80	0.80	0.80	**HISM&E**
	MoH Data warehouse (DHIS2) functional	1	1	1	1	1	1		Organise and hold quarterly review meetings at national and subnational level under Health	0.10	0.10	0.10	0.10	0.10	**HISM&E**
	Annual Joint Reviews organised	1	1	1	1	1	1		Prepare & disseminate M&E Plan for MOH Strategic Plan	0.30					**HISM&E**
	Quarterly Performance Reviews organised	4	4	4	4	4	4		Undertake MOH SP Mid-term and End-term evaluations	0.20			0.20		**HISM&E**
Strategic intervention 5.8: Improve performance management monitoring and reporting.	% of specialists whose performance outputs are tracked		20%	32%	45%	60%	70%		Rollout performance management tools to all health workers (Dashboards, digital timesheets, HCMS)	0.30	0.30	0.30	0.30	0.30	**HISM&E**
	% of health workers using the HCMS for performance management		30%	50%	65%	80%	100%								
Total Cost										**2,427.09**	**3,148.37**	**4,166.09**	**3,749.56**	**3,447.88**	

ANNEX 11: DETAILED PROJECT PROFILES

1. Karamoja Infrastructure Development Project (KIDP) Phase II

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Karamoja Infrastructure Development Project (KIDP) Phase II**
Project Code	1539
Project Duration	7 Years (2022/21 – 2026/27)
Estimated Cost (bn)	Euros 10 million (Soft Loan) and Shs 2.46 bn (GoU counterpart)
Officer Responsible	PS
Date of Submission	21st Jan, 2019
Section 1: Project Background	
1.1 Situational Analysis	The recent Uganda National Household Survey estimates poverty levels in the Karamoja Region at 60.8%, the highest in Uganda. The Italian Government has supported investments in the Karamoja Region over the last 10 years, including infrastructure expansion of hospitals and health centres, equipping of health facilities, supporting human resources for health training, introduction of innovative mobile health services for migratory populations in the Karamoja Region, seconding of Italian health experts to support the Ministry of Health and frontline health facilities, and supporting the supply chain by investing in Joint Medical Stores. A project to construct 68 staff housing units at selected health centre IIIs in the Region is currently under implementation using a Euros 4,200,000 Grant from Italy to the GOU. However, sub-optimal health system functionality and service delivery is still observed in the eight districts of the Karamoja Region, despite these investments. Key causes continue to be lack of adequate staff accommodation (gap of 145 units), inadequate maternal and child health infrastructure, sub-optimal referral system, and inadequate human resource availability at facilities. All these contribute to reduced access, especially for mothers and children.
1.2 Problem Statement	Despite significant support from the Government and several Implementing partners in the region, Karamoja is still lagging behind in terms of Health Services delivery as reported in the Annual Health Sector Performance Report FY 2017/18. Over the last 3 years, the region has had at least 3 Districts appearing in the last 10 districts in performance. Though Amudat District was ranked as the most improved district in the FY 2017/18, it was still ranked a dismal 121st out of 122 districts in the Country. The biggest bottlenecks being the indicator for PCV3 and ANC4. Further reference can be made to reports from the Infrastructure Department which state that the health infrastructure in the region is dilapidated and needs replacement and refurbishment. 68 units of staff houses have been constructed under phase I of this project. Following consultation with the Key stakeholders in the region, Phase II of the project intends to further invest in; mobilization of the communities to create demand for services, construction of service delivery structures

1.3 Relevance of the Project Idea	Data collected during implementation of the current Karamoja Staff Housing Project (phase I) has revealed that the 68 staff houses at selected HC IIIs will not optimally close the wider staff housing gap unless more is invested at other facilities. The data in the DHIS2 from Karamoja still shows sub-optimal access, equity, and in maternal and child health morbidity and mortality indicators. Lack of staff housing has resulted in failure to attract and retain staff at HC IIIs .In addition, it was found that the maternity units at the HC IIIs and IVs are not adequate to handle the numbers of mothers that seek maternity care at the facilities, referral mechanisms are still very poor, and facilities are in need of repair and expansion to handle growing demand. The investments would enhance access, coverage and equity in one of the most underserved regions of the country with health services
1.4 Stakeholders	Direct beneficiaries/ patients, health workers, local leadership, indirect beneficiaries and project affected persons
Section 2: Project Framework	
2.1 Project Goal	To accelerate the progress towards Universal Health Coverage (UHC) through the delivery of essential health services in Uganda
2.2 Project Outcomes	1. The broad objective of the Project is to improve health service coverage and access in the Karamoja region. 2. Improved public health awareness in the Karamoja region, creating demand for Health Services.
2.3 Proposed Project Interventions	1. Close infrastructure gaps in selected hospitals and health centres 2. Re-tooling for public health mobilization and promotion

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life.	%of sub counties with functional HC IIIs	DHIS 2	65%	90%	Availability of funds and staff
Outcomes Improve health service coverage and access in the Karamoja region.	% Access to healthcare in Karamoja	World Bank/UN/ EPRC	30%	75%	Availability of funds and staff

Improved public health awareness in the Karamoja region, creating demand for Health Services	Maternal mortality ratio	DHIS 2	588/100,000	200/100,000	Availability of funds and staff
Project Interventions/Outputs					
Designs and BOQs done					
Hospitals and health centres constructed/rehabilitated	%completion rate	Project reports PBS	20%	100%	Availability of funds and staff
Public health tools procured and distributed	Number of tools procured	Project reports	150	400	Availability of funds and staff
Monitoring and supervision	Number of project reports	PBS Reports	2	4	Availability of funds and staff

Section 3: Estimated Project Cost (bn)

Activity Plan	**FY 2025/26**	**FY 2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**Total cost**
Preparation of designs and BOQs and customization to the Karamoja Geology, Conduction of the Environmental Impact Assessment & Full feasibility analysis. Construction supervision	0.3					0.3
Procurement of Contractors	0.4					0.4
Construction of facility infrastructure at hospitals and health centres	17.5	13.18				30.68
Purchase of ambulance for Matany Hospital, 8 community mobilization and education vehicles and 16 motorcycles and 8 PA systems	4.32	2.45				6.77
Management, monitoring and supervision of works by MOH and MOFPED	0.9	0.8				1.7
Procurement of 4 vehicles for clerks of works	1.8					1.8
Sub – Total						
VAT (increase by 18%)						
TOTAL COST	**25.12**	**16.43**				**41.55**

2. Rehabilitation, Construction & Equipping of General Hospitals in Uganda (Phase II)

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Rehabilitation, Construction & Equipping of General Hospitals in Uganda**
Project Code	
Project Duration	7 Years
Estimated Cost (bn)	Ugx.1,632,332,426,379
Officer Responsible	PS
Date of Submission	2025
Section 1: Project Background	
1.1 Situational Analysis	The existing General Hospitals that need rehabilitation and expansion are in four Categories. - Category 1: Built in the 1930s consisting of hospitals whose buildings were originally Dispensaries not intended to be hospitals and were progressively upgraded. - Category 2: Built around 1969 (Commonly known as Phase 1): Comprise non-storied buildings spread. - Category 3; Built between 1970 – 71 (Commonly known as Phase 2): Comprise storied buildings built after 1970. - Category 4: These are 9 in number, built after 1998. Given the age of the hospitals in categories 1 to 3, these hospitals need remodelling of the existing buildings and provision of new extensions to match the current, policies, practices and technologies which were adopted in the new national standard designs for Health Facilities, 2012. This needs to be done together with the general renovations to the existing buildings Over the years, the government of Uganda together with partner support has undertaken on rehabilitating and equipping of some general hospitals in different regions of Uganda (e.g. Kawolo, Busolwe, Kayunga, Yumbe etc.) to enable them to deliver GH services and cope with the increasing population and high disease burden in the country. There are 52 government-owned general hospitals that all require rehabilitation and renovation to serve the population at that level of care since most of them were constructed in the early 30s, 70s, 80s, and 90s, whose infrastructure has since been dilapidating and non-functional.

	This intervention will reduce the financial burden of health expenditure from the bigger part of the population by building capacity for the General Hospitals to handle all cases at their level of care and provide better medical services; since the services largely demanded cannot be offered by lower-level health facilities (HCII, HCIII, HCIV). This will improve service delivery, and emergency and deliver a functioning referral system at large. The General Hospitals ought to provide advanced care services in outpatient, inpatient, blood transfusion, radiology, comprehensive maternal & child health services, emergency, surgical procedures etc. Therefore, infrastructure and equipment are needed to meet these targets because the buildings housing the hospitals (patients, staff and equipment) have degenerated over the years. In order to meet the health goals of Uganda, which include but not limited to achieving UHC 2030, Vision 2040, SDGs, NDPIV, National Health Insurance etc., improvement in the Infrastructure, Equipment, HRH (Human Resources for Health), medicines, vaccines, quality of service, Private Public Partnerships of Health (PPPs), community health, PHC, Better health systems (strengthening, M&E, Financing and information management) is paramount. Therefore, the project will entirely look at how to improve the quality of health services and increase access to secondary health care services through the Rehabilitation, Expansion by construction of new buildings and equipping of the selected General Hospitals in Uganda.
1.2 Problem Statement	The hospitals to be rehabilitated under the proposed project which were built and completed between 1930s-1990s have not had any major rehabilitation in the years of their useful life. Although some of the buildings are structurally sound concrete masonry structures, they need major renovations with some remodelling/expansion for improved service delivery to include specialist clinics to match current policies and standards. For the Hospitals done in the 1930s like Masindi and Kitgum where all the buildings are to be demolished. The existing buildings are generally characterized with the following: - Severe roof leakages - Broken door shutters and glazing in windows - dilapidated plumbing fittings and system - Collapsed Water supply and Sewage Systems - Insufficient ward space and complete lack of isolation wards.

	- Inadequate space for Outpatient Departments and complete lack of suitable accident and emergency unit - Inadequate operation theatres - Dilapidated access Roads and walkways. - Inadequate staff accommodation - Lack of space for specialist clinics - The mains power supply system is very old and obsolete with exposed terminals and loose cables and requires complete overhaul, all the wiring system and lighting fittings are in a very sorry state with many fittings missing and the existing ICT services are completely broken down. - Obsolete and inadequate equipment for diagnosis This is a major problem to service delivery coupled with other factors unique to Uganda as a country to deliver quality health services to the ever-increasing population. Uganda has a high disease burden caused by but not limited to; Changes of climate patterns causing frequent floods, droughts, landslides, tropical storms, poor agricultural production and management, etc. This has led to the transmission of waterborne diseases, poor nutrition, shortages of food, breeding ground for mosquitoes, other socio-environmental effects, and economic constraints to access and afford private health care. Urbanization has also led to congestion, poor air quality caused by pollution (air & water), high prevalence of NCDs, infectious diseases like STDs & STIs, Addiction, Mental health, Domestic violence, processed & fast foods containing high sugar and salt; all brought about by the lifestyle led in these centres. Uganda is also prone to global crises and epidemics because of the increased influx of refugees, porous borders e.g., Congo where several Ebola outbreaks have originated and other ecological factors contributing to the spread of viral fevers like Marburg, Crimean Congo Haemorrhagic Fever (CCHF), Measles & Rubella, yellow fever, zoonotic diseases, etc. Poor drug management has also led to increased anti-microbial and multi-drug resistance especially antibiotics used to treat infections, TB, pneumonia, etc. affecting mostly children and HIV/AIDs patients. Lack of theatres, equipment, including blood banks, wards and poor infrastructure are the major causes of poor functionality of GHs in Uganda. Infrastructure development and equipment placement is inadequately collaborated with utilities and staffing resulting in poorly utilized equipment and compromised ability of GHs to use modern equipment.

	These factors have led to increased numbers seeking medical services at the specialist or GH level requiring infrastructure upgrades like renovation, rehabilitation, equipping, construction, and functionalization of medical and non-medical units e.g. Staff housing, Emergency units, Neonatal Intensive Care Units (NICUs), theatres, specialist clinics, Radiology services and efficient medical equipment, Electronic Medical Records (EMR) etc. in all General Hospitals. Most Hospitals are unable to meet minimum standards of care at their level due to the dilapidated state of medical buildings and staff houses and obsolete equipment resulting in a high case fatality rate. Therefore, they need to be rehabilitated to enable them to meet the minimum standards of care and deliver services at general hospital level.
1.3 Relevance of the Project Idea	The refurbishment and equipping of selected Hospitals across the country is a critical intervention in the improving access to quality healthcare services and strengthening the referral system of the country. This project seeks to refurbish, expand and equip 16 selected General Hospitals, thereby contributing to the overall improvement of the healthcare system
1.4 Stakeholders	**Direct Beneficiaries** General Population – Improved quality of services Health workers – Improved working conditions **Indirect Beneficiary/Government** Employment opportunities for the public **Project affected persons** Health workers Development Partners
Section 2: Project Framework	
2.1 Project Goal	Improve Hospital Outcomes for the selected General hospitals
2.2 Project Outcomes	Increased utilization of hospital services by 20% by 2033 Improved outcomes for maternal and child health services by 20% by 2033
2.3 Proposed Project Interventions	1. Renovation and equipping of 16 General Hospitals (Abim, Apac, Atutur, Itojo, Bundibugyo, Kagadi, Kitagata, Kitgum, Pallisa, Kitagata, Masindi, Tororo, Bududa, Gombe, Kambuga and Kapchorwa) 2. Procure, Distribute and install new Medical Equipment 3. User Training 4. Project management, Supervision and Monitoring
2.5 Results Matrix	

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal: Contribute to improved health outcomes in the different Sub regions of the Project by 20%	Improved performance ranking of the hospitals on the National League Table	Annual Health Sector Performance Report (AHSPR)	48%	68%	Availability of funds for the implementation of the project
Outcomes 1: Increased utilization of hospital services by 30% by 2033	General Hospital Performance against APGS and DRGS	MoH - HIMS	36%	66%	Availability of funds for the implementation of the project Wage for staff not provided
Outcomes 2: Improved outcomes for maternal mortality by 10% by 2033	Maternal mortality rate (number of maternal deaths/100,000 live births)	MoH - HIMS	189/ 100,000 live births	168/ 100,000 live births	Availability of funds for the implementation of the project
Project Interventions/Outputs					
Renovation and equipping of 16 General Hospitals (Abim, Apac, Atutur, Itojo, Bundibugyo, Kagadi, Kitagata, Kitgum, Pallisa, Kitagata, Masindi, Bududa, Gombe,	% Completion rate	Project Reports	0%	100%	Availability of funds and staff

Tororo, Kambuga and Kapchorwa)					
Procure, Distribute and install new Medical Equipment	% medical equipment procured and installed	Project Reports	0	100%	Availability of funds
Staff and User Training	Number of persons trained	Project Reports	0	24	Availability of funds
Project management, Supervision and Monitoring	Number of project reports produced	Project Reports	0	24	Availability of funds

Section 3: Estimated Project Cost (bn)

Activity Plan/Outputs	**FY 2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**FY 2030/31**	**FY 2031/32**	**FY 2032/33**	**Total cost**
Rehabilitation, Remodelling, and Construction of new non-residential and residential buildings	60,651	303,254	121,302	181,953	303,254	121,302	121,302	1,213,018
Procure and install medical equipment	15,724	78,622	31,449	47,173	78,622	31,449	31,449	314,488
Carry out user training	749	3,744	1,497	2,246	3,744	1,498	1,498	14,976
Carry out project supervision, monitoring and evaluation	4,493	22,463	8,985	13,478	22,463	8,985	8,985	89,852
TOTAL COST	**81,617**	**408,083**	**163,233**	**244,850**	**408,083**	**163,234**	**163,234**	**1,632,334**

3. Emergency Medical Services Acceleration Project

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Emergency Medical Services Acceleration Project**
Project Code	
Project Duration	5 Years
Estimated Cost (bn)	76.84bn
Officer Responsible	PS
Date of Submission	August 2024
Section 1: Project Background	
1.1 Situational Analysis	The burden of emergency diseases and conditions vary based on the socio-economic status of the country where high income countries report more emergencies due to non-communicable diseases and injuries while the emergency disease burden in low - and middle -income countries (LMICs) like Uganda, which faces significant challenges dealing with emergency conditions with eight (8) out of the top ten (10) causes of mortality presenting as such. Malaria is the leading cause of mortality accounting for 10.9%, followed by pneumonia 6.4%, and other neonatal conditions There are maternal and perinatal emergency conditions and road traffic crashes (RTCs) which are a leading cause of death among young people aged 15–29 years and are estimated to be the 8th leading cause of death across all age groups globally. During the last decade, road crash fatalities averaged slightly more than 10 fatalities per day and there was a 13.5% increase in fatalities from 3,663 in 2020 to 4,159 in 2021, showing a worsening road safety situation in the country.
1.2 Problem Statement	The MOH Emergency Medical Services Department was set up to develop and oversee emergency health services across the country to avert mortality and morbidity arising out of preventable injuries and illnesses. Majority of these are time-sensitive, implying that a lot of lives could be saved if structures and resources are in place to respond in a timely manner. However, the EMS department is currently challenged with the non-existent at-scene emergency care system; ineffective emergency medical transportation systems; non-functioning emergency departments/units in receiving Hospitals and Health center IVs; and low capacity for facility-based emergency care Some emergency units and many of the ambulance vehicles lack the basic equipment and medicines required to monitor and treat emergency medical and surgical conditions.

1.3 Relevance of the Project Idea	The need for a well-structured, functional and responsive Emergency care system in Uganda has never been more glaring before than during the last 3 years when the country and world at large experienced COVID-19 pandemic. Since then, the country had been experiencing major incidents like road traffic crashes, famine and landslides alongside other public health emergency outbreaks, aggravated recently by the Sudan Ebola virus Outbreak of 2022. EMS alongside other departments provided the much-needed interventions to save lives during COVID-19 and Ebola public health emergencies. EMS infrastructure is needed to provide routine emergency services (Obstetric, surgical, NCDs, injuries and mental health) which are characterized by increased mortality, complications, and disability
1.4 Stakeholders	Direct Beneficiaries- Population at large, Community actors, Healthcare system at various levels (Community, health facility, District Health Officers and National level), Political leader, Civil society organizations, Health workers, Community leaders
Section 2: Project Framework	
2.1 Project Goal	To achieve a 10% reduction in mortality associated with emergency medical conditions by 2030
2.2 Project Outcomes	Reduced mortality in the Emergency Unit from 30% to 25% by 2027 Improved access to ambulance care services
2.3 Proposed Project Interventions	1. Undertake EMS ALS and aeromedical management training for 10 working days and 10 trainees. 2. Conduct emergency responder training in two sessions of 5 days. 3. Support EMT training in three sessions for 5 days each. 4. Follow up and continuous capacity development for 5 days every six months for two years.

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To achieve a 10% reduction in mortality associated with emergency medical conditions by 2030	Proportion of deaths due to emergency medical conditions	DHIS2	9.5%	8.5%	Availability of funds and staff
Outcomes Reduced mortality in the Emergency Unit from 30% to 25% by 2027	Proportion of deaths in the emergency unit	DHIS2	30%	25%	Availability of funds and capacity

Improved access to ambulance care services	Proportion of patients arriving at health facilities using an ambulance		11%	22%	
Project Interventions/Outputs					
1 Aeromedical and 12 road ambulances procured	Number of aeromedical and road ambulance procured	Project Reports	0	13	Availability of funds and capacity
Essential medical equipment for health facilities procured		Project Reports			Availability of funds and capacity
Emergency training and Know-how transfer program	Number of trainees	Project Reports	10	150	Availability of funds and capacity
Program Management, M&E and Financial Engineering	Number of project reports	PBS	0	12	Availability of funds and capacity

Section 3: Estimated Project Cost (bn)

Activity Plan	**FY 2025/26**	**FY 2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**Total cost**
Procure 1 EMS equipped Airbus H130 Helicopter and 12 ALS road ambulances		16.04	16.04			32.08
Undertake EMS management training in Paris – 1 program of 5 stages		0.75	0.76	0.76		2.27

Program Management and Financial Engineering including 10% contingencies		5.31	3.28	0.81		9.4
implement planned procurement process for medical equipment as guided by SFEH		19.86	13.24			33.1
Sub – Total		**41.97**	**33.32**	**1.57**		**76.86**
VAT (increase by 18%)						
TOTAL COST		**41.97**	**33.32**	**1.57**		**76.86**

4. Rehabilitation, Expansion and Equipping of Bugiri General Hospital

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Rehabilitation, Expansion and Equipping of Bugiri General Hospital**
Project Code	
Project Duration	4 years
Estimated Cost (bn)	81.75 Bn
Officer Responsible	PS
Date of Submission	November 2024
Section 1: Project Background	
1.1 Situational Analysis	**Bugiri General Hospital,** located in the heart of Bugiri town along the Jinja-Tororo highway, is a government-owned district hospital providing essential healthcare services to the people of Bugiri district, as well as surrounding districts including Iganga, Busia, Namayingo, Mayuge, and Namutumba. Although established in 1967 by the Obote I government, the hospital's infrastructure and equipment have since deteriorated, leaving the remaining staff overworked, underpaid, and under-motivated. Despite these challenges, Bugiri General Hospital continues to serve the local community with dedication and commitment. In 2015, the Uganda Ministry of Health carried out extensive repairs at the hospital, at a cost of approx. UGX 700M in a bid to improve the hospital's facilities and services. The rehabilitation ended around 2017, with the hope that the hospital will be able to provide even better services to the

	local community. However, this has not been the case since population pressure has required continued investment; the funds for this have not been availed leading to the dilapidation of major buildings requiring rehabilitation for services to continue.
1.2 Problem Statement	Bugiri like any other GH in Uganda faces the same challenges considering it was built in the 70s and its buildings and infrastructure have not had enough funds to take care of both maintenance and rehabilitation of the dilapidated structures. Lack of theatres, equipment, including blood banks, wards and poor infrastructure are the major causes of poor functionality of GHs in Uganda. Infrastructure development and equipment placement is inadequately collaborated with utilities and staffing resulting in poorly utilized equipment and compromised ability of GHs to use modern equipment. These factors have led to increased numbers seeking medical services at the specialist or GH level requiring infrastructure upgrades like renovation, rehabilitation, equipping, construction, and functionalization of medical and non-medical units e.g. Staff housing, Emergency units, Neonatal Intensive Care Units (NICUs), theatres, specialist clinics, Radiology services and efficient medical equipment, Electronic Medical Records (EMR) etc. in all General Hospitals
1.3 Relevance of the Project Idea	Most of Uganda's Health Infrastructure was built in the early 70's and has over the years been dilapidated due to civil wars that prevailed in the country in the 1970s and early 1980s which led to economic decline and lack of funds for maintenance. This contributed greatly to the low utilization of the existing infrastructure much as physical access had greatly increased. Hospitals were depleted of essential diagnostic equipment and even the few that remained are now obsolete the current emphasis of the Health Care Policy is to improve service delivery for the entire spectrum of health facility levels. The Regional Referral and General Hospitals have a main role to play in providing back-up services to the lower health units under their supervision, handling referred cases, thereby strengthening Health Care Delivery to the majority of the population who live in the rural area.
1.4 Stakeholders	**Direct Beneficiaries** General Population – Improved quality of services Health workers – Improved working conditions **Indirect Beneficiary/Government** Employment opportunities for the public **Project affected persons** Health workers
Section 2: Project Framework	
2.1 Project Goal	Contribute to improved health outcomes in Eastern region by 20% by 2030

2.2 Project Outcomes	Increased utilization of hospital services by 20% by 2030 Improved outcomes for maternal and child health services by 20% by 2030
2.3 Proposed Project Interventions	• Repair roof leakages • Installation of door shutters and glazing in windows • Rehabilitation of plumbing fittings and system • Improved Water supply and Sewage Systems • Construction of adequate infrastructure (i.e., sufficient ward space incl. isolation wards, Theatres, staff accommodation, OPD, Specialist Clinic and complete A&E unit • Procurement and installation of adequate equipment for diagnosis

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal Contribute to improved health outcomes in Eastern region by 20% by 2030	Improved performance ranking for Bugiri on the National League table	AHSPR	95	50	Availability of funds and capacity
Outcomes Increased utilization of hospital services by 20% by 2030 Improved outcomes for maternal and child health services by 20% by 2030	Bugiri General Hospital Performance against APGS and DRGS	AHSPR DHIS2	36	15	Availability of funds and capacity

	Improved ranking of Busoga on the regional league table				
Project Interventions/Outputs					
Construction of a 2 floor Outpatient Department (OPD) Block	%level of completion	Project Reports & PBS	0%	100%	Availability of funds and capacity
Construction of a new 3 ward Maternity block	% level of completion	Project Reports & PBS	0%	100%	Availability of funds and capacity
Remodeling and Refurbishment of the existing Auxiliary Services T – Block Structure	%level of completion	Project Reports & PBS	0%	100%	Availability of funds and capacity
Construction and rehabilitation of Hospital Staff Accommodation	%level of completion	Project Reports & PBS	0%	100%	Availability of funds and capacity
Procure, supply and installation of medical equipment	% of earmarked equipment procured and installed	Project Reports & PBS	0%	100%	Availability of funds and capacity
Project Management, Monitoring, Evaluation and Supervision	Number of project	Project Reports & PBS	0%	100%	Availability of funds and capacity

	M&E reports					
Section 3: Estimated Project Cost (bn)						
Activity Plan	**FY 2025/26**	**FY 2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**Total cost**
Construct 2 floor OPD block housing dental, ART, general, pediatric, orthopedic, physiotherapy, lab, imaging & eye clinics, blood bank, theatres and NICU	1.5	3.2	3.0	2.4		10.1
Construct new block housing maternity pre-natal, maternity post-natal and Private Maternal wing	2.2	4.3	5.0	3.5	1.8	16.8
Carry out remodeling of T block (i.e., house Material/Drug supply Management & storage, maternal Child Health, recreational Youth Centre & Clinic, mortuary and isolation, Engineering, Maintenance and Biomedical Workshop, Laundry, Main Kitchen)	3.8	2.5	4.0	4.7	2.8	17.8
Construct 6 blocks for accommodation of doctors and rehabilitation of hospital staff accommodation	2.6	5.3	5.3	3.4		16.6

Construct 1 new block housing senior staff	0.65	1.32	0.86			4.15
Construct 1 block to house medical interns	0.65	1.32	0.86			4.15
Procure and install assorted medical equipment in wards			4.10	4.10	1.00	9.200
Carry out Project Management, Monitoring, Evaluation and Supervision	2.90	4.22	3.16	0.73	0.23	11.25
Sub – Total	**13.00**	**19.52**	**24.56**	**18.83**	**5.83**	**81.75**
VAT (increase by 18%)						
TOTAL COST	**13.00**	**19.52**	**24.56**	**18.83**	**5.83**	**81.75**

5. Global Fund for HIV/AIDS, TB and Malaria

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Global Fund for HIV/AIDS, TB and Malaria**
Project Code	0220
Project Duration	5years
Estimated Cost (bn)	External 3,560.13Bn (Incl. 34Bn GoU Counterpart)
Officer Responsible	PS
Date of Submission	January 2024
Section 1: Project Background	
1.1 Situational Analysis	The Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria was created in 2002 to raise, manage and invest the world's money to respond to three of the deadliest infectious diseases the world has ever known. The Global Fund (GF) is a partnership designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics. As an international organization, the Global Fund mobilizes and invests more than US$4 billion a year to support programs run by local experts in more than 100 countries. In partnership with

	governments, civil society, technical agencies, the private sector and people affected by the diseases, GF addresses barriers while embracing innovation. The Global Fund partnership model is designed to promote innovative solutions to global health challenges. Countries take the lead in determining where and how to best fight AIDS, TB and malaria. Collectively, the Global Fund harnesses the best possible experience, insights and innovation in the public and private sectors to respond to diseases and build resilient and sustainable systems for health. To-date, Uganda has contributed a total of US$3.08 million to the Global Fund. The country pledged US$2 million for the Global Fund's Sixth Replenishment, covering 2020-2022. Uganda is both a donor to the Global Fund and an implementer of Global Fund-supported programs. As part of the global response to COVID-19, the Global Fund is working with health leaders, partners and governments to ensure the global response to COVID-19 includes lessons learned from the fight against HIV, TB and malaria: protect human rights and address stigma and discrimination, particularly among key and vulnerable populations; fight human rights and gender barriers to health; engage communities in the response; and fairly allocate limited COVID-19 resources and new tools so that no one is left behind. The Global Fund contributed US$ 129M to help Uganda continue to fight COVID-19 protect health workers and reinforce systems for health
1.2 Problem Statement	Malaria- Severe disease caused by a parasite, transmitted from one person to another through the biting of certain species of mosquitos in parasite-endemic regions. Those at greatest risk of severe forms of the disease, and death, are children under the age of 5 years, and pregnant women. Under TB, the treatment outcomes are still poor with a 72% treatment success rate for TB patients, 70% treatment success for TB/HIV co-infected patients and 64% of MDR-TB successfully treated. Under HIV, new estimates also indicate that 53,000 people were newly infected with HIV: 5,700 children aged 0 to 14 years and older. Among older adolescents and young people, HIV prevalence is almost four times higher among females than males. HIV prevalence has been found to be significantly higher among Key Populations(KPs) groups ranging from 13.7% to as high as 37% for sex workers
1.3 Relevance of the Project Idea	Many health workers still do not have the capacity to screen and diagnosis TB in Children including sample collection. Lack of access to important diagnostics for paediatric TB, such as X-ray and paediatric specimen collection equipment Lack of case- based surveillance, inadequate capacity and confidence among health workers in management of paediatric TB and inadequate contact tracing.

	Factors driving the HIV epidemic that are behavioural, sociocultural and biomedical include concurrent sexual partnerships, serodiscordance and non- disclosure, transactional sex and sex work, low and inconsistent condom use, low male circumcision and alcohol and drug abuse
1.4 Stakeholders	Health workers Project affected persons Private sector Health facilities and LGs
Section 2: Project Framework	
2.1 Project Goal	To reduce the mortality and morbidity due to TB, AIDS & Malaria
2.2 Project Outcomes	Reduce the burden of communicable diseases with focus on high burden diseases (Malaria, HIV/AIDS & TB)
2.3 Proposed Project Interventions	Strengthen Community systems Strengthen TB and Leprosy prevention, diagnosis and treatment services including adoption of new technologies, drugs and approaches for screening, diagnosis and treatment Strengthen information management including digital technology Strengthen supply chain management Resource mobilization, leadership and accountability, and multi-sectoral collaboration Strengthen the Public Private collaboration Mainstream TB in all Government Ministries, Departments & Agencies Engage the private sector and other players beyond health in TB service delivery Establish patient feedback mechanisms Engage CSOs, Informal community groups, and traditional healers in identification and referral of presumptive TB patients for care Build capacity for contact investigation at facility and community level. Strengthen community TB case finding activities Build health worker capacity on TPT including identification and management of side effects. Increase availability of TPT medicines and other supplies and expend access to TB LAM testing. Strengthen sensitization of clients on TPT Initiate and strengthen TB screening and prevention services among high risk populations. Intensify screening for active TB in public spaces Involve other sectors in TB prevention Strengthen implementation of TB prevention policies

2.5 Results Matrix					
Objective	**Indicator**	**Means of Verification**	**Baseline**	**Target**	**Assumptions**
Goal To reduce the mortality and morbidity due to TB, AIDS & Malaria.	Number of new HIV infections per 1,000 susceptible population	AHSPR	1.23	1.00	Availability of funds and capacity
Outcomes Reduce the burden of communicable diseases with focus on high burden diseases (Malaria, HIV/AIDS & TB)	Mortality rate as a result of communicable diseases (TB, Malaria & HIV)	AHSPR	40.4	30.4	Availability of funds and capacity
Project Interventions/Outputs					
Enrol 95% of People Living with HIV with a package of Treatment, care and support	ART Coverage	AHSPR	97%	100%	Availability of funds and capacity
14 regions supported with Community engagement, linkages and coordination to achieve the 95, 95, 95 national targets to end HIV pandemic	ART retention rate at 12 months	AHSPR	82%	95%	Availability of funds and capacity
Case Management, clinical operations and therapeutic for TB strengthened	Tuberculosis incidence per 100,000 population	AHSPR	198	104	Availability of funds and capacity

Conduct quarterly monitoring, evaluation and Surveillance for HIV, tuberculosis and malaria	No. of quarterly reports for HIV, TB & Malaria	Project reports & PBS	12	12	Availability of funds and capacity
Case Management, clinical operations and Malaria interventions strengthened	Malaria incidence per 1,000 of population	AHSPR	298	170	Availability of funds and capacity

Section 3: Estimated Project Cost (bn)

Activity Plan	**FY 2025/26**	**FY 2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**Total cost**
Malaria interventions (case mgt, program mgt i.e., LLINS, M&E, Health information systems support, health products/commodities, HRH, Vector control, integrated service delivery and quality improvement and specific prevention interventions.	198.20	472.16	203.21	180.85	402.11	1,456.53
TB Interventions (MDR-TB, Program management, community services, commodities, TB Care & prevention, health information systems & M&E	57.03	20.43	33.21	28.95	22.80	162.42
HIV Interventions (PMTCT, Treatment care & support incl. ARVs, financial mgt systems, community health	413.37	384.23	401.26	346.08	396.24	1,941.18

promotion/prevention services, HRH and program management						
Sub – Total	**668.6**	**876.82**	**637.68**	**555.88**	**821.15**	**3,560.13**
VAT (increase by 18%)						
TOTAL COST	**668.6**	**876.82**	**637.68**	**555.88**	**821.15**	**3,560.13**

6. Global Alliance for Vaccines (The Vaccine Alliance)-GAVI

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Population Health, safety and management
Project Name	**MOH GAVi Vaccines and Health Sector Dev't Plan support**
Project Code	1436
Project Duration	2024-2028
Estimated Cost (bn)	574.47 Bn (incl. 82bn GoU Counterpart)
Officer Responsible	PS
Date of Submission	19th March 2024
Section 1: Project Background	
1.1 Situational Analysis	Routine Immunisation is an important service delivery contact point for integrated maternal-child health interventions offered through static and outreaches at service delivery points across the country. Uganda has a national immunization DPT1 coverage of 95% (WUENIC 2023), leaving only 5% (83,000 zero dose children) of children unreached. However, according to recent reports, the number of unvaccinated children, particularly zero-dose and under-immunised children, has been decreasing. The high-risk/underserved communities identified were urban poor settlements, migrants, ethnic minorities, some religious sects, upcoming town settlements, fishing communities, Refugee communities, and remote rural, island, and mountainous communities. Currently in Uganda, the number of zero-dose and under-immunised children stands at 3% and 5%, respectively (Admin data 2024), with an estimated 37,452 children not receiving any vaccines by their first birthday (The reduction is attributed to Big Catch-up gains in November 2024) The high number of zero-dose children and under immunized children is due to multiple demands and supply-related factors such as stock outs, inadequate resources and health infrastructure, hesitancy, education

	level, and misinformation. The impact of zero-dose and under-immunised children in Uganda is significant and poses a threat to public health. These children are at risk of contracting vaccine-preventable diseases, which can lead to serious health complications, disability, and even death.
1.2 Problem Statement	The vaccination coverage for all childhood vaccination has steadily improved with DPT1 at 95% (WUENIC 2023). A build-up of zero-dose and partially vaccinated children erodes population immunity that increases vulnerability of communities and susceptibility of children to vaccine preventable diseases (VPDs). Access to vaccination services is generally high at 97% for DPT1 (UDHS report 22). Most (80%) vaccinated children in Uganda are vaccinated through static vaccination points in health facilities while 20% are through outreaches. There are children (3%) (Zero Dose) and communities (missed communities) who are not reached by the primary health care model in use of static and outreach immunisation, and therefore, keeping track of the vaccination status of target populations is an important coverage parameter. Under pinning the constraints to access and utilisation of available immunisation services are socio-cultural barriers, gaps in information as well as physical barriers to immunisation service points. These constraints are more magnified in peri-urban and poor communities, upscale gated communities, Island communities, mountainous regions, sparsely populated areas, communities with insecurity, and migrant populations. And these constraints affect access and utilisation of vaccination for all target groups including adult vaccination during epidemics and outbreaks
1.3 Relevance of the Project Idea	Support immunization coverage and equity, service delivery, human resources for health, supply chain, surveillance, research and vaccine demand generation
1.4 Stakeholders	WHO, UNICEF, PATH, CHAI, MoES, MoLG, NMS
Section 2: Project Framework	
2.1 Project Goal	To ensure that every child and high-risk group is fully vaccinated with high-quality and effective vaccines against the target diseases according to recommended strategies
2.2 Project Outcomes	To fully immunize every child and priority population at risk of vaccine-preventable diseases to achieve and sustain 95% coverage for all antigens, reduce the number of under-immunized children and intensify efforts to reach zero-dose children in Uganda.
2.3 Proposed Project Interventions	• Identify zero-dose, under-immunised children and missed communities identified • Tailored and sustainable strategies addressing supply and demand-side barriers and to serve as a platform for broader integrated PHC over life course

	• Monitoring and evaluation of program performance and occurrence of VPDs and AEFI • Demand generation for immunization services

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal	Every child and priority population at risk of Vaccine Preventable Disease is fully vaccinated.	UDHS	63	95	Political stability Economic stability Social trust
Outcomes	To fully immunise every child and priority population at risk of vaccines preventable diseases to achieve and sustain 95% coverage for all antigens, reduce the number of under-immunized children and intensify efforts to reach zero-dose children in Uganda.	UDHS	63	95	Stable geographical factors Stable epidemiological factors
Project Interventions/Outputs					
zero-dose, under immunised children and missed communities identified	Number of zero dose children identified	HMIS	83,000	37,452	Political stability Economic stability Social trust Stable geographical factors Stable epidemiological factors

Tailored and sustainable strategies addressing supply and demand-side barriers and to serve as a platform for broader integrated PHC over life course	DPT3 coverage	HMIS	92%	95%	
Support supervision conducted	Proportion of facilities supported to conduct supplementary outreaches	HMIS	85%	95%	
Adequate stocks procured and distributed	Number of districts reporting stock out of any vaccines	HMIS	88%	100%	

Section 3: Estimated Project Cost (bn)

Activity Plan	**FY 2025/26**	**FY2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**Total cost**
1. Human Resources (HR)	2.21	2.21	2.21			**6.63**
2. Transport and Travel-related Costs	17.30	17.30	17.30			**51.9**
3. External Professional Services (EPS)	5.59	5.59	5.59			**16.77**
4. Health Products (incl. vaccines), consumables and equipment	74.77	74.77	74.77			**224.31**
5. Event-related (trainings, meetings, workshops, launches)	3.18	3.18	3.18			**9.54**

6. Cold Chain	40.86	40.86	40.86			**122.58**
7. Infrastructure (INF) and Non-Health Equipment (NHE)	13.02	13.02	13.02			**39.06**
8. Communication Materials and Publications	5.06	5.06	5.06			**15.18**
9. Programme Administration (PA)	2.11	2.11	2.11			**6.33**
10. Medical Supplies (Vaccines) GOU Counterpart	27.39	27.39	27.39			**82.17**
Sub – Total	191.49	191.49	191.49			**574.47**
VAT (increase by 18%)	0	0	0			**0**
TOTAL COST	**191.49**	**191.49**	**191.49**			**574.47**

7. Hospital Outcome Quality and Client Engagement Improvement Project

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Hospital Outcome Quality and Client Engagement Improvement Project**
Project Code	
Project Duration	5 years
Estimated Cost (bn)	116.39 Bn
Officer Responsible	PS
Date of Submission	November 2024
Section 1: Project Background	
1.1 Situational Analysis	Over the recent decades, Government of Uganda has had concerted efforts towards improving health services availability and readiness for delivery to the general public in a bid to improve Universal Health Coverage (UHC). Facility level readiness has been found to be as high as 84% at National Referral Hospitals (NRHs), 86% at Regional Referral Hospitals (RRHs), 79% at General Hospitals (GHs), 85% at Health Centre IVs and slightly below the national

	target of 70% for HC III (68%) (Harmonized Health Facility Assessment 2022). Despite this improved access to services, the quality and safety of these services remain a major challenge as is depicted in the high institutional morbidity and mortality rates in Hospitals. The In-patient Case fatality rate (IP-CFR) for National Referral and Specialized hospitals stands at 9%; Regional Referral Hospitals at 7% and General hospitals at 4% (AHSPR-FY2022/2023), an indication of a lapse in the quality and safety of services in these institutions which are otherwise expected to be epitomes of safe and quality care. One big contributing factor to the high in-patient mortality rate has been found to be patients suffering harm, with an estimated proportion of 25% of hospitalizations and an associated mortality rate of 1.25% (WHO, 2022).
1.2 Problem Statement	In-patient Case fatality rates across hospitals in Uganda remain unacceptably high with national referral hospitals registering 9%, Regional referral and general hospital at 7%, and 4% Case Fatality Rates respectively. The leading causes of in-patient mortality in Uganda are Malaria, Neonatal conditions, Pneumonia, and anemia, conditions that are ordinarily non-fatal. In over 50% of the cases, the cause of death is not clearly defined, pointing to a gap in the quality of services being delivered, despite concerted efforts by the health subprogram to improve quality and safety of health services. This is negatively impacting on the client satisfaction levels, which have stagnated at 31%, well below the NDP-III target of 79%.
1.3 Relevance of the Project Idea	On the basis of these challenges and gaps in quality of health services in hospitals, there arises a need for interventions to address these challenges through capturing, measurement, summarizing and displaying of safety events, client feedback and satisfaction in real time (in form of dashboard). Trends in this data will from time to time offer benchmark information for prompt response by managers and health workers towards continuous quality improvement, mitigation of patient safety risks and events management. There is need therefore to digitize the patient feedback and alarm systems, provide pager systems to hospitals and enable hospitals to obtain ISO certification. With aim of reducing in-patient case fatality and improving client satisfaction with services the project directly contributes to improving population safety and Management through improving hospital outcomes. Conducting client satisfaction surveys is one of the health sub program indicators in the PIAP and the project proposes to introduce a platform through which client satisfaction can be measured on a routine basis
1.4 Stakeholders	Patients and or Careers/ General Public Health Workers Hospital Managers.
Section 2: Project Framework	
2.1 Project Goal	Contribute to improved patient outcomes, safety, quality of health services and client satisfaction with health services

2.2 Project Outcomes	Regular client feedback reporting and prompt response to feedback by health workers Improved adherence to protocols/Clinical pathways to enhance standardization of care.
2.3 Proposed Project Interventions	Establish an IT-based Platforms for Routine Monitoring of Client Satisfaction at Hospital Level Procure and install a Hospital Clinical pathways and Protocol-use adherence system. (Hospitals to be enabled to obtain ISO certification). Procurement and installation of a pager-based alarm system in Hospital for responding to emergencies

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal Contribute to improved patient outcomes, safety, quality of health services and client satisfaction with health services	% districts undertaking HFQA	AHSPR	80%	100%	Health services and systems in place
Outcomes Regular client feedback reporting and prompt response to feedback by health workers Improved adherence to protocols/Clinical pathways to enhance standardization of care	Institutional morbidity and mortality in referral hospitals	AHSPR	6%	1.5%	Health services and systems in place
Project Interventions/Outputs					
Procure and establish IT-based platforms for routine monitoring of client satisfaction at hospital level	Client Satisfaction rate improves from 31% to 65% by 2030	PBS Reports	31%	65%	Availability of funds

Procurement and installation of pager-based alarm systems in hospitals for responding to emergencies	% hospitals with pager-based alarm systems	Project Reports	1%	80%	Availability of funds, required equipment and capacity
Procure and install a Hospital Clinical pathways and Protocol-use adherence system. (Hospitals are to be enabled to obtain ISO certification).	% hospitals with clinical pathways and protocol adherence systems	Project Reports	2%	80%	Availability of funds, required equipment and capacity
Project management, monitoring and evaluation	Percentage of referrals managed in accordance with the referral pathway	PBS Reports	13	60	Availability of funds, required equipment and capacity

Section 3: Estimated Project Cost (bn)

Activity Plan	**FY2025/26**	**FY2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**Total cost**
Procure and install a Hospital Clinical pathways and Protocol-use adherence system. (Hospitals are to be enabled to obtain ISO certification).		1.70		2.92	2.92	7.54
Procure and establish IT-based platforms for routine monitoring of client satisfaction at hospital level.			1.2	2.4	2.4	6.0

Procurement and installation of pager-based alarm systems in hospitals for responding to emergencies.	18.40	30.73	32.72			81.85
Project management, Supervision, Monitoring and Evaluation.	2.0	6.5	6.5	2.5	3.5	21.0
Sub – Total	**20.40**	**38.93**	**40.42**	**7.82**	**8.82**	**116.39**
VAT (increase by 18%)						
TOTAL COST	**20.40**	**38.93**	**40.42**	**7.82**	**8.82**	**116.39**

8. Establishment, Expansion, and Rehabilitation of HC IVs for Upgrade to Community Hospitals in Uganda

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Establishment, Expansion, and Rehabilitation of HC IVs for Upgrade to Community Hospitals in Uganda**
Project Code	
Project Duration	5 years
Estimated Cost (bn)	1,371 Bn
Officer Responsible	PS
Date of Submission	December 2024
Section 1: Project Background	
1.1 Situational Analysis	The existing HC IVs, in addition to struggling with high patient loads, many of them operate under poor and inadequate infrastructure (clinical building space, medical equipment and staff housing). A bigger proportion of these HC IV were upgraded from HC IIIs to HC IVs and have continued to use the very HC IIIs building infrastructure. This infrastructure, particularly the building infrastructure requires upgrade by way of remodeling/expansion/construction of new ones to meet the service standards and requirement for a functional HC IV. Of the existing 222 HC IVs, about 100 HC IVs need to be improved in functionality by expansion/construction of building infrastructure and medical equipment

	Upgrade of selected HC IIIs to HC IVs numbering to 20 under government funding (Transitional Ad hoc Development Grants) was started but progressing at quite a slow rate due to limited funding that is required for both infrastructure and medical equipment upgrade. These facilities started in the year 2021-22, but to- date (4 years after), the progress of infrastructure upgrade still stands at an average of only 40% due to limited funding. These 20 facilities that are already being upgraded to HC IV have not been included in the proposed list for upgrade under this project, as their upgrade can continue under the Government Transitional Development Grant funding framework/Mechanism
1.2 Problem Statement	The existing HC IVs are inadequate and with poor infrastructure to meet the growing health care demands of the population at this level of health care. There are currently only 223 HC IVs out of 459 that are required as per the health service standards of 100,000 people per HC IV. This translates into a national coverage of HC IVs services of only 48% in respect of the population served. In terms of HC IV constituency coverage, only 229 out of 353 Constituencies have HC IVs, leaving 124 consistencies without. There is, therefore, an urgent need to strengthen the healthcare system and increase health care coverage and access by increasing the coverage of HC IV healthcare services across the country through establishment of HCIVs in all the areas without
1.3 Relevance of the Project Idea	This project greatly contributes achieving Universal Health coverage, which aligns with the WHO goal of achieving Universal Health Coverage by 2030 The projects greatly contribute to the specific targets under Uganda's SDG No.3, there by aligning with the SDG 3 which aims to achieve Good Health and well-being This project will improve health care coverage in the country, including improvement of maternal and child health care. Through this intervention, the projects will contribute to the strategy of the government under its Vision 2024, item 254, which targets to reduce maternal deaths by over 6,000 and children death by over 16,000 every year. Additionally, the projects' main objective is to improve the functionality of the health system to deliver quality and affordable healthcare services in the country, which is one of the focus points of Government under item 250 of the Uganda Vision 2040 The establishment of Health IVs in areas/constituencies without across the country is a critical intervention in the improving access to quality healthcare services and strengthening the referral system of the country. This project seeks to provide HC IVs in areas without, thereby contributing to the overall improvement of the healthcare system
1.4 Stakeholders	Patients Health workers Indirect beneficiaries LGs Private sector

	CBOS/NGOs/Donors & Development partners
Section 2: Project Framework	
2.1 Project Goal	To Improve the functionality of the health system to deliver quality, accessible and affordable healthcare
2.2 Project Outcomes	Reduced Maternal mortality Increased Access to healthcare
2.3 Proposed Project Interventions	**Under equipment supply, the following medical equipment shall be supplied:** Full Set of Theatre Equipment, Radiology Equipment (Mobile Digital X- Ray And Ultrasound Scan), OPD Equipment (Laboratory, Administration, Clinical Equipment), IPD Equipment, Dental Unit, MORTUARY Equipment (2 Body Fridge and Accessories), Central Sterilizing Equipment, Others (General Assortment Outpatient Clinics – ENT, Eye, Orthopedic) **Construction of the following medical buildings among others:** new standard Theatre, Outpatient Department Expansion and Remodeling, New construction Maternal Child Health (MCH)/Maternity Ward, General Ward, Mortuary, Additional 2 Staff House Blocks- Each Having 6 Units Doctor's House, sanitary facilities

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To Improve the functionality of the health system to deliver quality, accessible and affordable healthcare.	Population served with HC IV Health care services as per the MoH service standards	Project progress reports MoH - HIMS	48%	65%	Availability of funds for the project and functionalization
Outcomes Reduced Maternal mortality	Maternal mortality rate % population accessing health care	Annual sector performance reports	207/ 100,000 70%	70/ 100,000 85%	Availability of funds for the project and functionalization

Increased Access to healthcare	services within 3 Km radius				
Project Interventions/Outputs					
Site assessment, land acquisition Final Designs, B. OQs, Procurement, construction upgrade of 20 HC IIIs to HC IVs	No. of Assessments and designs done	Project reports PBS AHSPR	0	20	Availability of funds for the project and functionalization
Construction upgrade, including equipment supply of 20 HC IIIs to HC IVs	Number of upgraded HCIVs	Project reports PBS AHSPR	0	80	Availability of funds for the project and functionalization

Section 3: Estimated Project Cost (bn)

Activity Plan	**FY2025/26**	**FY2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**Total cost**
Civil works/construction for the upgrade HC III to HC IVs	217.54	326.31	326.31	217.54		1,087.7
Supply and installation of medical equipment and Furniture for the upgraded HC IVs		47.68	71.52	71.52	47.68	238.4
Capacity building in Health care management		0.40	0.60	0.40	0.60	2.0
Project Management	8.75	13.12	6.56	6.56	8.74	43.73
Sub – Total	**226.29**	**387.51**	**404.99**	**296.02**	**57.02**	**1,371.83**
VAT (increase by 18%)						
TOTAL COST	**226.29**	**387.51**	**404.99**	**296.02**	**57.02**	**1,371.83**

9. Rehabilitation, Expansion and Equipping of Katakwi and Lwengo Specialized hospitals

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Rehabilitation, Expansion and Equipping of Katakwi and Lwengo Specialized hospitals**
Project Code	
Project Duration	4 Years
Estimated Cost (bn)	608 Bn
Officer Responsible	PS
Date of Submission	Jan 2025
Section 1: Project Background	
1.1 Situational Analysis	Uganda has around 6,940 health facilities, of which 45% are government owned, 15% are private Not for Profit and 4o% are private for Profit. With a population of approximately 50 million, Uganda requires 100 general hospitals, each serving 500,000 people. Currently, there are only 48 public General Hospitals in the country. Hospitals play a vital role in the provision of health services through supervision of lower-level health units, training, referrals and research. In Uganda, hospital services are provided by Public, Private –Not For- Profit and private for-Profit facilities. The Public Hospitals are categorized into 3 groups according to the level of services to be provided and their responsibilities. These are General Hospitals, Regional Referral Hospitals and National Referral Hospitals. According to the National Hospital Policy (2006) General Hospitals are supposed to provide preventive, promotive, rehabilitative, outpatient, curative, maternity, inpatient health services, emergency surgery, blood transfusion, laboratory and other general services. They also provide in-service training, consultation and research to community-based health care programs
1.2 Problem Statement	Katakwi General Hospital was constructed in 1945 as a dispensary and later upgraded to HCIII then HCIV in 2004. In 2011, the facility was further upgraded to a General Hospital. Katakwi General hospital serves the district's population of 223,401 in addition to serving the neighboring Districts of Soroti, Amuria, Kapelebyong, Kumi, Nakapiripirit, and Napak Katakwi General Hospital is a rural based health facility and faces challenges in delivering reliable and quality healthcare. These challenges include limited access to specialized healthcare services, inadequate

	infrastructure (such as buildings, equipment, electricity, and water), and difficulty in attracting and retaining skilled medical professionals. Dependence on distant healthcare facilities leads to delays in critical care and worsened health outcomes, contributing to higher mortality rates and reduced quality of life for rural populations. There is a significant need for refurbishment and equipment replacement, with nearly 100% of facilities requiring refurbishment and over 70% of medical equipment needing replacement. These challenges have significantly contributed to increased burden of communicable diseases, Neonatal conditions which are the leading cause of deaths in health facilities, accounting for 10.3%, followed by malaria (7.4%), pneumonia (5.3%), anemia (3.9%), and road traffic injuries (2.3%). (Ministry of Health Annual Health Sector Performance report (2022-2023). Lwengo District has a population of approximately 320,000. In terms of healthcare services, the existing HCIVs are currently serving the population of the district and the neighboring catchment of approximately 250,000 people from the districts of Rakai, Masaka, Kyotera, Lyantonde and Sembabule. Worse still, Lwengo District does not have a general hospital for the referrals from HCIVs. This has made the HCIVs to refer patients to distant referral facilities for the surgery, Obstetrics and Gynecology, internal medicine, pediatrics, imaging and critical care services hence the negative healthcare outcomes (death, longer stay in Hospital and therefore high cost of healthcare) in the district.
1.3 Relevance of the Project Idea	Katakwi GH receives a high volume of casualty accident victims due to its central location to the 3 major weekly cattle markets including Ocorimongin market, the biggest cattle market in Eastern Uganda. These markets each attract over 10,000 people on a weekly basis. And so, casualty accidents are a common occurrence. Due to this need, the Hospital trained one of the doctors as an emergency physician. However, due to the lack of facilities for emergency care, the doctor is limited in how much intervention he can provide The Establishment of Lwengo General Hospital in Lwengo will enhance health service in the district and surrounding districts through provision of preventive, promotive, rehabilitative, outpatient, curative, maternity, inpatient health services, emergency surgery, blood transfusion, laboratory and other general services. It will also provide in-service training, consultation and research. Additionally, a state-of-the-art Accident and Emergency department, along this busy highway is imperative given the alarming road traffic accidents on the highway
1.4 Stakeholders	Project affected persons

	Direct beneficiaries Indirect beneficiaries Local governments of Lwengo & Katakwi Leadership of Lwengo and Katakwi Health workers
Section 2: Project Framework	
2.1 Project Goal	To undertake construction, rehabilitation, expansion and equipping of Katakwi and Lwengo General Hospitals to improve health services delivery, health outcomes and ultimately the quality of care in the regions where they are located.
2.2 Project Outcomes	Reduced preventable mortalities from Road Traffic Accidents along highways of at least 20% within a year of the upgrade and at least 50% within two years of the upgrade Reduced patient referrals to the higher-level health facilities for the upgraded services by at least 70% within a year of the upgrade and at least 95% within two years of the upgrade
2.3 Proposed Project Interventions	Equipping highway facilities with fully functional A&E department and ICUs and training health workers in the facilities on how to manage intensive care scenarios Construction of inpatient ward that offering the four disciplines of Surgery, Obstetrics and Gynaecology, Internal Medicine and Paediatrics Equipping the beneficiary facilities with all equipment including Radiology and laboratory including physiotherapy Equipping the General Hospitals with Healthcare ICT connectivity to allow remote expert opinions from regional referral Hospitals via tele-medicine

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To undertake construction, rehabilitation, expansion and equipping of Katakwi and Lwengo General Hospitals to improve health services delivery, health outcomes and ultimately the	% completion rate of the GHs	Project Reports AHSPR	45%	70%	Availability of resources for Implementation

quality of care in the regions where they are located.					
Outcomes Reduced preventable mortalities from Road Traffic Accidents along highways of at least 20% within a year of the upgrade and at least 50% within two years of the upgrade Reduced patient referrals to the higher-level health facilities for the upgraded services by at least 70% within a year of the upgrade and at least 95% within two years of the upgrade.	Proportion of deaths due to emergency medical conditions Maternal mortality ratio	DHIS2 AHSPR	4% 189/100,000	1% 100/100,000	Availability of resources for Implementation
Project Interventions/Outputs					
Design and Procure Consultant and contractors to implement the works	Consultant procured	Progress reports	Yes	Yes	Availability of resources and staff capacity for Implementation
Construct necessary infrastructure components based on approved engineering plans	%completion rate	PBS reports	0%	100%	Availability of resources and staff capacity for Implementation
Procure and install essential medical equipment within 1 year to enhance healthcare services as outlined in the project plan.	No. of equipment procured & installed	Project reports	150	300	Availability of resources and staff capacity for Implementation
Provide reliable off-grid building services including power, water, and waste management systems	No. of systems installed	Progress reports	2	6	Availability of resources and staff capacity for Implementation
refurbishment, upgrades, equipping and maintenance activities within project duration	No of facilities upgraded	PBS reports	0	2	Availability of resources and staff capacity for Implementation

Construct Staff Houses for at least 30 Critical health care Providers	Number of staff houses built	PBS reports	2	8	Availability of resources and staff capacity for Implementation	
Procure a Type B Ambulance and a station wagon for Blood collection for the Hospital	No. of vehicles procured	Progress reports	0	2	Availability of resources and staff capacity for Implementation	
Conduct training sessions for emergency care health workers and biomedical technicians	No of staff trained	Progress reports	10	210	Availability of resources and staff capacity for Implementation	
Section 3: Estimated Project Cost (bn) – ***Combined for Katakwi & Lwengo Specialized hospitals***						
Activity Plan	**FY2025/26**	**FY2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**Total Cost**
Design and Procure Consultant and contractors to implement the works	0.30	0.30				0.60
Procure and install essential medical equipment			22.20	51.81		74.01
Construct necessary infrastructure components based on approved engineering plans within 2 years to create a conducive environment for healthcare delivery	21.68	7.40	51.8			80.88
Rehabilitate and expand existing infrastructure		14.80	29.60			44.40
Provide reliable off-grid building services including power, water, and waste management			24.60	24.60	24.60	74.0
Refurbishment, upgrades, equipping and maintenance activities within project duration.		44.40	59.20			103.60
Construct Staff Houses for at least 30 Critical health care Providers		19.72	19.72	19.72		59.16

within project Duration to increase attraction of Health workers.						
Procure a Type B Ambulance and a station wagon for Blood collection for the Hospital to enhance Emergency Services				1.48	1.48	2.96
Conduct training sessions for emergency care health workers and biomedical technicians				14.80	14.80	29.60
Sub – Total	**21.98**	**86.62**	**207.12**	**112.41**	**40.88**	**469.21**
VAT (increase by 18%)						
TOTAL COST	**21.98**	**86.62**	**207.12**	**112.41**	**40.88**	**469.21**

10. Expansion and Rehabilitation of Selected Regional Referral Hospitals

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Expansion and Rehabilitation of Selected Regional Referral Hospitals**
Project Code	
Project Duration	5 years
Estimated Cost (bn)	1,173.6Bn
Officer Responsible	PS
Date of Submission	December 2024
Section 1: Project Background	
1.1 Situational Analysis	Most RRHs were established several decades ago and have not kept pace with Uganda's population growth and the evolving requirements of modern healthcare. The population of Uganda is projected to increase from 45 million in 2020 to over 60 million by 2040, which will significantly elevate the demand for specialized healthcare services. Uganda continues to grapple with high maternal and neonatal mortality rates, with maternal mortality standing at T336 deaths per 100,000 live births and neonatal mortality at 27 deaths per 1,000 live births

	(UDHS, 2020). Previous interventions have primarily focused on increasing access to skilled care during childbirth, constructing health centers, and providing essential medical equipment. However, there has been limited investment in upgrading the infrastructure of Regional Referral Hospitals (RRHs) to meet the demands of maternal and child health care, as well as other specialized medical needs
1.2 Problem Statement	The inadequacy of space and appropriate medical equipment to manage maternal child health and other specialized care in Regional Referral Hospitals in the country has been an issue of great concern for some time. Regional Referral Hospital, which are critical for advanced care, are inadequately equipped, which has resulted into delayed access to diagnosis and treatment, overcrowding of patients, hence severely impacting quality of care with resultant high morbidity and mortality. The lack of adequate clinical space and medical equipment has resulted not only in overcrowding of patients, delayed access to diagnosis and treatment, but also poor patient safety, leading to poor healthcare outcomes, high morbidity and mortality. The Regional Referral Hospitals, being the highest regional level of care, serving a population of 3 million or more people, requires an urgent intervention of improved infrastructure (Buildings, sanitation and medical equipment). There is therefore need to urgently source for funding for the expansion and rehabilitation of regional referral hospitals to be able to address the problem
1.3 Relevance of the Project Idea	Addressing the infrastructural deficiencies of Regional Referral Hospitals is imperative for Uganda to meet its healthcare goals and reduce all cause patient mortality rates. Expanding and rehabilitating RRHs to provide specialized care services will not only improve patient outcomes but also ensure that the healthcare system is robust enough to handle the increasing demands of a growing population and challenges of pandemics. This initiative represents a strategic investment in Uganda's healthcare infrastructure, aimed at delivering quality and accessible specialized medical care to all regions
1.4 Stakeholders	Project affected Persons Health workers Direct and indirect beneficiaries Lower-level health facilities Local Governments
Section 2: Project Framework	
2.1 Project Goal	To deliver enhanced Evidence-Based Integrated Curative Services by strengthening the health infrastructural system (buildings, medical equipment, and emergency transport) and a functional, efficient, safe and environmentally friendly health infrastructure and medical equipment
2.2 Project Outcomes	Reduced Mortality due to treatable causes of ill health (Neonatal, Under 5, Maternal, NCDs).

	Improved access to Health Care Services (Physical, Affordable, Quality, Social)				
2.3 Proposed Project Interventions	Invest in building and upgrading maternity wards, neonatal care units, and emergency obstetric care facilities (theatres and maternity HDUs) in the regional referral hospitals Equipping the beneficiary facilities with all equipment for specialized treatment and diagnostic services including Radiology and laboratory, dental and physiotherapy Equipping the Referral Hospitals with Healthcare ICT connectivity to allow remote expert opinions from regional referral Hospitals via tele-medicine including tele radiology				
2.5 Results Matrix					
Objective	**Indicator**	**Means of Verification**	**Baseline**	**Target**	**Assumptions**
Goal Enable Regional referrals to provide tertiary health services at their level of care	Average bed occupancy rate at RRHs	AHSPR	73%	50%	Availability of funds and staff
Outcomes Reduced maternal and infant mortalities especially from high-risk pregnancies of at least 25% within a year of the upgrade and at least 30% within two years of the upgrade.	Maternal deaths among 100,000 health facility deliveries	AHSPR	82.7	50	Availability of funds and staff
Reduced patient referrals to the higher-level health facilities for the upgraded services by at least 70% within a year of the upgrade and at least 95% within two years of the upgrade.	Average Length of Stay (ALOS) at RRHs	AHSPR	4	2	Availability of funds and staff

Project Interventions/Outputs					
Design and Procure Consultant and contractors to implement the works	Consultants procured for works	PBS & Project reports	N/a	Yes	Availability of funds and staff
Construct 2 multi-level buildings of 3 stories each: One for the OPD services, Diagnostics A&E and Administration	%referrals with refurbished OPD, diagnostics, A&E, and administration blocks	PBS & Project reports	30%	100%	Availability of funds and staff
Procure and install essential medical equipment within 1 year to enhance healthcare services as outlined in the project plan. And construction and equipping of Regional medical Equipment Workshop	%referrals with fully installed and functional equipment incl. workshops	PBS & Project reports	20%	95%	Availability of funds and staff
Construct 2 blocks of 4-storied staff houses (16 units each) and 2 Blocks of studio housing for Expatriates (6 units each)	% of staff residing at RRH	PBS & Project reports	10%	70%	Availability of funds and staff

Section 3: Estimated Project Cost (bn)						
Activity Plan	**FY 2025/26**	**FY2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**Total cost**
Project Implementation and Supervision		2.0	2.0	2.0	2.0	8.0

Train specialists and build clinical care capacity for RRHs		5.2	5.2	5.2	5.2	20.8
Rehabilitation of any existing structures and construction of customized In-patient structure that has Surgical theatres and all other wards targeting – 250 bed capacity		90.5	90.5	90.5	90.5	362.0
Construction and equipping of all the maintenance Workshops in the Referral hospitals		33.2	33.2	33.2	33.2	132.8
Construct 1 4-storied Block with 4 units of studio apartments		30.0	30.0	30.0	30.0	120.0
Construction of OPD Blocks in select Referral Hospitals		50.2	50.2	50.2	50.2	200.8
Equipping the facilities with the equipment including the medical and Healthcare ICT equipment		82.3	82.3	82.3	82.3	329.2
Sub – Total		**293.4**	**293.4**	**293.4**	**293.4**	**1,173.6**
VAT (increase by 18%)						
TOTAL COST		**293.4**	**293.4**	**293.4**	**293.4**	**1,173.6**

11. Health Sector Disability Inclusion Project

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Health Sector Disability Inclusion Project**
Project Code	
Project Duration	5 Years
Estimated Cost (bn)	113.28 Bn
Officer Responsible	PS
Date of Submission	March 2025
Section 1: Project Background	
1.1 Situational Analysis	In Uganda, the Disability Prevalence rate is estimated to be 3.5% among population aged below 5 years, 7.5% for people aged 5-17 years and16.5% for people of 18yrs and above (Uganda Functional Difficulties Survey, 2017). Disability prevalence rate is higher among females at 14.5% than males at 10% and higher in rural areas (90%) than urban (10%) areas; overall prevalence of 13.2% (NPHC, 2024). Disability rates are set to increase as the population ages and non-communicable diseases take their toll. Additionally, incidents such as traffic collisions, natural disasters, and industrial accidents have led to an increase in long-term musculoskeletal conditions. Consequently, these contribute to a growing demand for well-equipped and strategically planned rehabilitation and assistive technology (AT) services.
1.2 Problem Statement	Uganda has only 12 orthopedic workshops that provide AT (mainly prosthetic and orthotic) devices to PWDs, yet the workshops are still struggling with inadequate raw materials and equipment. There are also very few rehabilitation workshop artisans in the country that can develop assistive devices for the PWDs. Health Infrastructure in Uganda's health systems constructed before 2010 did not make provisions for access for PWDs. Majority Health Facilities don't have equipment adapted for care of the PWDs. This limits access by PWDs to rehabilitative health and Assistive Device services. While the majority of the PWDs get assistive devices from health facilities, the country significantly lacks proper raw materials to be supplied to these public workshops for making assistive devices for the PWDs and these rely on private workshops which make it costly for the PWDs to access assistive devices.
1.3 Relevance of the Project Idea	Access and utilization of inclusive health (assistive technology and rehabilitation) services have remained a huge challenge in Uganda as a result of inadequate availability and accessibility to Assistive technologies,

	inadequate funding, limited scope and capacity of human resources to provide inclusive health services and inadequate data management systems and equipment maintenance systems. Less than 10% of people who need assistive devices in Uganda have/use them (Uganda Functional Disabilities Survey, 2017). This in-line undermines the constitutional mandate as highlighted in the 1995 constitution, PWDs Act 3 of 2020, NHP III, National Disability Inclusive Planning Guidelines and SDG 1, 3, 8 and 10 which is to promote and protect the rights of persons with disability by ensuring access to AT and Rehabilitation services
1.4 Stakeholders	
Section 2: Project Framework	
2.1 Project Goal	To enhance access to quality rehabilitation and assistive technology for Equitable and Inclusive Healthcare services for all, including people with disabilities (PWDs) across all levels of care
2.2 Project Outcomes	1. Increased knowledge and skills of healthcare workers in providing disability-inclusive services. 2. Improved access to quality healthcare services for PWDs in health facilities. 3. Enhanced data collection and reporting on disability inclusion planning and programming
2.3 Proposed Project Interventions	❖ Assessment of Healthcare Facilities: Conduct a comprehensive assessment and audits of local healthcare facilities to identify accessibility barriers for individuals with disabilities. ❖ Renovation and Modifications: Modify facilities based on the assessment for full accessibility. This includes architectural modifications, signage, and installation of assistive technologies (e.g., hearing loops, Braille signs). ❖ Curriculum Development: Develop training materials and programs focused on disability inclusion, rights, and care strategies. ❖ Training Sessions: Conduct workshops and training for healthcare professionals on providing inclusive care ❖ Carry out Awareness Campaigns and community outreach programs, including seminars, workshops, and distribution of educational materials on disability rights and inclusion in health services of persons with disabilities. ❖ Collaboration with Disabled Persons Organizations (DPO): Partner with local DPOs for effective outreach and campaigning ❖ Provide Assistive Devices and Mobility Aids (wheelchairs, hearing aids, and other necessary devices) to individuals based on assessed need. ❖ Procurement of disability inclusive medical equipment, devices and supplies for PWDs
2.5 Results Matrix	

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To enhance access to quality rehabilitation and assistive technology for Equitable and Inclusive Healthcare services for all, including persons with disabilities (PWDs) across all levels of care	% of HSP Disability-inclusion Project budget executed	PBS Reports	0%	100%	Availability of funds and staff
Outcomes Improved access to quality and quantity of healthcare services for PWDs at the regional Rehab/ AT health facilities	% of Rehab units/AT workshops retooled	PBS Reports	30%	95%	Availability of funds and staff
Increased knowledge and skills of healthcare workers in providing disability-inclusive services	Number of Health Workers trained/retooled	PBS Reports	10	80	Availability of funds and staff
Improved efficiency and effective disability health service delivery	% of Functional Equipment/AT units	Asset Registers	30%	100%	Availability of funds and staff
Improved independence, wellbeing and quality of life of PWDs	Number of PWDs/Beneficiaries fitted with AT devices	PBS Reports	1,200	6,000	Availability of funds and staff
Project Interventions/Outputs					
Assorted AT Equipment and machinery procured	Number of AT equipment and	Project Reports	10	60	Availability of funds and staff

and installed in Rehab/AT units/Workshops in Mbale, Lira, Entebbe and Mbarara RRHs for local production of Assistive Devices (Wheelchairs, White canes, Reading glasses, Prosthetics and orthotics)	machinery procured & installed	Asset register			
Access remodelling of existing Hosp/HF infrastructure in the Health regions to improve access for PWDs	%ge of Hospitals/HFs remodeled and/or have access for PWDs	Project reports	25%	65%	Availability of funds and staff
Assorted materials and supplies for Rehab/AT units/workshops in Mbale, Lira, Entebbe and Mbarara RRHs for local production of Assistive Devices procured	Number and types of Rehab/AT devices locally produced/distributed	Project reports & Beneficiary reports	1,200	6,000	Availability of funds and staff
District-level Rehabilitation Centers established and functional	%ge of Districts with rehabilitation centers	Project reports & Beneficiary reports	2%	10%	Availability of funds and staff
Specialist Rehab health Professionals /PHC workers trained in disability-inclusive health services delivery	Number of Rehab Health/PHC workers offered training in Rehabilitation.	Project reports & Beneficiary reports LG reports	40	80	Availability of funds and staff

Section 3: Estimated Project Cost (bn)						
Activity Plan	**FY 2025/26**	**FY 2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**Total cost**
Establishment of functional Rehab /AT workshops in Entebbe, Mbale, Gulu, and Mbarara RRHs for production of Assistive devices i.e., (wheel chairs, white canes, reading glasses, Orthotics & prosthetics	5.0	5.0	5.0	5.0	5.0	25.00
Remodeling of existing Rehab/AT infrastructure to improve access for PWDs	3.0	3.0	3.0	3.0	3.0	12.0
Establish functional District Level Rehabilitation centers	4.0	4.0	4.0	3.0	3.0	18.0
Procurement of disability inclusive medical equip ment, devices and supplies for PWDs		15.0				15.0
Specialist training in Reha b Health Professionals/PHC workers in disability-inclusive health services delivery	3.0	3.0	3.0	2.0	1.0	12.0
Project Management, Monitoring and Evaluatio n	2.0	5.0	2.0	1.5	0.5	11.0

Sub – Total	**17.00**	**35.00**	**17.00**	**14.50**	**12.50**	**93.00**
VAT (increase by 18%)	**3.24**	**6.48**	**3.24**	**2.43**	**1.89**	**17.28**
TOTAL COST	**20.24**	**41.48**	**20.24**	**16.93**	**14.39**	**113.28**

12. Institutional Development for Ministry of Health

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Institutional Development for Ministry of Health**
Project Code	**1923**
Project Duration	5 years
Estimated Cost (bn)	1.7 Bn
Officer Responsible	PS
Date of Submission	March 2025
Section 1: Project Background	
1.1 Situational Analysis	The Ministry of Health organs operate in buildings that are spread in different locations of Wabigalo, Vector Control offices located on Buganda Road, National Tuberculosis and Leprosy Centre, National Chemotherapy Research Institute (NCRI), Central Public Health Laboratory (CPHL) and Ministry of Health Headquarters. The Ministry of Health headquarters building was constructed over 20 years ago and as such the building requires constant renovations, upgrades and repairs of broken systems, sewage, water, Telephone upgrades, and electrical systems. These several structures need constant maintenance to ensure a conducive working environment for the staff and other stakeholders. Ministry of Health is implementing a new structure that was approved in 2018 and the new structure increased the staffing by 100%. This calls for the acquisition of work tools like furniture and computers. Furthermore, there is an overwhelming shortage of Health workers' uniforms across the country. Uniforms are a prerequisite in health service delivery and in order to cover the whole country with the required uniforms, it would require 4-5 years at the current level of funding.
1.2 Problem Statement	The Ministry of Health organs operate in buildings, which are spread in different locations, that is, The Ministry of Health Headquarter, the Health Infrastructure Department at Wabigalo, which houses workshops and several maintenance equipment, and the Vector Control Buildings. These several structures need to be maintained to ensure a conducive working environment for the staff and other stakeholders. In addition, there is need for constant

	retooling to enable smooth running of the Ministry operations through having good functional furniture, robust IT and other equipment. There is significant wear, tear and depreciation of ministry and government assets that would have served a greater purpose for longer if only they are well maintained. The offices in certain departments have been forced to use non-standard registers to have records e.g. library and other critical areas. This affects the uniformity of reporting and therefore brings about deficiencies in the quality of data captured for decision-making. The project seeks to procure e tools across the departments and projects in order to cover the gap in the medical data e.g., DHIS2 etc required to ensure proper reporting. Therefore, this calls for the need to revitalize, extend and scale up interventions for digitization under the project to ensure the previous gains are not lost
1.3 Relevance of the Project Idea	This retooling project will generally improve the availability of furniture, transport and ICT equipment at the Ministry of Health headquarters and its subsidiaries to improve working conditions and give better service delivery. This Project Proposal, therefore, focuses mainly on providing institutional support to the Ministry of Health to partially address the goal of the ministry of health strategic plan to "Strengthen the Health System and its support mechanisms with a focus on Primary Health Care to achieve Universal Health Coverage by 2030" As a result, the outcome of the implementation of the project will optimally contribute to addressing both the health sector goals and the national goals as outlined in the NDP IV. The project is also in line with the Sustainable Development Goals (SDGs), goal 3: Achieving Health for All, Vision 2040 and NRM Manifesto
1.4 Stakeholders	General Public MoH staff and affiliates
Section 2: Project Framework	
2.1 Project Goal	To enhance MoH capacity through delivery of quality, efficient and effective health services and systems.
2.2 Project Outcomes	Improved functionality of MoH operational assets from 70% to 95% Improved quality and efficient services offered at MoH and its affiliates from 65% to 95%
2.3 Proposed Project Interventions	Procure Assorted ICT Equipment procured and installed, Install and maintain Assorted ICT Equipment procured and installed, Procure Assorted furniture and fittings procured and installed, Install and maintain Assorted furniture and fittings procured and installed, Procure Assorted Equipment and machinery for MoH Headquarter procured, Install and maintain Assorted Equipment and machinery for MoH Headquarter procured

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions

Goal To enhance MoH capacity through delivery of quality, efficient and effective health services and systems.	% of MOH staff with functional office space and tools to work efficiently	MOH quarterly reports	65%	95%	Availability of funds and capacity
Outcomes Improved functionality of MoH operational assets from 70% to 95% Improved quality and efficient services offered at MoH and its affiliates from 65% to 95%	% MoH assets functional % MoH departments retooled	Asset Register	70% 65%	95% 95%	Availability of funds and capacity
Project Interventions/Outputs					
Assorted ICT Equipment procured and installed	Number of ICT equipment procured and installed	Asset Register	150	450	Availability of funds and capacity
Assorted furniture and fittings procured and installed	Number of furniture and fitting items procured and installed	Asset Register	95	250	Availability of funds and capacity
Assorted Equipment and machinery for MoH Headquarters procured	% of Ministry of Health Assets repaired & maintained	Asset Register	70%	98%	Availability of funds and capacity

Section 3: Estimated Project Cost (bn)						
Activity Plan	**FY 2025/26**	**FY2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**Total cost**

Procure furniture and fitting items to furnish offices for all staff including tables, chairs, cabins and carpets for VIP offices etc	0.10	0.11	0.12	0.14	0.15	0.62
Procure Computers, ICT accessories, Software and Hardware procured and installed i.e., Switches, Wireless Equipment, CCTV, AC, Routers, servers, Laptops, Library ICT equipment, hosting DHIS2 and maintenance	0.10	0.11	0.11	0.12	0.15	0.55
Procure assorted equipment for maintenance/servicing of MoH headquarter assets e.g., elevator, CCTV, fire control and other fittings	0.07	0.08	0.09	0.10	0.10	0.46
Sub – Total	**0.27**	**0.30**	**0.32**	**0.35**	**0.38**	**1.63**
VAT (increase by 18%)						
TOTAL COST	**0.27**	**0.30**	**0.32**	**0.35**	**0.38**	**1.63**

13. Uganda Health Services Transformation Project (UHSTP)

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Uganda Health Services Transformation Project**
Project Code	
Project Duration	5 years
Estimated Cost (bn)	1,124.7 Bn

Officer Responsible	PS
Date of Submission	Nov 2024
Section 1: Project Background	
1.1 Situational Analysis	Uganda's current population is estimated to be 45.9 million in 2024. It is expected to increase at an average growth rate of 2.9%, which will result in 51 million by 2030; according to the 2024 census conducted by the Uganda Bureau of Statistics (UBOS), 44% of the population is under age15, and females of 10 – 19 years (teenage girls) are 12% of the population. Women of reproductive age (WRA, 15-49 years) constitute 24% of the total population, and 64% are under age 25. Uganda's current fertility rate is estimated to be 5.2%, which majorly contributes to the population growth within the country According to the Uganda Demographic and Health Survey (UDHS) 2022, Uganda's Maternal Mortality Rate (MMR) declined from 438 deaths per 100,000 live births in 2011 to 336 in 2016 and to 189/100,000 live births in 2022. Under-five mortality (per 1000 live births) reduced from 151 in 2001 to 36 deaths in 2022. Neonatal mortality, which had stagnated at 27 deaths per 1000 live births since 2006, was reduced to 22 deaths in 2022. Notwithstanding the above progress, the deaths remain unacceptably high, especially when compared to the targets of the` UN Sustainable Development Goals; by 2030, neonatal mortality is expected to have reduced to at least 12 deaths per 1000 live births, under 5 mortality to 25 deaths per 1000 live births and the global maternal mortality ratio of no more than 70 deaths per 100,000 live births. Pregnancy-related sepsis or abortion complications are relatively higher among adolescents and young mothers, accounting for 39% of deaths. About 60% of maternal deaths in health facilities are attributed to preventable factors such as late referrals and delays in accessing lifesaving interventions like safe cesarean sections, management of high blood pressure with magnesium sulfate, prevention and management of postpartum hemorrhage Functionalizing Basic Emergency Obstetric and Newborn Care (BEmONC) facilities at HCIIIs in all sub-counties and Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities at HC IVs in all constituencies would reduce preventable maternal deaths
1.2 Problem Statement	Lack of these services at HCIVs results in the following: avoidable referrals to Hospitals-which is costly to both the Government of Uganda and households; congestion at secondary and tertiary levels of care impacting quality of care; delay in accessing quality care; obstetric complications; maternal and newborn deaths. A recent survey to inform this concept note established that several HCIVs have obsolete and condemned theatres, some of which need reconstruction, while others require renovation and expansion to meet the revised MoH design standards and specifications. Wards are inadequate, especially as compared to the new standards of transforming HCIVs into community hospitals and with new services introduced, especially the focus on care for newborns.

	In Uganda, an estimated 6,600 women and 80,000 infants die of preventable deaths every year. Neonatal mortality, which had stagnated at 27/1,000 live births since 2006, has recently reduced to 22/1000 births but still falls short of the NDP III target of 19/1000 by 2024/25. Children younger than 5 years disproportionately contribute to almost half (44%) of the health facilities admissions despite One in three deaths (30%) of children in this age category being newborns. Of the newborn deaths, 73% occur in the first week of life, while 36% die on the day of birth. The deaths are due to asphyxia (breathing complications), complications of pre maturity (14%), and septicemia. Investment in improving capacity to care for newborns can significantly reduce avoidable deaths among neonates within the first week of life and under 5 years of age in general. This will include setting up Neonatal Intensive Care Units (NICUs), special care units (SCUs), continuous mentorship of health workers in the care for newborns and mothers, procurement of medicines to manage childhood conditions, and to manage children born with sickle cell anemia that also accounts for 16% of under 5 mortality. It is estimated that 50-90% of children with sickle cell disease die before 5 years of age. There is limited awareness about sickle cell disease and limited capacity to diagnose infants with the condition. Effective care for newborns and their mothers requires sustaining investments system as into the referral system as long as the priorities of the national emergency services strategy
1.3 Relevance of the Project Idea	To achieve full functionality of HC IVs, the renovated health facilities will be equipped with obstetric, neonatal, pediatric, surgical, diagnostic, and general equipment and medical furniture. There is also a need to supplement the budget for essential medicines, family planning commodities, and health supplies to realize the full potential of HCIVs. In line with the NDP IV focus on disease prevention, the Ministry will also, as part of improving the functionality of HC IVs, invest in community health along with the priorities of the recently launched national community health strategy (2022). Sensitization of communities is cost-effective as it aids disease prevention and referral of sick mothers and children The NDP IV proposes specific projects to improve the functionality of health facilities and referral systems, constructing staff housing, functionalizing neonatal care units, and training health workers. The interventions proposed under this project are, therefore, derived from the NDP IV and the Ministry of Health Strategic Plan. The project seeks to achieve the functionality of HCIVs to provide the nine signal functions of Comprehensive Emergency Obstetric and Newborn Care. This will improve access and quality of care for mothers and children with complications, thereby reducing maternal and neonatal mortality. The project will also invest in enhancing the management of newborn conditions. To address sickle cell disease, the project will invest in raising health awareness amongst health workers and the community, as well as early diagnosis and management. As highlighted in the proposal background, this condition is estimated to

	be responsible for up to 16% of under-5 mortality, with 13.1% of Uganda's population estimated to carry the sickle cell trait
1.4 Stakeholders	General Public (Patients) MoH staff and affiliates (Health Votes) District Local Governments Training Institutions
Section 2: Project Framework	
2.1 Project Goal	To increase the proportion of the population accessing Universal Health Care (UHC) from 49% in 2023/24 to 60% by 2029/30
2.2 Project Outcomes	Reduced mortality rate per 1000 admissions at HCIVs from 8 in 2023/24 to 4 by 2029/30 Increased availability of critical skills (cadres) from 5% to 20% by 2030
2.3 Proposed Project Interventions	199 HCIVs renovated and functionalized to provide services at the HCIV level of care Operationalize 55 Neonatal Intensive Care Units (NICUs) at General Hospitals. Construction of 4 regional Blood Banks and 1 National Biosafety Laboratory Construction of 2 and equipping of 15 Regional equipment maintenance workshops Health workers Trained and mentored Strengthen Emergency Medical Services

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To increase the proportion of the population accessing Universal Health Care (UHC) from 49% in 2023/24 to 60% by 2029/30	Universal Health Coverage (UHC) Index	AHSPR	49%	60%	Availability of funds and capacity
Outcomes Reduced mortality rate per 1000 admissions at HCIVs from 8 in 2023/24 to 4 by 2029/30	Number of HC IVs providing all the 9 signal functions of Comprehensiv	AHSPR	10	199	Availability of funds and capacity

Increased availability of critical skills (cadres) from 5% to 20% by 2030	e Emergency Obstetric and Newborn Care (CeMNOC) Percentage increase in availability of in-service skilled health workers	AHSPR/IHRIS	5%	25%	Availability of funds and capacity
Project Interventions/Outputs					
199 HCIVs renovated and functionalized to provide services at the HCIV level of care	Number of HCIVs renovated and equipped to provide services at the HCIV level of care	AHSPR PBS Project reports	43	199	Availability of required funds, skills, staffing levels and adequate Supervision by the Local Governments
Operationalize 55 Neonatal Intensive Care Units (NICUs) at General Hospitals	Number of Neonatal Intensive Care Units (NICUs) at General Hospitals fully Operationalized	Project Reports PBS	2	55	Availability of required space for renovation at the General Hospital. Adequate Supervision by the Local Governments
Construction of 4 regional Blood Banks and 1 National Biosafety Laboratory	Number of Regional Blood Banks Constructed and equipped	Project Reports PBS	8	13	Availability of funds and capacity Availability of unencumbered Land for construction

Construction of 2 and equipping of 15 Regional equipment maintenance workshops	Number of Regional equipment maintenance workshops equipped	AHSPR PBS Project reports	2	17	Availability of all key staff at the regional workshops
Health workers Trained and mentored	Number of people trained in specialized areas	AHSPR PBS Project reports	10	144	Availability of funds and capacity
Strengthen Emergency Medical Services	Number of functional Type B Road Ambulances procured and deployed	AHSPR PBS Project reports	0	20	Availability of funds and capacity

Section 3: Estimated Project Cost (bn)

Activity Plan	FY2025/26	FY2026/27	FY2027/28	FY2028/29	FY2029/30	Total cost
199 HCIVs renovated and functionalized to provide services at the HCIV level of care	43.96	263.77	263.77	175.85	131.89	879.25
Operationalize 55 Neonatal Intensive Care Units (NICUs) at General Hospitals	4.13	24.75	24.75	16.50	12.38	82.50
Construction of 4 regional Blood Banks and 1 National Biosafety Laboratory	2.58	15.45	15.45	10.30	7.73	51.51
Construction of 2 and equipping of 15 Regional	2.48	2.40	1.14	1.07	0.20	7.27

equipment maintenance workshops						
Health workers Trained and mentored	10.24	10.09	10.09	2.88	2.34	35.63
Strengthen Emergency Medical Services	0	2.43	2.43	1.22	0	6.08
Project Management and M&E	15.86	11.67	11.67	11.67	11.67	62.54
Sub – Total	**79.25**	**330.56**	**329.30**	**219.49**	**166.18**	**1,124.77**
VAT (increase by 18%)						
TOTAL COST	**79.25**	**330.56**	**329.30**	**219.49**	**166.18**	**1,124.77**

14. Healthcare Waste Management Project

Sector	**Health**
Vote	014
Program	Human Capital Development
Sub Program	Health
Project Name	**Healthcare Waste Management Project**
Project Code	
Project Duration	5 Years
Estimated Cost (bn)	26 Bn
Officer Responsible	PS
Date of Submission	August 2025
Section 1: Project Background	
1.1 Situational Analysis	Uganda's healthcare system is expanding at an increasing rate and thus posing a threat to proper healthcare waste management processes. This is evidenced in the current unsatisfactory management practices ranging from poor segregation, storage, and indiscriminate disposal of hazardous waste across the country due to lack of an efficient health care waste management (HCWM) system. These wastes end up mixed with biodegradable waste hence posing significant health risks to healthcare workers, patients, and the public, leading to the spread of infectious and other diseases including environmental pollution. An assessment conducted on WASH in HCFs by Ministry of Health (2022) across 4,272 HCFs in 136 districts on HCWM services indicators found only 23.4% of HCFs with advanced, 56% with basic, 18% with limited and 3% with no service at all, respectively. Across the demographic regions, West Nile, Acholi, Karamoja and Kampala regions had the highest number of HCFs with advanced level of access to HCWM estimated at 47.9%, 46.7%, 31% and 30% respectively. Bukedi, Bugishu and Busoga had the least number of HCFs with advanced HCWM estimated at 10%, 13.2% and 13.4% respectively.

	Relatedly, across the districts, Lamwo (82.8%), Obongi (70.6%) and Koboko (69.2%) were ranked as leading with the highest number of HCFs with advanced access to HCWM services. Dokolo and Bulisa districts did not have any HCF with access to safe HCWM
1.2 Problem Statement	Uganda's healthcare system is currently facing a critical challenge due to unsatisfactory healthcare waste management (HCWM) practices. Issues like poor segregation, inappropriate transportation, and indiscriminate disposal are not only jeopardizing the quality of healthcare service delivery but also actively exposing healthcare workers, patients, communities, and the environment to dangerous infectious materials. The severity of this problem was highlighted in a 2022 Ministry of Health (MoH) assessment of 4,272 healthcare facilities across 136 districts. This assessment revealed that a staggering 76.6% of these facilities lack efficient HCW management systems, with only a small minority (23.4%) possessing advanced systems. This significant gap demonstrates a widespread systemic failure in managing potentially hazardous waste. While the Ministry of Health has developed a National Healthcare Waste Management Strategy to address the risks posed by the high volume of infectious waste generated from both routine services and emerging/re-emerging epidemics, and the government has initiated deliberate investments, current efforts remain insufficient. These initiatives include engaging the private sector through Public-Private Partnerships (PPP) to procure and install environmentally friendly incinerators and 10 specialized waste transportation trucks. Additionally, the MoH has issued circulars urging local governments to adequately plan and budget for HCWM
1.3 Relevance of the Project Idea	Uganda's growing healthcare system, though essential for national well-being, is grappling with a substantial increase in Healthcare Waste (HCW) generation. This surge is largely due to the rising prevalence of preventable diseases, and unfortunately, current waste management practices are severely lacking. This inadequacy directly undermines the country's strides in healthcare service delivery. The problem is further exacerbated by Uganda's high vulnerability to public health emergencies. Located near multiple epidemic hotspots, such as the Congo Basin, and experiencing rapid population growth and a significant influx of refugees, Uganda's health system is prone to generating exceptionally large volumes of healthcare waste during outbreaks. Moreover, as a signatory to vital international agreements including the Stockholm Convention on Persistent Organic Pollutants (POPs), the Kyoto Protocol, and the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal, Uganda is obligated to establish and enforce mechanisms, guidelines, and regulations for the safe management of healthcare waste, aligning with global standards. The World Health Organization (WHO) also underscores the importance of enhancing climate resilience and environmental sustainability within healthcare facilities through effective HCW management.
1.4 Stakeholders	Direct beneficiaries/communities, health and environmental health workers, NEMA, local leadership, indirect beneficiaries and project affected persons
Section 2: Project Framework	
2.1 Project Goal	To establish a sustainable healthcare waste management system that protects public health and the environment
2.2 Project Outcomes	• Competent and skilled healthcare workforce to manage healthcare waste • Enhanced infrastructure, technology and supplies for healthcare waste management

2.3 Proposed Project Interventions	1. Enhanced best practices for HCWM among the health workforce 2. HCWM committees constituted and operationalized at sub-national levels 3. HCWM infrastructure and equipment procured, installed and operationalized 4. HCWM supplies procured and distributed

2.5 Results Matrix

Objective	Indicator	Means of Verification	Baseline	Target	Assumptions
Goal To establish a sustainable healthcare waste management system that protects public health and the environment	% of LGs with access to basic HCW services	DHIS2 AHSPR	55%	70%	Availability of funds and staff
Outcomes Effective healthcare waste management achieved through a competent workforce and robust multi-level governance Competent and skilled healthcare workforce to manage healthcare waste	% of HCF with competent and skilled healthcare % of HCF with appropriate HCWM equipment and supplies	DHIS2 AHSPR	10% 74%	60% 100%	Availability of funds and staff
Enhanced infrastructural, technology and supplies for healthcare waste management	% of HCF with access to function incinerators	DHIS 2/PBS	56%	65%	Availability of funds and staff
Project Interventions/Outputs					
Enhanced best practices for HCWM among the health workforce	Number of health facilities supported to improve HCWM	Project reports PBS	70	170	Availability of funds and staff/capacity
HCWM committees constituted and operationalized at sub-national levels	Number of district local governments	Project reports PBS	20	146	Availability of funds and staff

	with functional HCWM committees				
HCWM infrastructure and equipment procured, installed and operationalized	No. of functional HCWM incinerators	Project reports AHSPR	3	20	Availability of funds and staff
HCWM supplies procured and distributed	% availability of HCWM supplies procured and distributed	PBS Reports AHSPR	30%	90%	Availability of funds and staff

Section 3: Estimated Project Cost (bn)						
Activity Plan	**FY 2025/26**	**FY 2026/27**	**FY 2027/28**	**FY 2028/29**	**FY 2029/30**	**Total cost**
Skilling, mentoring, retooling and administrative support to the health workforce to enhance best practices for healthcare waste management	0.6	0.7	0.8	0.9	1.0	4.0
Establish and operationalize HCWM committees at sub-national levels	0.3	0.35	0.4	0.45	0.5	2.0
Procure, install and maintain HCWM equipment such as incinerators, storage sheds, disinfection areas trucks, autoclaves, shredders	3.0	3.0	3.0	3.0	3.0	15.0
Procure and distribute HCWM supplies such as Personal Protective Equipment (PPE), bins, bin liners, and safety boxes	1.0	1.0	1.0	1.0	1.0	5.0
Sub – Total	**4.9**	**5.05**	**5.2**	**5.35**	**5.5**	**26.0**
VAT (increase by 18%)						
TOTAL COST	**4.9**	**5.05**	**5.2**	**5.35**	**5.5**	**26.0**

ANNEX III: RISKS MANAGEMENT STRATEGY

Risk Category	No.	Risk	Description/Cause	Likelihood	Impact	Overall Risk Rating	Mitigation Strategy	Lead Actor
Operational	1	Inadequate staffing at MoH Headquarters and decentralized levels	Delays in recruitment, limited wage bill, high attrition rates, and limited specialized skill sets	High	High	High	Continuous engagement with Service Commissions and MoPS to fast-track recruitment, implement staff retention strategies, and strengthen HRH planning systems	MoH HRM Division, HSC, MoPS
	2	Inadequate Financing and Budget shortfalls	Inadequate GoU allocations, overdependence on donors, and delayed fund disbursements	High	High	High	Engagement with MoFPED and partners to increase sector funding and adopt performance-based financing and resource mobilization strategies	MoH P&P and B&F Divisions, MoFPED
	3	Limited digital infrastructure and system interoperability	Inadequate ICT infrastructure, poor internet connectivity, and siloed health information systems	High	High	High	Invest in ICT infrastructure, strengthen interoperability standards, and implement the e-Health policy	MoH-DHI, NITA-U
Risk Category	**No.**	**Risk**	**Description/Cause**	**Likelihood**	**Impact**	**Overall Risk Rating**	**Mitigation Strategy**	**Lead Actor**
	4	Loss of public trust in health services	Perceived or actual poor quality of care, corruption, stockouts, and negative media coverage	Medium	High	High	Strengthen client feedback systems, enforce quality assurance protocols, and enhance transparency in communication	MoH - SCAPP Department, PRO Unit
	5	Non-adherence to planning, budgeting, and reporting guidelines	Limited capacity and oversight at sub-national levels	Medium	Medium	Medium	Capacity building, regular audits, and integration of digital compliance monitoring systems	MoH P&P Division, LGs, MoLG
Strategic	6	Poor intersectoral coordination and governance	Fragmented roles among MDAs, weak policy implementation, duplication of functions	Medium	High	High	Operationalize the HPAC, strengthen joint planning, and enforce MoUs with other stakeholders like MDAs	MoH - HP&MSC, OPM
	7	Inadequate legal and regulatory enforcement.	Outdated laws and weak enforcement mechanisms	Medium	Medium	Medium	Review and update health sector legislation; enhance inspection and compliance monitoring	MoH – P&P Division, Parliament, MoJCA
	8	Frequent restructuring and policy changes	Changes in leadership, unclear mandates, and institutional overlaps	Medium	Medium	Medium	Strengthen policy coherence, maintain institutional memory, and engage stakeholders in reform processes	MoH Top Management, OPM, MoPS

Risk Category	No.	Risk	Description/Cause	Likelihood	Impact	Overall Risk Rating	Mitigation Strategy	Lead Actor
	9	Operating under an uncertain environment	Lack of an enabling law for comprehensive Healthcare Services	High	Medium	Medium	Enact a comprehensive Healthcare Services Law	MoH – P&P Division, Parliament, MoJCA
	10	Misalignment of national & subnational planning	Weak coordination and data harmonization	Medium	Medium	Medium	Strengthen subnational planning capacity; link performance with financing	MoH, LGs, MoLG
External	11	Economic shocks and inflation	Unpredictable exchange rates, rising commodity and construction costs	High	Medium	High	Improve budget forecasting; build financial buffers; prioritize critical expenditures	MoH F&A, MoFPED
	12	Instability or insecurity in certain regions	Civil unrest, conflicts, and refugee influx disrupting health service delivery	Low	High	Medium	Strengthen coordination with security agencies, develop contingency plans, and integrate emergency health response in fragile settings	MoH NDC, OPM, MoD
	13	Pandemics and global health emergencies	Globalization, refugee influx, weak surveillance and laboratory systems	High	High	High	Invest in IHR core capacities, strengthen disease surveillance, and emergency preparedness at all levels	MoH NDC, WHO, OPM
	14	Climate change and environmental hazards	Extreme weather, floods, drought, vector migration, poor waste management	Medium	High	High	Mainstream climate resilience into health programming and promote intersectoral collaboration with NEMA and MWE	MoH EHD, NEMA, MWE

ANNEX IV: STAFFING LEVEL BY DEPARTMENT (JULY 2025)

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Post	Approved No.	No. Filled	No. Vacant	% Filled
Ministers' office	16	11	5	69%
Office of the Permanent Secretary	12	8	4	67%
Office of Director General of Health Services	4	4	0	100%
Department of Finance and Administration	56	50	50	89%
Human Resource Management Department	11	15	3	136%
Procurement Division	10	8	2	80%
Internal Audit Division	9	8	1	89%
Directorate of Strategy, Policy and Devt				
Office of the Director of Strategy, Policy and Devt	4	3	1	75%
Department of Planning, Financing and Policy	39	27	12	69%
Department of Health Infrastructure	32	23	9	72%
Department of Institutional and Human Resource Development	47	21	23	45%
Department of Health Education, Promotion and Communication	16	11	5	69%
Directorate sub-total	**138**	**85**	**50**	**62%**
Directorate of Public Health				
Office of the Director of Public Health	4	3	1	75%
Department of Reproductive and Child Health	17	11	6	65%
Department of Community Health	18	13	5	72%
Department of Environmental Health	36	17	10	47%
Department of Communicable Diseases Prevention and Control	60	38	22	63%
Department of Non-Communicable Diseases	15	12	2	80%
Department of National Health Laboratory and Diagnostic Services	22	8	15	36%
Department of Integrated Epidemiology, Surveillance and Public Health Emergencies	30	22	7	73%
Directorate Sub-total	**202**	**124**	**68**	**61%**
Directorate of Curative Services				
Office of the Director of Curative Services	4	3	0	75%
Department of Nursing and Midwifery Services	20	11	9	55%
Department of Clinical Services	117	89	48	76%
Department of Pharmaceuticals and Natural Medicines	12	13	3	108%
Department of Emergency Medical Services	8	7	1	88%
Directorate Sub-total	**161**	**123**	**61**	**76%**
Directorate of Health Governance and Regulation				
Office of Director Health Governance and Regulation	4	2	2	50%
Department of Standards, Accreditation and Patient Protection	25	14	10	56%
Department of Health Sector Partners and Multi-Sectoral Coordination	14	4	10	29%
Professional Councils	6	5	1	83%
Directorate sub-total	**49**	**25**	**23**	**51%**
GRAND TOTAL	**668**	**461**	**267**	**69%**

10 REFERENCES

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2) Draft 3rd National Health Policy
3) MoH Strategic Plan 2020/21 - 2024/25
4) Annual Health Sector Performance Reports
5) Uganda Malaria Reduction Strategic Plan 2014 – 2020, MoH
6) National HIV/AIDS Strategic Plan 2025/26 - 2029/30, UAC 2015
7) Health Financing Strategy 2015/2016 - 2024/2025, MoH
8) Reproductive Maternal, New-born, Child and Adolescent Health Sharpened Plan, MoH 2016
9) National Population and Housing Census, UBOS 2014
10) National Health Accounts Report 2019/20 - 2020/21, MoH
11) Uganda Demographic and Health Survey, UBOS 2022
12) Uganda HIV/AIDs Impact Assessment, MoH 2022
13) Health sector Ministerial Policy Statements, Financial Years 2020/21 to 2024/25
14) The Emergency Medical Services Strategic Plan 2020/21 to 2025/26
15) The Emergency Medical Services Status Report 2023, MoH 2023

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