THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Sector Grant and Budget Guidelines to Local Governments

FY 2020/21

FOREWORD

These guidelines are issued by the Ministry of Health to Local Governments to provide information about the sector conditional grants and to guide on utilization and accountability of these grants during the Financial Year 2020/21. The guidelines are tools to prepare accurate work plans and budget estimates for health service delivery in each District Local Government.

The guidelines consist of; National Policies for the sector, an overview of Central Government Grants to Local Governments, the role and mandate of Local Governments in the sector, an explanation of how these are allocated to each Local Government, and budget requirements.

The sector continues to implement policies that are aligned to H.E the President's **23 Strategic Guidelines** and Directives that will deliver a minimum development package for every Ugandan in order to attain the middle income status by 2020.

During FY 2020/21 the sector continues to re-prioritize **Health Promotion, Disease Prevention, hygiene and Sanitation** and **30% of Non-wage Recurrent** has been earmarked to undertake activities related to these priority areas across the spectrum. **Thirty percent (30%)** of the Non- Wage Recurrent at each level, i.e. Local Government Health Office, District Hospital and each Facility shall be used for this purpose. It will be at the discretion of the Local Government to appropriately agree on the percentage based on the need and performance in these priority areas.

The sector grants to Local Governments are divided into seven categories: namely; the Conditional Wage Grant, Conditional Non-Wage Grant, The Transitional Development Sanitation Grant, the Transitional Development Ad Hoc Grant, Result Based Financing (RBF), GFTAM and GAVI HSS2 subventions. Local Governments are required to provide timely accountabilities of these grants and comprehensive guidelines for RBF and HSS2 shall be provided.

Lastly, allow me to re-echo my appeal that during FY 2020/21 we all refocus on activities associated with **Health Promotion, Disease Prevention, Hygiene and Sanitation** so as to reduce the cost of health care in localities.

Dr. Diana Atwine
PERMANENT SECRETARY

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ABBREVIATIONS AND ACRONMYNS

AWP&B	Annual Work Plan & Budget
BFP	Budget Framework Paper
BOQ	Bills of Quantities
CAO	Chief Administrative Officer
CBO	Community Based Organizations
CHEW	Community Health Extension Worker
CPD	Continuous Professional Development
DDP	District Development Plan
DHO	District Health Office/Officer
EMHS	Essential Medicines and Health Supplies
GAVI	Global Alliance for Vaccines and Immunization
GH	General Hospital
GoU	Government of Uganda
GRC	Grievance Redress Committee
GRM	Grievance Redress Mechanism
HC	Health Centre
HF	Health Facility
HLG	Higher Local Government
HMIS	Health Management Information Systems
HRM	Human Resource Management
HSD	Health Sub District
HSDP	Health Sector Development Plan
HUMC	Health Unit Management Committee
IFMS	Integrated Financial Management System
IGFT	Inter-Governmental Fiscal Transfer
IGG	Inspector General of Government
IMR	Infant Mortality Rate
IPF	Indicative Planning Figure
JMS	Joint Medical Stores
LGFAR	Local Government Finance and Accountability Regulations
LG	Local Government
LLHU	Lower Level Health Unit
PFMA	Public Financial Management Act
M&E	Monitoring an Evaluation
MC	Municipal Council
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
NDP	National Development Plan
NMS	National Medical Stores
NWR	Non-Wage Recurrent
O&M	Operation and Maintenance
O/W	Of Which
OPD	Out Patient Department
OPM	Office of the Prime Minister
OTIMS	Online Transfer Information Management System

P4R	Program for Results
PFMA	Public Finance Management Act
PHC	Primary Health Care
PHP	Private Health Providers
PNFP	Private Not for Profit Providers
PPDA	Public Procurement & Disposal of Assets
RDC	Resident District Commissioners
RMNCAH	Reproductive Maternal Neonatal Child & Adolescent Health
RRH	Regional Referral Hospital
SG	Solicitor General
TC	Town Council
TCMP	Traditional Complimentary Medicines Practitioners
TEC	Technical Evaluation Committee
UHC	Universal Health Coverage
UNMHCP	Uganda National Minimum Health Care Package
USF	Uganda Sanitation Fund
VHT	Village Health Teams

1. CHAPTER ONE: INTRODUCTION

1.0 Introduction

These guidelines are issued by the Ministry of Health to Local Governments to provide information about the sector conditional grants and guide the preparation of Local Government budget estimates for the Health sector. They give details of (i) the national policies for the sector, (ii) the role and mandate of LGs in the sectors, (iii) an overview of Central Government grants to LGs, (iv) an explanation of how grants are allocated to each LG, and (v) requirements that LGs must follow when preparing the budget.

1.1 Purpose of the Guidelines

This document is to provide guidance for the budgeting and utilization of the Primary Health Care (PHC) grants and other decentralized health grants in Financial Year (FY) 2019/20. These guidelines should be used to prepare and implement annual work plans for both Public and Private-Not-For-Profit (PNFP) facilities as well as Private Health Provider facilities where applicable.

Financial Management and Accounting procedures should be guided by the Public Finance Management Act 2015, Local Government and Accounting Regulations 2007, the Public Procurement and Disposal Act (PPDA) 2015 and any other guidelines as approved by the MoH, particularly the Clinical Guidelines 2016, the Results based financing implementation manual, and guidelines issued by GAVI.

1.2 National and Sector Policy and Priorities

In line with the National Development Plan (NDP III) the health sector efforts will be geared towards attainment of Universal Health Coverage (UHC) through: Strengthening of the national health system including governance and regulatory framework, Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Services, Communicable and Non-communicable disease prevention, mitigation and control, Health Education and Promotion (Lifestyle, hygiene, nutrition) using a multi-sectoral approach, Essential clinical care services including rehabilitation and palliative care, Health infrastructure development**.**

1.3 Health sector strategic approaches to improve health service delivery

The Ministry has prioritized the following strategies to improve health service delivery in FY 2020/21;

1. Scaling up public health interventions to address the high burden of preventable diseases in the country. This will be done through Prioritizing Health Promotion, Prevention and early intervention with focus on scaling up interventions to address the high burden of HIV/TB, malaria, nutritional challenges, environmental sanitation and hygiene, immunization, Hepatitis B and Non Communicable Diseases.
2. Infrastructural developments; constructions, rehabilitation and remodeling focusing mainly on HC IIIs, HC IV and General hospitals with special needs like islands, difficult to reach areas, large populations.
3. Improvement of Reproductive, Maternal, Neonatal, Child and Adolescent health services to reduce on mortality and morbidity and improve their health status.
4. Performance Management, Efficiency and Accountability.

5. Human resources for health training, attraction, job scheduling, motivation, retention and development will be prioritized. Additional resources for recruitment and incentives have been mobilized.

1.4 Mandate of Local Governments

In order to achieve the above priorities, LGs have the responsibility of ensuring that the population has access to health services through annual operational planning, management and delivery of quality health services by carrying out:

a) Community mobilization
b) Supervision
c) Monitoring
d) Resource mobilization, and allocation according to guidelines and other restrictions
e) Enforcement of the health related laws and regulations

The Local Government Act (schedule 2) specifies that Local Governments (LGs) have the responsibility of delivering on the National Health Policy. This includes responsibilities for medical and health services such as: hospitals, but not regional referral hospitals; all health centres (HCs); government facilities; Private Not For Profit (PNFP) health facilities; maternity and child welfare services; communicable disease control, especially malaria, HIV/AIDS, TB and leprosy; control of other diseases; ambulance services; vector control; environmental sanitation; health education; quality monitoring of water supplies; supervision and monitoring of the private sector; and implementation/enforcement of the various Health Acts.

The responsibility centres for implementation of these activities are at four levels: the District Local Government (DLG) level, the health sub-district (HSD) level (HC IVs), lower level health facilities level and the community level. The District Health Officer (DHO), under the supervision of the Chief Administrative Officer (CAO) and Ministry of Health (MoH), provides overall leadership in the delivery of Health Services.

2. CHAPTER TWO: THE UGANDA HEALTH SYSTEM

2.0 Overview of the PHC Service Delivery System

This chapter provides an overview of the PHC service delivery system and the responsibilities of the LGs and the health facilities.

The Constitution and the LGs Act 1997 (with Amendment Act 2001) defines the legal mandate of the District/Municipal Councils. In the health sector, the District/Municipal Councils are responsible for Medical and Health services including:

i. Management of general hospitals and health centres in the respective catchment areas
ii. Supervision and monitoring of the private sector
iii. Implementation/enforcement of the various health acts
iv. Delivering the UNMHCP. The components of the UNMHCP are grouped under the four clusters of the health sector interventions listed below;
    a) Health promotion, disease prevention and community health initiative elements
    b) Maternal and child health elements
    c) Prevention and control of communicable diseases
    d) Prevention and control of non-communicable diseases

The responsibility Centres for implementation of these activities are at four levels: the District LG level, the HSD level, Lower Level Health Facilities (LLHF) level and the Community level. The DHO, under the supervision of the CAO and MoH, provides overall leadership in the delivery of health services.

The MoH Service Standards recommend that a General Hospital should serve a population of 500,000 people, HC IV should serve 100,000 people, HC III should serve 20,000 people and HC II 5,000 People.

The MoH continues to prioritize the process of establishing and functionalizing Health facilities as per the above standards across the country in a phased manner by; upgrading HC IIIs to HC IVs in constituencies/counties where they do not exist, upgrading HC IIs to IIIs in Sub-Counties/ Town Councils/ Divisions without a HC III; and construct HC IIIs in Sub-Counties/ Town Councils/ Divisions without health facilities at all.

At parish level and village level, Village Health Teams (VHTs) will continue as voluntary structures until MoH communicate further.

2.1 Role of Local Governments

The roles of the LGs in Health can be summarized as:

- Mobilize and allocate resources
- Plan and Budget for the services they are responsible for including compiling the LG Budget Framework Papers (BFP)
- Approve District Development Plans (DDP) and Annual Work plans and Budgets (AW&B)
- Monitor the overall performance of the district/municipal health care delivery system
- Human resources for health development management (recruitment, deployment, in- service- training, career development, payroll management, etc.)
- Control of epidemics
- Advocacy for health
- Health Systems Research.

2.2 Role of the District Health Offices and Municipal Health Offices

The District/Municipal Health Office is the technical arm of the District/Municipal Council in the management of the District/urban health system. The core functions of the office revolve around the following management and technical support functions:

1. Policy Implementation and Planning:
2. Human Resource Development Management
3. Quality Assurance / Support Supervision
4. Coordination and Integration of Health Services
5. Disease and Epidemic Control / Disaster Preparedness
6. Monitoring and Evaluation (M&E) of District Health Services
7. Advocacy for Health Services
8. Health Systems Research

2.3 The General Hospitals

These provide preventive, promotive, outpatient curative, maternity, inpatient services, emergency surgery, blood transfusion, laboratory services and other general services. They also provide in-service training, consultation and research in support of the community based health care Programmes.

The General Hospital funds should be allocated to the following expenditure categories; capital items, domestic arrears, Hospital based PHC activities, Maintenance of medical equipment and buildings, training and capacity building, cleaning wards and compounds, utilities, vehicles and generator O&M, Medical and office equipment, food supply (including firewood), Other supplies, Administration, staff allowances, transport and training).

Support for Hospital based PHC activities. About 10% PHC primary health care activities such as immunization, supervision visits, outreach activities, sensitization, health promotion talks, Household/community based activities e.g. environmental health issues, sanitation etc**. it has a target population of 500,000.**

2.4 The Role of a Health Centre IV

The HC IV is mainly a PHC referral facility where patients are assessed, diagnosed, stabilized, and either treated or referred back to a lower level or referred to a higher level of health facility. The HC IV OPD functions as the entry point 7to the health system where there are no LLHUs within 5KMs. It is also the first point of entry for referrals from the LLHUs and for self-referrals in case of an emergency. The HC IV brings inpatient and emergency services including emergency obstetric care closer to the population in rural areas. Provision of 24-hour comprehensive emergency obstetric care service is a crucial aspect of a HC IV. It has a target population of 100,000.
In addition, a HC IV serves the functions of the basic peripheral unit in the constituency where it is located and also serves the function of a HC III, over and above the functions elaborated above.

2.5 The Role of a Health Centre III

A HC III serves the functions of the basic peripheral unit in the Sub-county where it is located while at the same time performing the supervisory function for all the HC IIs in the Sub-county. It has a target population of 20,000.

2.6 The Role of a Health Centre II

The lowest planning unit of the district/municipal health system is the HCII. This is the health unit that serves as the interface between the health care system and the community at parish level. This arrangement fulfils the principle of "close to client" and enables close collaboration between the health service providers and the community structures like the Village Health Teams (VHTs), Parish Development Committees, Women Councils, Youth Councils and Councils for Disabled Persons.it has a target population of 5,000.

3. CHAPTER THREE: GRANT DETAILS

3.0 Structure and Purpose of Wage, Non-Wage Recurrent, Development Grants, and selected subventions

This chapter elaborates the guidelines, including the allocation formulae for generating the Indicative Planning Figures (IPFs) for Financial Year (FY) 2020/21 and the budgeting requirements for LGs.

In order to access conditional grant funding, LGs are required to adhere to a number of specific requirements relating to the budget allocation and utilization guidelines.

As per the decentralization policy, the LGs are responsible for planning, procurement and construction of health infrastructure investments. These guidelines should apply to decentralized health infrastructure construction irrespective of funding source.

The MoH will remain responsible for formation of policies, setting national standards, providing guidelines, offering support supervision and monitoring outcomes within the context of Minimum Quality Standards.

Health Sector grants are provided to LGs and health facilities to provide Health Services, in order to achieve UHC with emphasis on access, quality and affordability aspects.

Table 1: Summary of Grants and Selected Subventions

Grant/Subvention			Budget (UGX billion) in FY 2020/ 21	Purpose	Allocation basis	Summary of budget requirements
Wage Conditional Grant			448.2Bn	To pay salaries for all health workers in the district health service including health facilities and hospitals.	Additional wage has been allocated to each upgraded Health Centre II in a Local Government (LGs). Otherwise, ad hoc increments.	• Districts and municipalities are responsible for payment of salaries of health staff in health facilities and DHO/MHOs • Salary allocations must be aligned to the filled posts within the approved structure, recruitment plan and salary scales in a given financial year. • The Health Department must prepare a recruitment plan and submit it to the Human Resource Management (HRM) Department for the vacant positions of health workers and DHO/MHOs • Hard to reach allowance must be provided for staff in hard to reach areas outside town councils and HLG headquarters, in line with the hard to reach framework and schedule designated by the Ministry of Public Service (MoPS)
Non-Wage Conditional Grant	o/w PHC 92.1Bn	Health Offices		To fund service delivery operations by the health department supervision, management, and epidemic preparedness	**Population (60%); Infant mortality (10%); Poverty headcount (20%); Population in Hard to Reach Hard to Stay Areas (10%).** Additionally, fixed costs have been considered at all levels of care	• The total allocation to lower level facilities (HC II, HC III, HC IV) must be at least 85% of the PHC non-wage recurrent budget (excluding PHC Hospital NWR Grant) • PNFP health facilities should be funded from the window of non-wage grant for PHC, but only if they meet the eligibility criteria in **Sub annex 1**, have been approved by the MoH, and have signed an MoU with the LG • Allocations to general hospitals should be at least the value of the non-wage grant for hospitals • Only PNFP (NGO or CBO) hospitals which meet the eligibility criteria in **Sub annex III** and have been approved by the MoH should be allocated PHC funds. • A maximum of 15% of the Non-Wage Recurrent Budget (excluding PHC Hospital NWR Grant) can be used for monitoring and management of District/ Municipality health services.
		PHC Health Centres		To fund service delivery operations by the health centres, both government and private not for profit – prevention, promotion, supervision, management, curative, epidemic preparedness		

Grant/Subvention			Budget (UGX billion) in FY 2020/ 21	Purpose	Allocation basis	Summary of budget requirements
	o/w Hospital			To fund service delivery operations by hospitals both government and private not for profit – prevention, promotion, supervision, management, curative, epidemic preparedness	**Population of HLGs with Public or PNFP hospitals, adjusted for number of hospitals (60%); Infant mortality (10%); Poverty headcount (20%); hard to reach and hard to stay area** (10%). Additionally, fixed costs have been incorporated.	All hospital grants must go directly to hospitals. Eligibility and JM, S for PNFPs as per **Sub annex 1**.
Development Conditional Grants	o/w Development Grant - Health (IGFT) 83.81Bn	Facilities upgrading	41.6Billion	This will fund the upgrading of HCIIs to IIIs in the Sub Counties with no HC IIIs which have HCIIs. A maximum 650Million shall be used for facility upgrades. Additionally 210million has been provided in the development grant for equipping of the upgraded facilities.	Capital allocations should be prioritized as follows. o To upgrade HC IIs to IIIs in Sub Counties without a HC III or higher level health facility. o To construct new HC IIIs in Sub Counties with no health facilities at all in sub counties with populations greater than 10,000. o In large and highly populated sub counties, additional new HC IIIs shall be constructed to attain a 5km walking distance to a health facility. Other geographical features like islands, mountainous areas will be considered in the allocation of HC IIIs.	All health infrastructure and equipment budgeted for must: o be approved by: (a) chair of the HMC; (b) the in charge of the health facility; and (c) the village (LC1) and district/municipal councilor for the area in which the health facility is located using the form specified in the sub annexes of these guidelines. o Be accompanied by (a) duly filled application form which is accompanied by (b) a completed environmental and social safeguards checklist and (c) evidence of land availability. LGs must not budget for activities specified as ineligible expenditures for capital investment. Local governments must budget at least 95% of the value of their Sector Health Development allocation for "Upgrading of HCIIs to HCIIIs on construction of facilities" for construction of the facilities listed in **Sub annex 2** to these guidelines or otherwise agreed with the MoH. A maximum 5% of the allocation to capital investments may be allocated to investment servicing costs for the construction of those facilities. *Allowed activities:* Service delivery infrastructure and equipment - Health centre III, IV - Outpatient department (OPD) block - Maternity ward - Female ward - Male ward
		Infrastructure maintenance		This will finance repairs to health infrastructure in and equipping and completion of existing public health facilities and capacity development activities. The development budget will be used for capital investments, to fund rehabilitation, construction or equipping of service delivery and/or administrative infrastructure. Capital allocations for the functioning of existing health facilities should be prioritized as follows:	To incentivize health related local government performance, by linking LGPA scores to allocations. Squared scores are weighted by 50% existing number of HC3s-Hospitals and 50% Population per GOU or PNFP health facility above 22,000.	

Grant/Subvention			Budget (UGX billion) in FY 2020/ 21	Purpose	Allocation basis	Summary of budget requirements
				○ Firstly, rehabilitating, completing and equipping existing facilities in lower local governments with HCIIIs which serve more than 20,000 people where there are gaps in basic buildings' requirements and equipment; ○ Secondly, upgrading HCIIs, completing, expanding existing or constructing new HCIIIs in LLGs which have either have no HCIIIs or where HCIIIs on average serve less than 20,000;		- Operating theatre (Health Centre IV) - Drug store - Mortuary - Staff houses - Toilets/pit latrines & bathrooms - Medical waste pit - Water source - Medical equipment - Furniture - Electricity (grid or solar) - Fencing *Not allowed:* Construction of new HCIIs
	o/w Transitional Ad Hoc		6.3Billion	The Ministry of Health will provide specific guidance to individual local governments with allocations for the Transitional Development Ad Hoc Health Grant on the investments to be financed from the grant.	Ad hoc	
	o/w Sanitation		2.6billion	Funds sanitation related activities such as community sensitizations and advocacy work that contribute to the reduction of morbidity and mortality rates from sanitation-related diseases.	As per donor	
Total grants						See **Sub annex 5** for a list of grievance mechanisms to be followed in each local government; **Sub annex 1** for agreements
GAVI			18.154bn	135 Districts[1]. In FY 2020/21, this subvention, which is financed by a Development Partner, will fund	**1.** Support districts to implement additional outreaches.	GAVI through the Ministry of Health has provided a cash grant, paid as a subvention, with the objective of strengthening Health systems in Uganda. The

[1] Only LGs included in the total. A further UGX. 285.93 million Available for KCCA.

Grant/Subvention		Budget (UGX billion) in FY 2020/ 21	Purpose	Allocation basis	Summary of budget requirements
			health systems strengthening activities in the LGs.	**2.** Hold quarterly one day district stakeholders performance review meeting on EPI targeting (DHO, ADHO-MCH, DHEO), Chairpersons (LCV & LC III), sub county chiefs, RDC, DISCO. **3.** Hold health sub district quarterly performance review meetings; targeting sub county chiefs, HSD in charges, Health facility in charges, health Assistants. **4.** Support data improvement teams (DIT) to conduct follow up mentorship of health workers in data quality improvement (of EPI/HMIS programs) at all levels in the district. **5.** Support to implement ICHDs. **6.** Support supervision for DHT. **7.** Vaccines and supplies distribution.	GAVI HSS II is a subvention (Other Government Transfer) directly from MoH to local governments, outside of the local government transfers system. However local governments are still required to budget for the use of HSS II funding based on IPFs communicated further to these Guidelines by MoH.
GFTAM		3Billion	Covers 126 districts	1. IMM 2. Facility clinical audits 3. Training vector control officers 4. EQA 5. District Malaria Epidemic review and response coordination meetings.	These funds are meant for implementation of district based activities including integrated management of malaria, facility clinical audits, external quality assurance and also district malaria epidemic review and response coordination meeting
URMCHIP RBF	DHMT	6.86billion	131 Districts and 40 municipalities. In FY2020/21, this subvention is financed by the World Bank Loan, GFF and SIDA Grants, will be paid to the DHTMs based on achievement of the agreed outputs on a quarterly basis.	Fuller guide in the URMCHIP RBF Implementation Guidelines.	Funds are transferred to the District General Fund Account upon submission of District Invoice and verification by the Regional RBF Unit. Districts are required to have wok plans and Performance Improvement Plans for utilization of these funds.
	Hospital	20.6billion	98 Hospitals. Will be paid to Hospitals based on achievement of		Funds are transferred to the District General Fund Account in the case of Public General Hospitals or

Grant/Subvention		Budget (UGX billion) in FY 2020/ 21	Purpose	Allocation basis	Summary of budget requirements
			the agreed outputs and quality scores on a quarterly basis.		Hospital Accounts for RHHs and PNFP Hospitals upon submission of District Invoice and verification by the Regional RBF Unit Hospitals are equipped to have work plans and Performance Improvement Plans for utilization of these funds.
	Health centre	62billion	1350Health Facilities. Will be paid to the Health Facilities based on achievement of the agreed outputs and quality scored on a quarterly basis.		Funds are transferred to the Health Facility Account upon submission of District Invoice and verification by the Regional RBF Unit. Health Centres are required to have work plans and Performance Improvement Plans for the utilization of these funds.
Selected subventions					

3.1 Budget Requirements and Guidelines for the Wage Conditional Health grants

A summary of budget requirements was provided above in **Table 3**. Other instructions from MoH and the MoPS accompany the short summary below.

3.1.1 Human Resource (Health Workers) Management

The District/Municipal LG is required to ensure:

- The structure for health workers with a wage bill provision is filled.
- A comprehensive recruitment plan is prepared and implemented.
- The recruitment plan for the following Financial Year should be submitted by the CAO to MoPS by 30th of September of this Financial Year.
- Health worker deployment and management should be in line with minimum standards and strengthened approach
- Minimum staffing levels are met for all health facilities (see tables below). If this is impossible, the districts and the facilities within the districts furthest behind that staffing level should be favored.
- After minimum staffing levels are met, health workers should be deployed equitably across health facilities.
- Performance appraisal for the Health facility in-charges is properly conducted.

Minimum staffing levels are shown below for HC2 and HC3, and HC4 – due to variation, the same is not reprinted for hospitals.

Table 2: staffing schedules for Health centres II, III and IV

Row	Title	Scale	Minimum Number of staff (MoPS)		
			HEALTH CENTRE IV	HEALTH CENTRE III	HEALTH CENTRE II
1	Senior Medical Officer	U3	1	0	0
2	Medical Officer	U4	1	0	0
3	Senior Nursing Officer	U4	1	0	0
4	Senior Clinical Officer	U4	0	1	0
5	Public Health Nurse	U5	1	0	0
6	Clinical Officer	U5	2	1	0
7	Ophthalmic Clinical Officer	U5	1	0	0
8	Health Inspector	U5	2	0	0
9	Dispenser	U5	1	0	0
10	Public Health Dental Officer	U5	1	0	0
11	Laboratory Technician	U5	1	1	0
12	Assistant Entomological Officer (Medical)	U5	1	0	0
13	Nursing Officer/ Nursing	U5	1	1	0
14	Nursing Officer/ Midwifery	U5	1	0	0
15	Nursing Officer/ Psychiatry	U5	1	0	0
16	Assistant Health Educator	U5	1	0	0
17	Anaesthetic Officer	U5	1	0	0
18	Theatre Assistant	U6	2	0	0
19	Anaesthetic Assistant	U7	2	0	0
20	Enrolled Psychiatric Nurse	U7	1	0	0
21	Enrolled Nurse	U7	3	3	1
22	Enrolled Midwife	U7	3	2	1
23	Laboratory Assistant	U7	1	1	0
24	Stores Assistant	U7	1	0	0

Row	Title	Scale	Minimum Number of staff (MoPS)		
			HEALTH CENTRE IV	HEALTH CENTRE III	HEALTH CENTRE II
25	Health Assistant	U7	1	1	1
26	Health Information Assistant	U7	1	1	0
27	Cold Chain Assistant	U7	1	0	0
28	Accounts Assistant	U7	1	0	0
29	Office Typist	U7	1	0	0
30	Nursing Assistant	U8	5	3	2
31	Driver	U8	1	0	0
32	Askari	U8	3	2	2
33	Porter	U8	3	2	2
	TOTAL		**48**	**19**	**9**

Source: Ministry of Public Service

3.2 The Allocation Formulae and Budgeting Requirements for the NWR Grant

Allocation formula applied to NWR are below, which provides a rationale for the shares shown in **Table 3** above.

Table 3: Allocation Formula for Grants

Subgrant	Variable	Weighting (%)	Rationale
Primary health care NWR	Population	60%	Population represents the overall target beneficiaries, and is an indicator of need for health services and the scale of services required
	Poverty Head count	20%	Approximates socio-economic goal of increasing access for poorer communities
	Infant Mortality	10%	Equalizing health outcomes: most of the causes of infant mortality are preventable using already proven interventions. These include immunisation, ORS, nutrition and hygiene. Therefore strengthening the health system will address the causes that enhance disparities in IMR.
	Population in hard to reach and hard to stay	10%	Mountainous, islands, rivers etc. have peculiar terrain. Provides greater allocations to areas where costs are likely to be high
Hospital non wage recurrent	Population	60%	Population represents the overall target beneficiaries, and is an indicator of need for health services and the scale of services required
	Poverty Head count	20%	Approximates socio-economic goal of increasing access for poorer communities
	Infant Mortality	10%	Equalizing health outcomes: most of the causes of infant mortality are preventable using already proven interventions. These include immunisation, ORS, nutrition and hygiene. Therefore strengthening the health system will address the causes that enhance disparities in IMR
	Population in hard to reach and hard to stay	10%	Mountainous, islands, rivers etc. have peculiar terrain. Provides greater allocations to areas where costs are likely to be high

Table 4: Health Facility Fixed costs

Gov	
HC II	**2,000,000**
HC III	**4,000,000**
HC IV	**8,000,000**
PNFP	
HC II	**1,000,000**
HC III	**2,000,000**
HC IV	**4,000,000**
HC IV (Special)	**50,000,000**

Table 5: Hospital Fixed Costs

Gov	
Hospital	**100,000,000**
o/w Highway Hospital	**15,000,000**
PNFP	
Hospital	**50,000,000**
o/w Solo PNFP	**50,000,000**
o/w Tourism PNFP	**100,000,000**

Expanding on **Table 3** above:

3.2.1 Budgeting for Disease Prevention, Health Promotion and Sanitation

One of the priorities of the Ministry of Health is to prevent Ugandans from diseases and ensure a productive population. However, over time, the above has not yielded the expected outcomes, and subsequently resulted into unnecessary health care costs.

In order to address the challenges related to the high diseases burden, in FY 2020/2021 the Ministry of Health is re-prioritizing Disease Prevention, Health Promotion, Hygiene and Sanitation to ensure better health outcomes are registered at household level.

It is again at this background that during the budgeting for FY 2020/21, at **least 30%** of the total NWR budget, shall be dedicated to Disease Prevention, Health Promotion, Hygiene and Sanitation activities at District Hospital level, DHO offices and lower level of health facilities.

The Ministry of Health expects Management at each of the entity in LGs to implement above activities and timely provide an integrated work plan and quarterly reports regarding the utilization of all PHC funds, including funds disbursed to the Districts as required in the Public Financial Management and Local Government Act.

The above shall cover all facilities receiving Public funds, including all PNFP facilities.

3.2.2 Budgeting for Lower Level Public Health Facilities (HC IV- HC II)

- The total allocation to Lower Level facilities must be at least 85% of the PHC non-wage recurrent budget (excluding PHC Hospital NWR Grant).
- The ratios used for Health Facility Allocation were 8:4:2 for Government facilities whereas for private not for profit facilities it is 4:2:1 for the lower level health facilities.

3.2.3 Budgeting for Private-Not-For-Profit Facilities (HC IV - HC II)

Allocations to PNFP facilities will be made as an integral part of the district health service as follows:

a) PNFP health facilities should be funded from the window of non-wage grant for PHC.
b) Only PNFP (NGO or CBO) health facilities which meet the eligibility criteria in this subsection and have been approved by the MoH should be allocated PHC funds.
c) All eligible and approved PNFP (NGO or CBO) health facilities must sign a Memorandum of Understanding (MoU) with the respective LGs.
d) For each PNFP facility, in addition to the funding appropriated under the LG grant, additional funding equal to the local government grant funding will be appropriated under MoH and will constitute a medicines credit line facility at Joint Medical Stores (JMS) for FY 2020/21. This is budgeted outside the PHC NWR Grant.
e) The PNFP health facilities will be required to make half annual procurement plan for EMHS from JMS based on quarterly budgets and guidelines from JMS and MoH.
f) The following items should be planned for under PHC NWR Grants by PNFP health facilities: Employee costs (other than Wage), Administrative expenses, Food supply, Medical and office equipment, Operation and maintenance, Utilities, Cleaning services, Material supplies and manufactured goods, Training costs, Payment of interns, Outreaches, Monitoring, supervision and reporting, Property costs
g) The activities to be undertaken by the PNFP health institutions are to be integrated in the LGs BFP and the AW&B for the LGs for FY 2020/21.
h) The PNFP facilities are required to comply to the accounting and financial arrangements stipulated in the LGFAR 2007, the PPDA 2005, PFMA 2015 and the LGA Amendment 2008 to guide financial management, reporting and accounting procedures. In addition, sub annexes to the guidelines provide specific formats for monthly and annual reporting as well as cash books.

Criteria for Access of Public Subsidies by PNFPs and Private Health Providers

The MoH, under the PPPH strategy developed the following guidelines that must be fulfilled for access of public subsidies (PHC Funds) by PNFPs and Private Health Provider

1) If a PNFP (NGO or CBO), it should be registered and certified as Not For Profit by the NGO Board (not for profit body with full and open accountability for the use of public funds and the quality and effectiveness of the services, and their constitutional document includes rules to this effect)
2) Should be registered / accredited by an all-embracing and credible national body
3) Registration through an Umbrella Organization with a national outlook and acceptable by Government
4) Approval and recommendation to MoH by the LG Council
5) Licensed by the LG for non-facility based PNFPs
6) PHPs/ PNFOs must be licensed by the respective statutory Professional Council
7) Geographical Location (Serving rural, disadvantaged and hard to reach populations or being the only service provide in the area) to increase access, equity and also minimize duplication
8) Evidence of participation in community health services
9) Income by source and expenditure data: Requirement to provide financial reports to Government oversights organs (MoH, MoFPED, OAG and IGG) with income and expenditure by source clearly indicated
10) Must agree to be supervised and audited by public governance bodies (LGs, MoLG, MoH, MoFPED, and OAG). This agreement is documented in a MOU with Ministry of Health and / or LG signed by both parties.

11) Must demonstrate evidence of reduction or elimination of service consumption costs for consumers (provide evidence that subsidy is passed to consumers)
12) If it's a private for profit facility, it must have a designated public wing where free / subsidized care is given to community or private providers delivering community health services
9) MOU/ Explicitly Contract with the LG, MOH and the respective umbrella body registration body to purchase a package of services from the provider
10) Evidence that provider is delivering the Uganda National Minimum Healthcare Package
11) Agreement to share input and output data with LGs and MoH, including financial data
12) Agreement to stick to PNFP/ PHP implementation guidelines developed by MoH
13) Approval and registration by the district health office and the LG Council
14) PHPs/ PNFPs must be licensed by the respective statutory Professional Council
15) Evidence of HMIS reporting to MoH and Umbrella Organizations
16) Must have reported utilization data to MoH for at least two years
17) PHPs / PNFPs must be licensed by the respective statutory professional council
18) PHPs must submit HMIS returns to the MoH and the respective district health office, explicitly reporting on the free services they provide in form of outputs using the standard Government HMIS reporting format
19) Evidence of involvement of communities in the governance processes of the subsidy recipients
20) Must have reported utilization data to MoH for at least two years
21) Income by source and expenditure data: Requirement to provide financial reports to Government oversights organs (MoH, MoFPED, OAG, IGG) with income and expenditure by source clearly indicated.

The Ministry of Health will therefore on a continuous basis undertake a verification and validation of all private health facilities that are benefiting from PHC NGO grants and any facilities found non-compliant with the eligibility criteria will be suspended until evidence of compliance is provided.

3.2.3 Budgeting for Hospitals (Public & PNFP)

Criteria for budgeting for Public and PNFP Hospitals are as follows:

- Allocations to general hospitals should be at least the value of the non-wage grant for hospitals.
- PNFP hospitals should be funded from the window of non-wage grant for hospitals.
- For each PNFP hospital, in addition to the funding appropriated under the local government grant, additional funding equal to the local government grant funding will be appropriated under MoH and will constitute a medicines credit line facility at JMS for FY 2020/21. This is budgeted outside the PHC NWR Grant.
- Only PNFP (NGO or CBO) hospitals which meet the eligibility criteria in **Sub annex 1** and have been approved by the MoH should be allocated PHC funds.

3.2.4 Budgeting for Health Management and Supervision (District / Municipal Health Offices)

A maximum of 15% of the Non-Wage Recurrent Budget (excluding PHC Hospital NWR Grant) can be used for monitoring and management of District/ Municipality health services under 0883: Health Management and Supervision.

Budgeting for sanitation and health promotion and Medical Supplies for Health Facilities is the responsibility of the health office under the following outputs:

- Output: 088101 Public Health Promotion
- Output: 088104 Medical Supplies for Health Facilities
- Output: 088106 Promotion of Sanitation and Hygiene
- And any Lower Local Services Outputs where documentation can show what the money is being spent on, relating to sanitation and promotion.

3.3 Allocation formula and budgeting requirements for the IGFT Conditional Development Grant

The development grant allocation formula for FY 2020/21 has two components:

(i) The facilities policy component allocated based on the basic allocation criteria i.e. 80% of the grant; and
(ii) The performance component based on the results of the LG performance assessment system i.e. 20% of the grant.

Health Sector Development Grants are provided to LGs in order to achieve UHC with emphasis on access, quality and affordability aspects. The structure, purpose and summary LG budgeting requirements of the health sector development grants is shown in **Table 3** above.

Squared LGPA scores are used. They are weighted by 50% and 50% respectively of the basic formula components.

Variable	Weight
Number of existing GOU HCIIIs, HCIVs and hospitals	50%
Population per GOU or PNFP health facility 22000 (HCIII, IV, hospitals)	50%

3.3.1 Performance component of the allocation formula

An annual performance assessment by the Office of the Prime Minister (OPM) was conducted in October 2019 for all but the newest 13 Local Governments (totaling 162 Local Governments) with the results posted on the Budget Website on http://budget.go.ug/fiscal_transfers/page/assessment_results. The intention is to repeat the exercise around August-September of each year, derive the performance scores, and allocate resources based on those scores.

Local Governments that score above average (the mean score) in this assessment will receive a larger share of the development grant relative to other Local Governments in the next fiscal year. Scores are squared for the allocation calculation. This means that a district that performs well, receives a relatively greater reward than if the scores were not squared.

3.3.2 IGFT Development Budget Requirements and prioritisation

A summary of development budget requirements and prioritization is set out and expanded upon below.

In the medium term, as directed by His Excellency the President, the health sector will focus its efforts towards establishing a **functional HC III per Sub County** across the country. The LG's development budget will be used for capital outputs 088180-85 relating to fund the construction, rehabilitation and equipping of health facilities and these allocations should prioritize the achievement of this objective.

The Health Development Grant allocation for **the functioning of existing health facilities** shall be allocated for the rehabilitating, completing and equipping existing facilities.

Due to the element of World Bank co-financing across the sub grants, health facilities upgrades listed in the Sub annex are deemed not to attract VAT. Costs in these guidelines are shown net of VAT.

Priorities

The "Upgrading Health Centre" window of the Health Development Grant and other funding sources may be used for **upgrading and new health facility** construction on the following priority order:

- The first priority will be to upgrade HC IIs to IIIs in Sub Counties without a HC III or higher level health facility. Currently, there are 331 Sub Counties with no HC III but have a HC II that can be upgraded.
- To construct new HC IIIs in Sub Counties with no health facilities at all with populations greater than 10,000. Currently, there are 132 Sub Counties with populations greater than 10,000 with no health facilities at all.
- In large and highly populated sub counties, additional new HC IIIs shall be constructed to attain a 5km walking distance to a health facility. Other geographical features like islands, mountainous areas will be considered in the allocation of HC IIIs.

Capital allocations will also be made to the **functioning of existing health facilities** which should be prioritized as follows:

- Firstly, rehabilitating, completing and equipping existing facilities in lower local governments with HCIIIs which serve more than 20,000 people where there are gaps in basic buildings' requirements and equipment;
- Secondly, upgrading HCIIs, completing, expanding existing or constructing new HCIIIs in LLGs which have either have no HCIIIs or where HCIIIs on average serve less than 20,000;

Additionally, funds under the development grant have been provided for equipping of the upgraded health center IIs to Health centre IIIs

Priority-setting and project preparation steps

To guide the prioritization and selection of investments, Local Governments need to maintain an up-to-date asset register of health facilities and their condition using the Performance Budgeting System (PBS) where possible. The asset register should at a minimum contain the information in **Form 1** in **Sub annex 1**. The register should be compiled from annual health facility reports (in the Facility-level guidelines).

As part of the decision making process for investments, wide consultation must take place at the LCIII and facility level for a request to be generated for health facility infrastructure and equipment using the application **Form 2** in **Sub annex 1**.

From the applications made, the asset register and the criteria in **section 5.2**, the LG should prepare a prioritized list of investments to be constructed over the next three years and select those investments that can be implemented with available resources.

LGs must follow the MoH guidelines on upgrading and accreditation of health facilities. A LG must receive written authorization from MoH before budgeting for a new health facility to be constructed, or an existing one to be upgraded. To facilitate this process, the Ministry of Health has prepared a list of HCIIIs which have been pre-authorized for construction or upgrading.

All health infrastructure and equipment budgeted for must be accompanied by

- A duly filled application Form 2 approved by: (a) chair of the HMC (if the facility exists); (b) the in charge of the health facility; and (c) the village (LC1) and district/municipal councilor for the

area in which the health facility is located using the form specified in the sub annexes of these guidelines.
- A completed basic environmental and social safeguards checklist (**Form 3** in **Sub annex 1**)
- Evidence of land availability
- Detailed project profile and work plans for the projects to be undertaken in FY 2020/21.

Budget requirements

Table 4 above provides an indicative list of capital investments and other development activities which may or may not be funded under the sector development budget from Central Government grants for HCII to HCIV NWR.

The Health Development Grant allocation for **Upgrading of HCIIs to HCIIIs** (80% of the national grant value) should be budgeted for Outputs 088180-85 relating to health facility construction and equipping for the facilities specified in **Sub annex 2** or as otherwise agreed by the Ministry of Health upon request from the LG.

At most 5% of allocations to capital outputs (088180-85) should be used for monitoring and supervision and investment servicing costs of the project under the following items: 281501 Environment Impact Assessment for Capital Works; 281502 Feasibility Studies for Capital Works; 281503 engineering and Design Studies & Plans for Capital Works; 281504 Monitoring, Supervision & Appraisal of Capital Works. In exceptional circumstances, LLS outputs could also be used for investment servicing costs.

Of this at most 2.5% of the allocation for capital outputs should be used for monitoring and supervision of the project under the following items: 281504 Monitoring, Supervision & Appraisal of Capital Works.

Up to 10% of the development budget may be allocated to **performance improvement** outputs to strengthen service delivery in health centres and its management by the district/municipality.

3.4 Budgeting for Activities under the Transitional Development Sanitation (Health) Grant

This transitional development grant for Sanitation shall be allocated centrally and annually to LGs that are implementing the Uganda Sanitation Fund (USF) programme.

The IPFs for Sanitation Grant – Health for FY 2020/21 provided for the LGs which shall implement the programme are attached as **Sub annex 3**.

The grant should fund sanitation related activities such as community sensitizations and advocacy work that contribute to the reduction of morbidity and mortality rates from sanitation-related diseases.

Refer to the USF implementation Guidelines FY 2020/21 for details.

3.5 Budgeting for Transitional Development Ad Hoc Health Grant

The Ministry of Health will provide specific guidance to individual Local Governments with allocations for the Transitional Development Ad Hoc Health Grant on the investments to be financed from the grant.

3.6 Budgeting for GAVI-Health Systems Strengthening (HSS) II

Ministry of Health with the district local governments will be responsible for providing oversight during implementation. These resources will support activities as per **Table 1** above. The UNEPI program shall provide to Local Governments detailed implementation guidelines for the grants.

3.7 Budgeting for RBF-URMCHIP

Refer to the issued URMCHIP guidelines for FY2020/21 and any subsequent communication from MoH. For ease of planning, guidelines have been issued already, but the planning figures are repeated below. Unlike the grant guidelines, these IPFs are based on facility-level outputs. Historical output levels have been projected forward (in **Sub annex 3** below); however, unlike the grant guidelines, these function as neither a floor nor a ceiling for allocations, merely a guide assuming a given level of performance. Detailed guidelines on RBF have already been shared with Districts.

3.8 Budgeting for global fund for TB, MALARIA & HIV

Funds shall be used for implementation of district based activities including integrated management of malaria, facility clinical audits, external quality assurance and also district malaria epidemic review and response committee meetings.

4. CHAPTER FOUR: BUDGET EXECUTION

4.0 Procedures for Budget Execution

Development grants

The construction of health infrastructure is expected to have positive economic and social impacts including improved service delivery; increased employment opportunities during the construction or rehabilitation of infrastructure; development of the private sector; and increased accountability downwards as well as upwards in the public sector.

It has to be acknowledged that the construction might have negative environmental and social impacts.

However, construction location and design should be chosen to minimize these potential negative impacts. These guidelines have the following in-built measures to mitigate these risks.

Non-wage recurrent grants

A detailed guide to the procurement at the facility level is supplied in those newly developed guidelines, while LGs are expected to be familiar with all relevant Laws, Regulations and any correspondence from MoFPED, PPDA, OAG, IGG and MoH and any other relevant body. In particular, any decision to top-up facilities allocations should be reflected in the Programme Budgeting System. Facilities allocations should not normally be lower than the indicative planning figures (IPFs) in **Sub annex 3**.

Specific instructions relating to medicine are provided in section 4.8

Subventions

Covered in the relevant specific GAVI and URMCHIP guidelines.

4.1 Environmental and Social Screening of Projects

Prior to procurement of any investments, and preferably during budget preparation, the LG must ensure that environmental and social screening has taken place in accordance with the guidelines, prior to contracting.

This includes:

- The screening relevant forms have been completed as per **Sub annex 1**.
- Where risks are identified, the forms include mitigation actions must be identified and the responsible parties, and
- The Environmental Officer and Social Safeguard Specialist or certified professional have visited the site to complete the exercise and have approved the mitigation plans.
- The location of the health faculty should not have adverse environmental and social impacts:
- The infrastructure must be constructed on land owned by the LG/ Health facility evidenced by a land title and/or agreement in the names of the health facility.
- Construction of health infrastructure should not require involuntary resettlement
- The construction of facilities should not restrict use and access of the land and its resources e.g. water points.
- Construction of health infrastructure should not be done in wetlands.
- The infrastructure to be constructed must follow the standard technical designs provided by the MoH.

The Environmental Officer and Social Safeguard Specialist or certified professional shall approve contract provisions for environmental and social safeguards in bidding documents and confirm that environmental and social safeguards requirements have been implemented satisfactorily prior to issuance of the certificate of completion of works and payment to contractors. Any other issues as per the Sub annexe(s) and further MoH communications over the course of the year.

A minimal list of topics under environmental safeguards is below. However, the mandatory Format in **Sub annex 1** apprises readers of the full list of concerns. This applies to all development activities under IGFT and other development grants.

i) Minimal vegetation clearing; revegetating cleared areas as quickly as practicable.
ii) Ensuring proper site drainage.
iii) Proper solid waste management: stripped soil (overburden) used for site restoration and landscaping, rather than being dumped offsite; workers do not litter health facility compound with litter (plastic bags, water bottles, etc.); reusable waste (e.g. timber planks, paper bags, etc.) given to local people if requested, pit latrines lined with masonry brickwork to enable their emptying with a honey sucker when full.

Social safeguards
A selected list of topics is below. **Sub annex 1** covers the full list.

i) Schedule transporting of materials and other noisy activities outside health facility active hours to minimize risk of accidents, road dust and traffic noise at health facilities.
ii) Fencing off construction sites to avoid risk of accident of falling debris to children.
iii) HIV awareness among the surrounding community and workers.
iv) All workers should have appropriate safety gear and latrines should be safely dug on firm ground, carefully watching out for signs of possible wall failure to minimize risk of workers at heights or depth.

v) Labor influx and labor disputes issues.

4.2 Procurement procedures (development)
Comments under **4.2** apply to all procurement - while specific procedures for joint procurement under the conditional development grant are outlined specifically in section 4.3.

All procurements must be done in accordance with PPDA Regulations 2017. The synopsis of some of the provisions is outlined below; however, materials available at https://www.ppda.go.ug/ and any subsequent PPDA communication, are definitive and final.

i) The procurement to be done must be incorporated in the LG Procurement Plan.
ii) All LGs shall submit a pre-qualification list of service providers.
iii) The Bills of Quantities (BoQs) should incorporate measures to mitigate social and environment impacts.
iv) Bids shall be opened publically on the closing date and all bidders are free to attend.
v) The Technical Evaluation Committee (TEC) shall be appointed by CAO and DHO shall be a member; The TEC shall carry out the evaluation exercise using a clearly stated evaluation criterion and recommend the competent contractors to the Contracts Committee.
vi) The LG Contracts Committee shall a ward to the best evaluated bidder in accordance with the PPDA regulations;
vii) The award letter shall be written to the successful bidder and a 10% Performance Guarantee from a Commercial Bank shall be issued and verified by the CAO.

viii) The Contract shall be signed between the District/Municipal LG and the Contractor witnessed by the HUMC / Hospital Board after clearance from Solicitor General (SG).

4.3 Roles of LGs and MoH in the Procurement of Construction Contractors under the facility-specific allocation (development)

4.3.1 Joint selection and procurement procedures

Updates to the procedure described in previous correspondence will be issued, and arrangements should be according to the PPDA Act 2015.

4.3.2 Construction Supervision by LGs

The project manager shall be the district engineer who will be responsible for supervising the site at least at the stages of works considered for payment and issue payment certificates for satisfactorily executed works.

The CAO/TC shall chair the grievance redress committee with either a Community Development Officer or Human Resource Officer, as the secretary. Copies of minutes of the grievance redress committee meetings should be provided to the district executive committee and the Resident District Commissioner (RDC).

Monthly site meetings to be held with all key stakeholders, but technical supervision to be done more frequently by relevant technical officers (engineers, environmental officers, etc.). Site meetings may also be attended by RDCs, District Chairpersons or Town Mayors and LC III chairperson.

The Hospital Board / HUMC shall be responsible for day to day supervision of works on behalf of the LG; and to conduct monthly site meetings for the projects.

Construction supervision should ascertain compliance with the following among others:

Technical Requirements:

i) Conformity to the structural designs
ii) Conformity to the architectural drawings
iii) Conformity to the required specifications
iv) Timeliness
v) Cost control

4.4 Transparency and Accountability (all resources received)

At the LG level, the health facility prioritized and selected for construction shall be disseminated as widely as possible, as should repairs and major maintenance projects. Incomes, grants to facilities and expenditures should be publicly displayed. The minimal display list is in the Facility level guidelines.

At the health facility level, the Hospital Board / HUMC will publically display all incomes and expenditures. A specific list of the formats to be displayed, is included in the sub annexes.

4.5 Development Projects Progress Reports (development)

All LGs carrying out development projects under the Health Development Grants and any other health related grants are required to prepare and submit quarterly project progress reports to the Permanent Secretary/MoH.

4.6 Payment Procedure for the works executed (all resources received)

The payment procedure shall conform to the PFMA and other statutory requirements. The release for subsequent quarters shall depend on the satisfactory report on utilization and accountability of funds disbursed.

4.7 Monitoring (development)

The MoH shall be responsible for the monitoring & evaluation of construction projects across the country. District / Municipal Local Governments are responsible for monitoring and evaluating the performance of health facilities and contractors in implementing construction projects at district / municipality level.

4.8 Guidelines on Medicine Procurement, Supply and Management for public health facilities

i. In FY 2010/11 medicines and health supplies budget under PHC (NWR) for LGs and District Hospitals was transferred to Vote 116 under NMS to enable NMS appropriately procure and distribute adequate levels of Medicines and Health Supplies.

ii. NMS will communicate to the districts the available credit line budget for EMHS per health facility level.

iii. LGs will prepare detailed procurement plans for medicines and health supplies for the whole FY based on the credit line budget for the FY and submit to NMS with copies to MoH.

iv. Emergency drugs supplies shall be planned for by MoH in collaboration with NMS. An account for the supply of medicines for emergencies has been created in NMS. Other national shared services shall be coordinated by the MoH.

v. The essential medicines kit which is supplied to HC II's and HC III's on a bi- monthly basis. The kit is reviewed every 6 months with input from the DHOs to tailor it to the catchment population disease burden.

vi. In addition, ACTS and TB medicines will be supplemented by a special credit line in NMS.

vii. All Health facilities should have a drugs account in NMS which accounts have to be reconciled on quarterly basis.

viii. Private wings of Public Hospitals should open private pharmacies within the private wing and create their own seed capital to operationalize the private wings service delivery.

ix. The responsibility of collection and destruction of expired drugs lies with the MoH but LGs have a responsibility to collect and properly store the expired drugs in a central place and prepare a special report on the expired drugs. Up to a maximum of 4% is the acceptable level of drug expiry of the consignment ordered and received.

4.8.1. Roles of LGs in the Procurement and management of Medicines

1. LGs are responsible for; compiling and submitting annual medicines procurement plans to MoH and with copies to NMS.
2. Regular and documented quantification of medicines and other health supplies needs by the Districts and timely submission of orders to NMS with copies to MoH.

3. Establishing impeccable inventory and records management at the District level for a well-structured Supplies and Logistics Management Systems for purposes of monitoring.
4. Monitor and reconcile the health facility EMHS accounts at NMS on quarterly basis.
5. Place EMHS orders to NMS based on the order and delivery schedule for the FY using the prescribed forms. Each order should cover a range of medicines only from the essential medicines list. Other special drug requests shall be dealt with as per the MOU.
6. Monitoring and follow up distribution of drugs to LLHU using the health unit management committees, RDC, DISO/GISO, Internal Audit.
7. Reporting quarterly on the 6 key performance indicators on medicines and health supplies.

Table 6: Summary of average central allocation per facility

Level	Average central allocation per facility, UGX million
085906 – HC II	4.4
085907 – HC III	7.5
085907 – HC IV	11.7
085909 – General Hospitals	189.4

4.8.2 Guidelines on Medicine Procurement, Supply and Management for Private Not for Profit health facilities

4.8.2.1 Procurement and Stock Monitoring

JMS shall receive quantifications from PHC beneficiaries, consolidate quantification and determine the stock requirement levels based on the needs of both PHC and regular customers. A semi-vertical system shall be used in managing the EMHS stocks. The stock levels will be adjusted to consider both the regular and PHC requirements. The adjustments should be proportional to the PHC requirements. Stock levels will be robustly monitored to ensure sufficient buffer stock levels.

4.8.2.2 Ordering of Health Care Supplies by Beneficiaries

JMS technical representatives shall help Health facilities decide when and what to order by referring to JMS order and delivery schedule and their stock levels and AMC. HFs shall start the process 2weeks before their order date to give them ample time to complete the process

HFs shall estimate the cost of their total order using prices indicated on JMS order form. They shall compare the total cost of the order with the available funds (budget). In the event the funds are not sufficient they shall use the VEN classification to guide on which adjustments to be made ensuring the vital items are picked first then essential and finally the necessary.

Order forms shall be filled and quality assurance done on the form to ensure that correct order is placed in terms of level of care and unit pack. All orders shall be duly signed off and a copy retained by HFs. JMS sales representatives shall deliver the original order forms to JMS

The facilities shall additionally send reports on consumption of medical supplies at the time of ordering to enable JMS plan accordingly

4.8.2.3 EMHS Order Process

Order processing at JMS which includes receipt, review and keying of orders, picking, checking and packing of orders shall be managed by a dedicated team at JMS. PHC Customized order and delivery schedules, and orders shall be routinely distributed to all beneficiaries.

4.8.2.4 Order Receipt and Keying in.

JMS shall call all PHC customers per zone, ten days before the order deadline. SMS reminders will also be sent at 10 days, 5 days and 2 days to the order deadline. The PHC orders from the beneficiaries shall be received through the JMS Sales Representatives in the respective regions. Acknowledgement of receipt of all orders shall be done within 2 hours of receipt. The orders shall then be keyed in and Proforma invoices (PFIs) generated. Verification of PFI accuracy in comparison to customer orders shall be done on a regular basis, as per JMS procedure.

4.8.2.5 Order Processing, dispatch and delivery

The order items shall be picked within the warehouse, packed, checked and dispatched as per JMS procedures. The consignments shall be delivered directly to the beneficiaries.

4.8.2.6 Receipt of Consignment at Health Facility

HFs shall prepare adequately for receipt and verification of the medical supplies from JMS ensuring that verification and storage areas are secure and free from direct sunshine, rain, dust and heat. They shall confirm the supplies are accurate and consistent with the documentation (suppliers invoice, delivery note, packing list and copy of the order form) in terms of facility name and code, items descriptions and quantities in presence of JMS transporters.
HFs shall sign off delivery by signing and stamping on all the three copies of the invoice and delivery note indicating name, date of receipt, time. A copy of both Invoices and delivery notes shall be sent back to JMS through its transporters.

Additionally, HFs shall confirm that items requiring special storage conditions like cold chain are received, verified and stored as required by Good Distribution practices

All discrepancies discovered such as damages, missing items, wrong delivery and excess delivery shall be documented in the discrepancy report/customer complaint form and delivered to JMS through JMS transporters or sale representative

4.8.2.7 Capacity Building

JMS through its team of Technical Representatives (TRs), shall regularly train and mentor beneficiaries in Management of EMHS, as well as reporting requirements. The team of TRs shall be based on ground, and will therefore be fully accessible by the beneficiaries.

4.9 Guidelines on the Health Sector refugee response management

4.9.1 District level coordination

- ✓ **Extended DHMT** to involve other stakeholders
- ✓ **Integrate** HSIRRP fully into DDPs and carry out joint planning ,supervision, monitoring, reviews and reporting
- ✓ Need for a **multi-sectoral approach** within the district in view of the social determinants of health

- ✓ Districts to establish/update (quarterly) **resource databases** that highlight all sources of resources (financial, Human resource, equipment, infrastructure, medicines and supplies) being invested into the districts
- ✓ Need for all for refugee hosting districts to update the 4W matrix at district level to **map all partners** and to avoid duplication of health services (activities) by partners within the same catchment area
- ✓ There is need to strengthen host community and refugee **involvement** in program implementation.
- ✓ It is important for the DHTs to identify **co-lead partners per pillar** (Service Delivery, Commodities, Human Resource, Resource mobilization, HMIS, NCDs, WASH, CDs)
- ✓ A member of the DHT to **co-chair monthly refugee health** coordination meetings with UNHCR
- ✓ Strengthen **Coordination** committees-TWGs, etc.

4.9.2 District level service delivery

- ✓ DHTs to submit documentation for health facilities within the refugee settlements that need **accrediting or upgrading** as requested by the Permanent Secretary and follow the guidelines
- ✓ **Advocate** for the phase out of temporary health facilities in the settlements that were already approved in the district development plans
- ✓ The **ownership of permanent health facilities** constructed by developmental partners such as UNHCR, World Bank, etc. should be changed to government so they benefit from future resource allocation by the central govt
- ✓ **Track performance** through HMIS
- ✓ **Strengthen the functionality** of all health facility committees especially the HUMCs
- ✓ DHTs to **rationally re-locate health workers** (both govt and partner staff) basing on caseloads and service packages at the different health facilities
- ✓ DHTs to review the **positions of in-charges at health facilities** (). Some partner supported health facilities have two in-charges – govt in charge and partner in-charge
- ✓ DHTs to **map all available ambulances** (govt, private, NGO) in the district and assign catchment health facilities for each of the ambulance
- ✓ **Establish/Update the VHT database** for the entire district (already settlements have these databases)
- ✓ Health facility in-charges to strengthen the health facility – VHT - community linkage with more focus on **disease prevention, HPE, Lifestyles**
- ✓ **Minimize fragmented programming** of activities (e.g. partner supported defaulter tracking of HIV patients should also track other program defaulters (TB, nutrition, ANC, EPI, Mental patients) in the same catchment area (village)
- ✓ **Reduce segmentation of programme** areas (e.g. nutrition screening can take advantage of a mass immunization campaign **or** LLIN distribution campaign. **Or** HIV testing can be done during a routine community sensitization meeting on malaria)
- ✓ **Improve systems for community delivery of medicines** for patients on chronic care programme to reduce defaulters and congestion at health facilities (this applies to patients that usually need regular medicine refills – TB, HIV, Epileptic, Hypertensive, Diabetes, children with SAM, etc.)
- ✓ **Sustain the functionality** of all services required at the HC IVs including emergency surgical procedures and blood transfusion
- ✓ **Infrastructure** –adhere to MOH guidelines and designs and cost estimates for all works

4.3 District Level: Medicines

- ✓ Senior DHT members and partners to provide more technical support to health facility in-charges during **medicine quantification** basing on caseloads per disease, average monthly consumption and seasonality

- ✓ DHOs and partners to strengthen the capacity of the district medicine focal person to regularly **review and redistribute stock** across health facilities
- ✓ DHOs to institute **daily and weekly reconciliation of medicines** and supplies in all user departments at the health facilities to improve accountability, minimize wastage and pilferage.
- ✓ All partners **procuring/donating medicines** and supplies for health facilities within the district should notify the medicines focal persons of the quantities and expiry dates of these medicines
- ✓ Sustain **buffer stocks of critical medicines** and supplies for epidemic preparedness/response at the district store- How do **we integrate SCM**

4.4 District Level : Human Resources

- ✓ Establish and maintain an **update database** of all health workers in the district both govt and partner staff
- ✓ **Leverage** from the skills and knowledge of senior health workers at the Regional and district Hospitals to mentor health workers (both govt and partners) at lower health facilities either through regular support CMEs or onsite mentorship or temporary staff rotations.
- ✓ Lobby for **more health workers** from International NGOs and developmental partners that are operating within the districts.
- ✓ Advocate for health **workers rotation** to have regular placements at high volume, high level health facilities for skills development.

5. CHAPTER FIVE: Grievance Mechanisms under GoU Grants

5.0 Grievance Redress Mechanism (GRM)

The grievance redress mechanism (GRM) describes avenues, procedures, steps, roles and responsibilities for managing grievances and resolving disputes. Every aggrieved person should be able to trigger this mechanism to quickly resolve their complaints.

The purpose of the grievance redress mechanism is to:

- Provide affected people with avenues for making a complaint or resolving any dispute that may arise during implementation of health facility activities.
- Ensure that appropriate and mutually acceptable corrective actions are identified and implemented to address complaints;
- Verify that complainants are satisfied with outcomes of corrective Actions;
- Avoid the need to resort to judicial (legal court) proceedings unless it is warranted.

There are a number of **types of grievance**, these may include:

- Quality of works delivered by contractors
- Quality of health care
- Misuse of personal data
- Violence against and abuse of patients by health workers, staff, contracted labor, donated support workers
- Bullying
- Condition of health infrastructure and facilities
- Functioning of the Hospital Board/ HUMC
- Corruption and misuse of funds
- Health Workers absenteeism
- Land issues related to development
- Other issues relating to behavior of Health staff, Hospital Board/ HUMC and contractors

There are a number of **stakeholders**, who may be the source of grievance:

- Patients
- Health Workers
- Members of the Hospital Board/HUMC
- Members of the surrounding community
- Others

Wherever possible, the first port of call for Grievances should be at the health facility level, but other avenues must also be available to those with grievance and there must be appropriate referral processes.

The main avenues and their purposes are set out in **Sub annex 1** below. It should be displayed on the noticeboard of any administrative officer and the facility. The local and facility level guidelines should be filled out at the appropriate level.

5.1 Health Facility Grievance Redress

At the health facility level, the GRM provides avenues for affected persons to lodge complaints or grievances against various stakeholders directly to the Health facility management and also get redress. This, wherever possible and appropriate should be the first point of grievance redress. All health facilities are required to:

a) Ensure that there is a systematic process for handling of grievances that arise among various stakeholders within a timely manner.

b) Post information on the different avenues for grievance redress, including the health facility level mechanism and other mechanisms available.

5.2 District/Municipal Grievance Redress

At the district level, the DHO is charged with overall responsibility for managing complaints from the community and other stakeholders relating to provision of health services and implementation of planned projects.

Implementation of the GRM in an effective and transparent manner will require establishing a simple Grievance Redress Committee (GRC) at each institution with the involvement of the Local Councils, relevant staff of the institutions and the implementing agency, MoH (Project Coordinating Unit), etc.

At the health facility and district level, the GRC shall specify a set of simple referral processes, which should be displayed at the relevant health facilities, District Offices and made widely available to the community. The LG shall specify a system for recording, investigating and responding to grievances, which should be displayed at the district offices and made widely available.

The **general steps of a Grievance Redress process** are as follows:

1. Receipt of complaints - Is the first step when a verbal or written complaint from a complainant is made, received and recorded in a complaints log by the GRC. Complaint boxes and contact details for lodging complaints should be made available at each LG and institution. Complaints with the designated focal persons should be available at each institution**.**

2. Determining and implementing the redress action - If in his/her view, a grievance can be solved at this stage, the GRC will determine a corrective action in consultation with the aggrieved person. Grievances will be resolved and the status reported back to complainants within 5 working days. If more time is required, this will be communicated in writing, and via practical means to accompany the written notice, clearly and in advance to the aggrieved person.

3. Verifying the redress action - The proposed corrective action and timeframe in which it is to be implemented will be discussed with the complainant within 5 days of receipt of the grievance. Consent to proceed with corrective action will be sought from the complainant and witnessed by the area's local council chairperson (LC Chairman).

4. Amicable mediation and settlement - Agreed corrective action will be undertaken by the project or its contractor within the agreed timeframe. The date of the completed action will be recorded in the grievance log.

5. Dissatisfaction and alternative actions - To verify satisfaction, the aggrieved person will be asked to return and resume the grievance process, if not satisfied with the corrective action.

In the event that there is no resolution to the grievance, then: (a) The GRC at the institution and the aggrieved PAP(s) shall refer the matter to the relevant District Authorities; (b) An Appeal to Court - Ugandan laws allow any aggrieved person the right to access courts of law. If the complainant still remains dissatisfied with the District's Decision, the complainant has the option to pursue appropriate recourse via a judicial process in Uganda. Courts of law will be a "last resort" option, in view of the above mechanism.

SUBANNEX 1. Health Facility Infrastructure Forms

Sub annex 1, Format 1 - Health Facility Asset Register

Facility Name	***HMIS Number***		**Medical Buildings**							**Staff houses**	**Equipment**
			-Out Patient Department	-Drug Store with HSD Office	Operation Theatre	General Ward	Maternity Ward	Mortuary	Placenta Pit and Medical Waste Pit		
		Existing Facilities									
		No in need of rehabilitation									
		Number required									
		Existing Facilities									
		No in need of rehabilitation									
		Number required									

Sub annex 1, Format 2 - Health Facility Application Form for facilities improvements

Facility Name: _____

Facility HMIS Number: _____

Facility level: _____

District: _____

Sub county: _____

	Medical Buildings							**Staff houses**	**Equipment**
	Out Patient Department	**Drug Store with HSD Office**	**Operation Theatre**	**General Ward**	**Maternity Ward**	**Mortuary**	**Placenta Pit and Medical Waste Pit**		
Existing Facilities									
No. Existing Facilities									
Description of condition facilities									
Planned routine maintenance									
Facilities Required									
*No. facilities requiring **rehabilitation***									
*No. **new** facilities required*									
Justification									

We certify that:

- The land required for the construction and operation of the new facilit(y/ies) is owned by the facility and formal evidence of land ownership is attached;
- The guidelines at facility and local government levels, applicable laws and regulations, have been fully reviewed and this request is in accordance with them;
- An inclusive process of consultation has been followed regarding key aspects of the application (state those consulted by name and designation and changes made to take into account results of consultations below and in additional pages attached):

  ……;
- The information contained on this form is truthful and other financing options to build the facilities have been fully investigated prior to this application.
- An ESSP has been filled out for this application, and is attached.

Signed: Chairperson HUMC …….. Date: ……

Designation on HUMC: …….

Signed: 2nd Representative HUMC …….. Date: ……

Designation on HUMC: ……..
Signed: Local councillor of the parish/sub county/TC/Division in which the facilit(y/ies) is/are to be built:
…….Date: ……..

Designation: …….

Signed: OIC……..Date:…….

Signed: owner of facility…… Date: …….
Description of others consulted, how they were consulted, and what changed as a result of the consultation: …….
AFFIX MORE PAGES IF REQUI

Sub annex 1, Format 3 – Basic Environment and Social Screening Checklist to Accompany Application

District/Municipal Council	
Sub-county/Town Council/Municipal Division	
Parish	
Village	
Name of the Facility	
HMIS Code	
Description of Infrastructure to Construct	

No.	Will the health infrastructure have any of the following impacts (please mark **X** next to the relevant potential impact)	Yes	No	If Yes, describe mitigation measures
1.	• Loss of vegetation cover causing erosion of soil			
2.	• Dumping of construction debris in wetlands or other sensitive areas			
3.	• Use of limited or sensitively located local construction materials			
4.	• Dust pollution due to movement of equipment, digging			
5.	• Noise pollution due to construction			
6.	• Pollution of surface water			
7.	• Health hazards due to inadequate cleaning and maintenance of latrines			
8.	• Occupation and safety hazards due to collapsing latrine and placenta pits			
9.	• Privacy concerns and sexual violence due e.g. to lack of gender separated facility latrines			
10.	• Dust and noise pollution due to movement of vehicles etc.			
11.	• Safety concerns due to speeding vehicles			
12.	• Land disputes related to the infrastructure (including access)			
13.	• The relevant authority does not own the land required			
14.	• Involuntary resettlement required to make the land available			
15.	• Influx of labor to carry out the works			

NB: This list is not intended to be exhaustive. For more detailed guidance please refer to the local government environment guidelines issued by NEMA. Please provide more information on a separate sheet.

Sub annex 1, Format 4: FULL ENVIRONMENTAL AND SOCIAL SCREENING FORM (ESSF)

This form is to be filled in by the Environment Focal Point Person at Sub-county level or Environment officer at the District/Municipal level for selected projects

REPUBLIC OF UGANDA

Health Facility Environmental and Social Screening Form

Please type or print clearly, completing this form in its entirety. You may provide additional information on a separate sheet of paper if necessary. Kindly note that the information you are to provide is required by Section 19 of the National Environmental Act, Cap. 153.

Name of the project: …….

Sector of the project: ……

Department implementing the project ……

Name of the District/Municipality where the project is to be implemented: ……..……

Name of Lower Local Government: …….

Name of Approving Authority …….

Name, job title, and contact details for the person who is responsible for filling out this form.

Name: ……

Job Title: ..……

Telephone number: ……

Fax number: ……...

E-mail address …….

Date: …….

Signature: ……

1. Brief Project Description

Please provide information on the type and scale of the project (project area, area of required land, approximate size of total building floor areas, etc.)

_____
_____
_____
_____
_____
_____

2. The Natural Environment

(a) Describe the land formation, topography, vegetation in/adjacent to the project area (*e.g. is it a low lying land, water logged, rocky, swampy or wetland, etc.,)*

_____
_____
_____

(b) Estimate and indicate whether vegetation might need to be cleared

_____
_____
_____

(c) Are there any environmentally sensitive areas or threatened species that could be adversely affected by the project (specify below)?

(i) Intact natural forests Yes_____ No_____

(ii) Riverine forest Yes_____ No_____

(iii) Wetlands (lakes, rivers, seasonally inundated [flooded] areas) Yes_____ No_____

(iv) How far are the nearest wetlands (lakes, rivers, seasonally inundated [flooded] areas)?
_____km

(v) Habitats of endangered species for which protection is required under Ugandan laws and/or international agreements. Yes_____ No_____

(vi) Others (describe). Yes_____ No_____ (*e.g. cultural sites, burial places, etc.,)*

3. Rivers and Lakes Ecology

Is there a possibility that due to construction and operation of the project the river and lake ecology will be adversely affected? Attention should be paid to water quality and quantity; the nature, productivity and use of aquatic habitats, and variations of these over time.

Yes_____ No_____

4. Protected areas

Does the project area (or components of the project) occur within/adjacent to any protected areas designated by government (national park, national reserve, world heritage site, etc.)

Yes_____ No_____

If the project is outside of, but close to, any protected area, is it likely to adversely affect the ecology within the protected area (e.g. interference with the migration routes of mammals or birds)
Yes_____ No_____

5. Geology and Soils

Based upon visual inspection or available literature, are there areas of possible geologic or soil instability (erosion prone, landslide prone, subsidence-prone)?

Yes_____ No_____

Based upon visual inspection or available literature, are there areas that have risks of large scale increase in soil salinity?

Yes_____ No_____

6. Landscape/aesthetics

Is there a possibility that the project will adversely affect the aesthetic attractiveness of the local landscape?

Yes_____ No_____

7. Historical, archaeological or cultural heritage site.

Based on available sources, consultation with local authorities, local knowledge and/or observations, could the sub-

project alter any historical, archaeological or cultural heritage site or require excavation nearby?

Yes_____ No_____

8. Resettlement and/or Land Acquisition

Will involuntary resettlement, land acquisition, or loss, denial or restriction of access to land and other economic resources be caused by the project implementation?

Yes_____ No_____

9. Loss of Crops, Fruit Trees and Household Infrastructure

Will the project result in permanent or temporary loss of crops, fruit trees and household infrastructure (such as granaries, outside toilets and kitchens, etc.)?

Yes___ No_____

10. Noise pollution during Construction and Operations

Will the operating noise level exceed the allowable noise limits?

Yes___ No_____

11. Solid or Liquid Wastes, including Medical Waste.

Will the project generate solid or liquid wastes, including medical waste?

Yes____ No___

If "Yes", does the project include a plan for their adequate collection and disposal?

Yes____ No____

12. Pesticides, Insecticides, Herbicides or any other Poisonous or Hazardous Chemicals.

Will the project require the use of such chemicals? Yes___ No_____

If, "Yes", does the project include a plan for their safe handling, use and disposal? Yes___ No____

13. **Occupational health and safety**

Will there be any risks of accidents during construction or operation of the project which could affect both human health and environment? Yes____ No___

14. **Community Health and Safety**

Will the surrounding community be exposed to accidents due to increased traffic and movement of heavy machinery, Communicable diseases brought by workers from outside of the area?

15. Land use

Are there any plans for future land uses on or around the location which could be affected by the project? Yes____ No_____

16. **Climate Impacts**

Is the Project location susceptible to earth quakes, landslides, flooding, erosion, or extreme weather conditions that could affect the project?

17. **Human health**

Will the project involve the use, storage, transportation and/or handling of substances that could be harmful to human health or the surrounding environment?

RECOMMENDATIONS:

Based on the above screening results, the following recommendations are made:

_____ (a) Implementation of the environmental mitigation measures as proposed in the Environmental and Social

Management Plan and Clause 8 contained in the Bidding Documents

_____ (b) before construction can commence, preparation of the relevant safeguard instruments (site specific ESMPs) and implementation of a resettlement action plan/compensation plan consistent with the provisions of the Resettlement Policy Framework, November 2002, will be required

TESTIMONY

I confirm that the information provided herein is accurate to the best of my knowledge. I will also endeavor to provide additional information and facilitate a site visit if required.

Signed: Environment Officer Date:

Signed:

Signed:

SUBANNEX 2: Memoranda of Understanding and Agreement

Sub annex 2a: Copy of the MOU between the GoU and PNFP Health Service Providers

1.0 PREAMBLE

This memorandum of understanding is made this ……. day of …… 20….. Between the Ministry of Health on the one part (hereafter referred to as MOH), and Ministry of Finance, Planning and Economic Development on the second part (hereafter referred to as MoFPED) and the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau and the Uganda Orthodox Medical Bureau on the third part representing the faith-based Private Not for Profit Health facilities (hereafter referred to as the Facility-Based PNFPs).

Whereas The Ministry of health is responsible for stewardship of the health sector of Uganda,

And whereas the Ministry of Finance is responsible for fiscal coordination and policy,

And whereas the Facility-Based PNFPs represent a network of health service providers complementing the efforts of GOU through provision of (…. % of) health services in Uganda,

The Government of Uganda represented by the Ministry of Health and the Ministry of Finance, Planning and Economic Development desires to enter into a Memorandum of Understanding with the Facility-Based PNFPs.

Now therefore in consideration of the mutual covenants and agreements herein contained, the parties do hereby agree as follows:

i. This memorandum of understanding is intended to promote cooperation and advancement in Public-Private partnerships for health between the Parties to their mutual benefit and the Public good.

ii. ii. This Memorandum of Understanding is a statement of intent which sets forth the general basis upon which the Parties wish to proceed; no contract will arise as to the subject matter hereof unless and until an agreement regarding each objective is negotiated, approved, executed and delivered by all the Parties.

2.0 OBJECTIVES

The purpose of this Memorandum of Understanding is to enable the Parties to pursue the objectives as set out below;

To provide a framework to formalize the working arrangements between the Parties

To define the expectations and obligations of each Party within the partnership framework

To strengthen accountability and transparency within the partnership framework

3.0 GUIDING PRINCIPLES

This memorandum of understanding shall be based on the following principles:

3.1 Responsibility for policy formulation and planning

Overall responsibility for health policy formulation and for safeguarding and improving the health status of the population is maintained by central government who will consult and aim at consensus with the partners whenever appropriate. Effective representation of the Facility Based PNFP in the appropriate fora at different levels shall constitute a pre-condition for consensus building.

3.2 Integration of plans and operations

Plans and operations of the Facility-Based PNFP sub-sector will support the NDP and the HSSP and will support and be integrated into district health plans.

3.3 Responsibility for service provision

The ultimate responsibility of Government and the Local Health authority for the delivery of service to the entire population shall be reconciled with the delegated responsibility to the Facility-Based PNFP. In the process of negotiating and making agreements, equal respect for the methods of work, legal and regulatory frameworks, dignity and views of either partner shall be exercised including commitment to roles and obligations described in the agreement.

3.4 Complementarity

Government and Facility-Based PNFP partners will strive to rationalize and complement services rather than duplicating them.

3.5 Identity

The identity of Facility-Based PNFP is based on their individual foundations and missions, and will be respected.

3.6 Autonomy

The Facility Based PNFP will retain their autonomy in the management of health services within the framework of NHP, HSSP and the relevant regulations and standards.

3.7 Equity

Government and Facility-Based PNFPs will ensure the equitable allocation of resources for health in accordance with the needs of the population, and according to the volume and quality of contribution to implementation of the HSSP. Priority shall be given to the poorest and most disadvantaged people, reducing economic barriers which prevent access to health services for the most in need population.

Service level agreements shall be established as a mechanism for maximizing efficiency and ensuring access to health services by the population.

3.8 Transparency

Allocation of government resources for service delivery shall be determined by utilization rates, type of service provided to the population and by roles and capacity of mobilizing additional resources. Inputs available to Facility-Based PNFPs, including their capacity to mobilize additional resources shall be mutually disclosed.

3.9 Accountability

Accountability for inputs, outputs and outcomes between partners at different levels shall be ensured. Facility-Based PNFPs shall be responsible for accounting and reporting within their organizational structures, to central and local government, and to the community.

3.10 Continuity of Care

Continuity of care will entail that referrals between public and Facility-Based PNFPs shall be ensured in the same manner as referrals between public facilities and referrals between PNFP facilities.

4.0 OBLIGATIONS OF THE PARTIES

4.1 The Ministry of Health

4.1.1 Communication

4.1.1.1 The Ministry of Health shall put in place structures to facilitate dialogue and feedback with the Facility-Based PNFPs, using SWAP mechanisms and other Government reporting procedures.

4.1.1.2 The Ministry of Health shall maintain an open system of communication through established partnership structures and shall share information with the Facility-Based PNFPs on relevant issues including providing feedback to the Facility-Based PNFPs on reports routinely submitted to the Ministry of Health**.**

4.1.1.3 The Ministry of Health shall recognize and respect institutional structures and systems of the Facility-Based PNFPs.

4.1.2 Human Resources for Health

4.1.2.1 The Ministry of Health shall, where negotiated and agreed upon, support human resources for health of the Facility-Based PNFP through secondment of staff and wage subsidies.

4.1.2.2 The Ministry of Health shall ensure equal opportunities to staff serving in the Facility-Based PNFP for training and scholarships.

4.1.2.3 The Ministry of Health shall advocate for GOU and Development Partners' support to the Facility-Based PNFP health training institutions**.**

4.1.3 Medicines, Medical supplies and Medical equipment

4.1.3.1 The Ministry of Health shall ensure that the Facility-Based PNFP are allocated resources for medicines, medical supplies and medical equipment as negotiated and agreed upon, taking into consideration the proportion of health sector outputs attributable to the Facility-Based PNFP service providers.

4.2 The Ministry of Finance, Planning and Economic Development

4.2.1 Planning and Financing the health services

4.2.1.1 The Ministry of Finance, Planning and Economic Development shall supplement the financial requirements of the Facility Based PNFP health services based on approved annual budgets and work-plans submitted to district local governments and approved by the Ministry of Health.

4.2.1.2 The Ministry of Finance, Planning and Economic Development shall, upon advice from the Ministry of Health, make quarterly disbursements to the Facility-Based PNFPs through the District local governments, which disbursements shall be ring-fenced.

4.3 The Facility Based PNFP

4.3.1 Policy formulation and implementation

4.3.1.1 The Facility-Based PNFPs shall participate in policy formulation, implementation and monitoring at all levels of the health system.

4.3.1.2 The Facility-Based PNFPs shall implement services in line with Government of Uganda policies, strategies and guidelines.

4.3.2 Resource management and utilization

4.3.2.1 The Facility-Based PNFPs shall ensure efficient and effective management and utilization of resources provided by the Government of Uganda and her partners through strengthening facility-level governance and management systems.

4.3.2.2 The Facility-Based PNFPs shall make available their books of accounts for review by auditors of the Government of Uganda on request.

4.3.2.3 The facility based PNFP agrees to set a flat user fee for the following services, including any related services, at the rates indicated below:

a. Under five year out patient visit for a fee not exceeding ……. per visit
b. Normal delivery at a fee not exceeding …….. per delivery
c. Under five-year admission at a fee not exceeding ……per admission.
d. Caesarean section delivery at a fee not exceeding ……per caesarean section.
e. HIV/AIDS patient reviews at a fee not exceeding …….per visit.
f. Ante natal care visit at a fee not exceeding …… per visit.

4.3.2.4 Maternal and child health services whose inputs are provided free of charge by the Government of Uganda shall continue to be provided to clients free of charge.

4.3.3 Reporting

4.3.3.1 The Facility-Based PNFPs shall, on a routine basis and according to Government reporting guidelines, submit service data and financial returns and shall comply with mandatory reporting for epidemiological surveillance purposes and any other operational reports as required within the National Health Management Information System.

4.3.3.2 Reporting channels shall be through the District local governments to the Ministry of Health and also directly to the respective Medical Bureaus at National level.

4.3.3.3 The Facility-Based PNFPs service shall, upon request, provide annual audited financial statements to the Ministry of Health and the Auditor General.

4.3.3.4 The Facility-Based PNFPs shall provide quarterly work plans, budgets and reports to the respective District local governments and the Ministry of Health for approval, contingent upon which funding for each subsequent quarter shall be disbursed by the Ministry of Finance, Planning and Economic Development**.**

5.0 NO ASSIGNMENT

Neither party shall sell, assign, transfer or hypothecate any rights nor interests created under this MOU or delegate any of their obligations without the prior written consent of the other. Any such assignment or delegation of either party without such consent shall be considered void.

6.0 AUTHORIZATION

The signing of this MOU implies that the signatories will strive to reach, to the best of their ability, the objectives stated in the memorandum of understanding.

7.0 TERMS OF THE UNDERSTANDING

This Memorandum of Understanding shall be in full force with effect from the date of signing and shall continue to be in force for the duration of the NDP and HSSP III, unless terminated by either party giving notice in writing at least three (3) months prior to the expiration of such yearly period.

This MOU shall be reviewed annually to ensure that it is fulfilling its purpose and to make any necessary revisions. Modifications within the scope of this MoU shall be made by mutual consent of the parties, by the issuance of a written modification, signed and dated by all parties, prior to any changes being performed.

8.0 DISPUTE RESOLUTION

8.1 Government and Facility-Based PNFPs enter into this MOU in a spirit of mutual trust and intend that all unforeseen matters on issues that arise, as the relationship evolves, will be resolved in a spirit of mutual understanding.

8.2 In the event that there is a conflict, it shall be resolved in a peaceful and amicable manner. Every effort will be made to settle the matter through dialogue and negotiation and to accommodate the policies and intention of each other's respective governing entity and constituents.

In witness thereof the undersigned have executed and delivered this Memorandum of Understanding on this …….. Day of ……20…….:

Signed for and behalf of The Ministry of Health

By the Permanent Secretary, Ministry of Health

……

Name & Signature

In the presence of

……

Name & Signature

Signed for and behalf of The Ministry of Finance,

By the Permanent Secretary, Ministry of Finance, Planning and Economic Development

……

In the presence of

……

Name & Signature

Signed for and behalf of The Uganda Catholic Medical Bureau By the Chair Person of the Catholic Health Commission

……

In the presence of

……

Name & Signature

Signed for and behalf of The Uganda Protestant Medical Bureau By the Representative of the UPMB Trustees

……

In the presence of

……

Name & Signature

Signed for and behalf of The Uganda Muslim Medical Bureau By the Representative of the UMMB Trustees

……

In the presence of

……

Name & Signature

Signed for and behalf of The Uganda Orthodox Medical Bureau By the Representative of the UOMB

……

In the presence of

……

Name & Signature

Sub annex 2b: Copy of Memorandum of Understanding between the DLG and PNFP Health Service Providers for FY 20…../…..

MEMORANDUM OF UNDERSTANDING BETWEEN THE UGANDA DISTRICT LOCAL GOVERNMENT AND ……FOR USE OF FUNDS OF THE PHC CONDITIONAL GRANT FOR THE FINANCIAL YEAR……FOR THE DELIVERY OF HEALTH SERVICES WITHIN THE DISTRICT OF ……...

This memorandum is made this……day of……20…..

BETWEEN

On the one part

THE ……. DISTRICT, represented by the chief Administrative Officer, P.O Box ……..., ……. (Hereinafter referred to as "District")

AND

(On the one part)

THE…….. (Name of Health Facility) represented by the Head of the Unit (hereinafter as "the Health Unit" on the other part.

1. INTRODUCTION

WHEREAS District wishes to improve the quality of life of the people of ……District.

1.1.1. WHEREAS District, in order to achieve the above objectives will provide funds to the Health Unit in the form of PAF (PNFP) PHC Conditional Grant (hereafter referred to as "the Grant").

The specific objectives of which are set out in the district guidelines on the Utilization and management of Grants for the Delivery of Health Services (hereafter referred to as "the Guidelines).

1.1.2 WHEREAS District has examined the Health Unit Annual Work plan for the Grant, which forms annex 1 this Memorandum of understanding (hereinafter referred to as the work plan).

1.1.3. WHEREAS district confirms that the work plan has been prepared according to the Guidelines, adequately addresses the objectives of the Grant as set out in the Grant Guidelines and the needs of the District, is realistic and achievable, is in line with Government of Uganda policy, and within the budget ceilings provided by District.

1.2. WHEREAS District agrees to provide funds for the implementation of activities identified in the work plan.

1.3 WHEREAS District has attempted to ensure that the budget ceilings provide accurately project the level of funding that will be available to the Health Unit in the financial year 2016/17 Government of Uganda Budget.

AND

1.3.1. WHEREAS Health Unit has developed the Work in accordance with the guidelines, and with Government Policy, and the Health Unit has ensured that the work plan addresses the needs of the District.

1.4 WHEREAS THE Health Unit agrees implement the activities in the Work plan using the funds provided by District.

NOW THEREFORE IT IS AGREED HEREIN AS FOLLOWS

2. RESPONSIBILITIES OF THE HEALTH UNIT

2.1 The Health will make every reasonable effort to implement all the activities set out in the work plan.

2.2 The Health Unit will implement the work plan, and report on the use of funds

2.2.1 The Health Unit will submit a Quarterly Progress Report, Cumulative progress Report and Budget Request to District by the end of the first week after the close of the quarter to qualify for release of funds for that quarter, to enable the district to confirm to the regulations as specified in the Guidelines.

2.2.2 If the Health Unit encounters problems in implementation of the Work plan, it will seek technical assistance from District or any other part in a position to Government will act on this assistance, and make efforts to overcome any problems in implementation. If the Health Unit does not act on technical advice from District, it must give reasons for the same.

2.3 The Health Unit will not alter the work plan before getting written approval from the District.

3. RESPONSIBILITIES OF THE DISTRICT

3.1.1 The District will fund the implementation of activities identified in the work plan, and the implementation of any other activities resulting from changes in the work plan, provide that the Health Unit has followed the procedures for altering the work plan set out under clause 2.4 and 2.5 of this Memorandum of Understanding and has acquired approval of the District.

3.1.2 Provided that the District has received the required reports on time, as set out in the General guidelines will ensure that release of funds is made on time.

3.2 The District will not release funds if the required reports set out in 2.3 are not received.

3.2.1 The District will analyze all Activity reports (if applicable), progress reports and Budget Requests submitted by the Local government. Each budget Request will be considered on its own merit and the funds released are below the Budget Request. Central Government must give reasons for the same in writing to the District.

3.3 The District will provide technical assistance for the preparation of work plans for next Financial Year.

3.4 Changes to the work plan

3.4.1 The District will consider each request for authority to make changes to the Work plan on its own merit.

3.4.2. If the District does not find proposed changes in a work plan acceptable, it must give reasons for the same, and suggest viable alternatives to the Health Unit.

4. VALIDITY OF MEMORANDUM OF UNDERSTANDING

4.1 This memorandum of Understanding is valid from the date of signing until such time as District has both received the Verified Cumulative annual Reports for the Grant and any unspent funds returned to District in accordance with the Grant guidelines and the
4.2 Any modification to this Memorandum of Understanding of shall by mutual agreement of both parties.

SIGNED for and on behalf of

IN THE PRESENCE OF HEALTH UNIT OWNERSHIP

……. Name & Signature

…….. Name & Signature

SIGNED FOR and on behalf of

IN THE PRESENCE OF THE DISTRICT

…….. Name & Signature

…….. Name & Signature

SUBANNEX 3: Indicative Planning Figures

Sub annex 3.1 summary of RBF IPFS FOR LGS FOR FY 2020/21

Summary of RBF IPFs for LGs for FY 2020/21						
s/n	**District**	**Vote No.**	**Total RBF IPFs _ FY 2020/21**	**O/w - DHMT IPFs _ RBF Grants FY2020/21**	**O/w - District Hospital IPFs _ RBF Grants FY2020/21**	**O/w - Health Center IPFs _ RBF Grants FY2020/21**
1	Abim District	573	344,677,999	40,200,000	179,030,421	125,447,578
2	Adjumani District	501	730,203,525	58,600,000	172,790,623	498,812,903
3	Agago District	611	735,933,917	58,000,000	291,195,760	386,738,158
4	Alebtong District	588	440,014,055	38,600,000		401,414,055
5	Amolatar District	564	382,109,456	34,000,000	106,522,113	241,587,343
6	Amudat District	581	210,904,304	27,000,000	110,665,634	73,238,670
7	Amuria District	565	586,716,344	45,600,000	100,336,006	440,780,338
8	Apac District	502	433,297,741	39,000,000	172,790,204	221,507,538
9	Arua District	503	2,256,625,854	77,400,000	743,347,929	1,435,877,925
10	Budaka District	571	620,071,313	44,400,000		575,671,313
11	Bududa District	579	558,876,092	37,800,000	174,121,667	346,954,425
12	Bugiri District	504	835,571,945	60,000,000	266,111,308	509,460,638
13	Bugweri District	624	323,645,550	41,600,000		282,045,550
14	Buhweju District	610	254,444,613	35,800,000		218,644,613
15	Buikwe District	582	1,274,915,508	62,400,000	485,203,471	727,312,038
16	Bukedea District	578	440,760,763	33,400,000		407,360,763
17	Bukomansimbi District	600	230,373,438	38,000,000		192,373,438
18	Bukwo District	567	388,206,883	41,400,000	149,549,913	197,256,970
19	Bulambuli District	589	419,473,875	47,400,000		372,073,875
20	Buliisa District	576	472,454,921	29,000,000	220,435,421	223,019,500
21	Bundibugyo District	505	798,984,368	51,400,000	184,334,608	563,249,760
22	Bunyangabu District	622	430,544,100	45,600,000		384,944,100
23	Bushenyi District	506	762,158,503	56,400,000	291,974,703	413,783,800
24	Busia District	507	1,146,697,791	51,200,000	368,725,103	726,772,688
25	Butaleja District	557	801,702,585	49,000,000	199,254,160	553,448,425

Summary of RBF IPFs for LGs for FY 2020/21						
s/n	**District**	**Vote No.**	**Total RBF IPFs _ FY 2020/21**	**O/w - DHMT IPFs _ RBF Grants FY2020/21**	**O/w - District Hospital IPFs _ RBF Grants FY2020/21**	**O/w - Health Center IPFs _ RBF Grants FY2020/21**
26	Butambala District	608	324,322,488	39,200,000	172,790,201	112,332,288
27	Butebo District	619	231,437,663	29,000,000		202,437,663
28	Buvuma District	590	186,988,543	30,400,000		156,588,543
29	Buyende District	583	521,166,725	39,200,000		481,966,725
30	Dokolo District	575	372,351,475	38,200,000		334,151,475
31	Gomba District	591	313,377,270	41,000,000		272,377,270
32	Hoima District	509	657,994,318	54,000,000		603,994,318
33	Ibanda District	558	606,008,612	60,600,000	116,547,737	428,860,875
34	Iganga District	510	885,137,174	58,400,000	351,981,524	474,755,650
35	Isingiro District	560	1,218,312,750	88,800,000		1,129,512,750
36	Jinja District	511	1,215,963,539	86,000,000	211,870,526	918,093,013
37	Kaabong District	559	380,015,271	44,400,000	172,730,421	162,884,850
38	Kabale District	512	646,083,152	75,000,000	259,483,465	311,599,688
39	Kabarole District	513	865,531,873	61,000,000	343,008,411	461,523,463
40	Kaberamaido District	514	366,696,220	30,800,000	62,990,870	272,905,350
41	Kagadi District	613	819,598,312	51,200,000	259,134,612	509,263,700
42	Kakumiro District	614	742,769,100	45,600,000		697,169,100
43	Kalaki District	635	279,132,925	30,000,000	65,244,187	183,888,738
44	Kalangala District	515	211,926,213	37,000,000		174,926,213
45	Kaliro District	561	335,619,113	39,200,000		296,419,113
46	Kalungu District	598	526,197,241	46,600,000	122,594,116	357,003,125
47	Kampala District	800	2,929,696,402	407,800,000	612,361,364	1,909,535,038
48	Kamuli District	517	1,398,129,208	77,000,000	618,424,296	702,704,913
49	Kamwenge District	518	967,913,431	50,400,000	150,303,868	767,209,563
50	Kanungu District	519	1,139,002,246	68,800,000	533,467,346	536,734,900
51	Kapchorwa District	520	352,956,646	39,800,000	179,030,421	134,126,225
52	Kapelebyong District	627	240,187,950	32,000,000		208,187,950
53	Karenga District	634	121,202,940	27,000,000		94,202,940

Summary of RBF IPFs for LGs for FY 2020/21						
s/n	**District**	**Vote No.**	**Total RBF IPFs _ FY 2020/21**	**O/w - DHMT IPFs _ RBF Grants FY2020/21**	**O/w - District Hospital IPFs _ RBF Grants FY2020/21**	**O/w - Health Center IPFs _ RBF Grants FY2020/21**
54	Kasese District	521	2,949,844,702	72,400,000	1,158,268,532	1,719,176,170
55	Kasanda District	625	666,932,613	106,600,000		560,332,613
56	Katakwi District	522	407,560,551	45,800,000	149,287,413	212,473,138
57	Kayunga District	523	945,945,597	48,000,000	240,058,485	657,887,113
58	Kazo District	630	232,572,050	37,800,000		194,772,050
59	Kibaale District	524	360,072,213	31,000,000		329,072,213
60	Kiboga District	525	471,457,618	45,200,000	172,790,201	253,467,418
61	Kibuku District	605	599,423,775	37,800,000		561,623,775
62	Kikuube District	628	711,800,075	50,400,000		661,400,075
63	Kiruhura District	562	521,276,062	45,600,000	169,981,394	305,694,668
64	Kiryandongo District	592	791,146,496	44,200,000	324,058,146	422,888,350
65	Kisoro District	526	995,327,155	72,600,000	391,889,742	530,837,413
66	Kitagwenda District	632	284,971,895	31,400,000		253,571,895
67	Kitgum District	527	1,092,502,622	50,400,000	518,928,407	523,174,215
68	Koboko District	563	717,604,586	41,400,000	124,966,461	551,238,125
69	Kole District	607	394,081,075	35,200,000		358,881,075
70	Kotido District	528	433,007,138	35,200,000		397,807,138
71	Kumi District	529	741,350,625	41,000,000	337,227,200	363,123,425
72	Kwania District	626	404,504,988	38,600,000		365,904,988
73	Kween District	612	249,319,178	45,000,000		204,319,178
74	Kyankwanzi District	597	393,857,260	41,000,000		352,857,260
75	Kyegegwa District	584	765,617,813	39,400,000		726,217,813
76	Kyenjojo District	530	1,006,673,161	50,800,000	277,540,486	678,332,675
77	Kyotera District	621	548,136,532	67,000,000	163,148,824	317,987,708
78	Lamwo District	585	643,567,060	48,000,000		595,567,060
79	Lira District	531	732,242,175	51,000,000		681,242,175
80	Luuka District	593	343,780,725	50,000,000		293,780,725
81	Luwero District	532	1,667,148,022	93,400,000	506,108,434	1,067,639,588

Summary of RBF IPFs for LGs for FY 2020/21						
s/n	**District**	**Vote No.**	**Total RBF IPFs _ FY 2020/21**	**O/w - DHMT IPFs _ RBF Grants FY2020/21**	**O/w - District Hospital IPFs _ RBF Grants FY2020/21**	**O/w - Health Center IPFs _ RBF Grants FY2020/21**
82	Lwengo District	599	573,204,500	49,000,000		524,204,500
83	Lyantonde District	580	366,532,600	41,600,000	170,294,112	154,638,488
84	Madi-Okollo District	633	344,513,713	42,800,000		301,713,713
85	Manafwa District	566	445,621,350	32,600,000		413,021,350
86	Maracha District	577	607,116,493	45,000,000	149,683,368	412,433,125
87	Masaka District	533	512,152,073	51,400,000	177,950,398	282,801,675
88	Masindi District	534	539,123,956	51,000,000	189,164,206	298,959,750
89	Mayuge District	535	960,764,661	59,000,000	285,623,411	616,141,250
90	Mbale District	536	1,263,672,588	74,800,000		1,188,872,588
91	Mbarara District	537	668,972,356	62,400,000	187,361,131	419,211,225
92	Mitooma District	601	435,496,710	42,800,000		392,696,710
93	Mityana District	568	907,955,359	82,400,000	331,130,971	494,424,388
94	Moroto District	538	160,486,815	33,000,000		127,486,815
95	Moyo District	539	587,111,117	55,000,000	314,054,442	218,056,675
96	Mpigi District	540	902,204,070	55,600,000	161,885,733	684,718,338
97	Mubende District	541	515,624,108	55,800,000		459,824,108
98	Mukono District	542	2,199,469,664	74,400,000	245,267,934	1,879,801,730
99	Nabilatuk District	623	179,472,860	25,400,000		154,072,860
100	Nakapiripiriti District	543	236,700,925	29,000,000		207,700,925
101	Nakaseke District	569	702,316,709	48,800,000	393,819,512	259,697,198
102	Nakasongola District	544	345,447,850	54,200,000		291,247,850
103	Namayingo District	594	367,273,388	46,200,000		321,073,388
104	Namisindwa District	617	699,050,658	41,200,000		657,850,658
105	Namutumba District	574	360,317,388	47,800,000		312,517,388
106	Napak District	604	564,315,585	36,600,000	309,860,390	217,855,195
107	Nebbi District	545	1,119,098,174	48,200,000	497,318,539	573,579,635
108	Ngora District	603	663,422,516	35,200,000	238,109,453	390,113,063
109	Ntoroko District	595	165,512,398	27,200,000		138,312,398

Summary of RBF IPFs for LGs for FY 2020/21

s/n	District	Vote No.	Total RBF IPFs _ FY 2020/21	O/w - DHMT IPFs _ RBF Grants FY2020/21	O/w - District Hospital IPFs _ RBF Grants FY2020/21	O/w - Health Center IPFs _ RBF Grants FY2020/21
110	Ntungamo District	546	1,021,824,589	69,400,000	284,933,251	667,491,338
111	Obongi District	629	197,641,400	32,000,000		165,641,400
112	Otuke District	586	288,431,520	38,600,000		249,831,520
113	Oyam District	572	770,463,305	50,600,000	255,896,668	463,966,638
114	Pader District	547	389,784,523	50,800,000		338,984,523
115	Pakwach District	618	462,767,313	40,000,000		422,767,313
116	Pallisa District	548	813,079,226	44,200,000	217,420,013	551,459,213
117	Rakai District	549	596,349,670	63,600,000	185,741,195	347,008,475
118	Rubanda District	616	348,446,693	54,800,000		293,646,693
119	Rubirizi District	602	275,099,563	36,200,000		238,899,563
120	Rukiga District	620	224,779,613	48,800,000		175,979,613
121	Rukungiri District	550	1,091,275,446	106,600,000	267,327,411	717,348,035
122	Rwampara District	631	232,346,515	36,000,000		196,346,515
123	Sembabule District	551	449,174,598	48,400,000		400,774,598
124	Serere District	596	676,247,063	45,600,000		630,647,063
125	Sheema District	609	774,695,937	54,200,000	172,790,612	547,705,325
126	Sironko District	552	509,928,913	53,600,000		456,328,913
127	Soroti District	553	508,551,525	47,800,000		460,751,525
128	Tororo District	554	2,005,358,456	93,000,000	673,147,493	1,239,210,963
129	Wakiso District	555	3,692,016,491	130,800,000	1,399,838,928	2,161,377,563
130	Yumbe District	556	1,740,920,823	56,600,000	346,107,223	1,338,213,600
131	Zombo District	587	753,322,060	43,000,000	174,719,623	535,602,438
	Grand Total		**90,022,263,814**	**6,860,800,000**	**20,612,052,152**	**62,549,411,663**

Sub annex 3b. Summary of GAVI HSS IPFs for LGs for FY 2020/21

NO	DISTRICT	1.1.4 Support the districts to implement additional outreaches	5.2.5.B Hold quarterly one day district stakeholders performance review meeting on EPI targeting: (DHO, ADHO-MCH, DHEO), Chairpersons (LCV and LCIII), Sub county Chiefs ,, RDC, DISO.	5.2.5.C Hold Health Sub District Quarterly Performance review meetings; Targeting Sub county chiefs, HSD in charges, Health facility in charges, Health Assistants	3.1.2 Support Data Improvement Teams (DITs) to conduct Follow –up Mentorships of Health Workers in data quality improvement (of EPI/HMIS programs) at all levels in districts	Support to implement ICHDs in April and October	Support supervision for DHT	Vaccines and supplies distribution	Grand Total
1	ABIM	132,240,000	19,600,000	11,600,000	4,320,000	16,020,000	3,680,000	1,488,000	188,948,000
2	ADJUMANI	36,272,000	13,200,000	10,320,000	4,320,000	29,360,000	3,680,000	1,984,000	99,136,000
3	AGAGO	79,216,000	19,920,000	14,000,000	4,320,000	27,260,000	3,680,000	3,472,000	151,868,000
4	ALEBTONG	44,104,000	12,400,000	8,480,000	4,320,000	15,500,000	3,680,000	2,480,000	90,964,000
5	AMOLATAR	79,008,000	15,440,000	9,520,000	4,320,000	11,020,000	3,680,000	2,976,000	125,964,000
6	AMUDAT	53,528,000	10,320,000	6,080,000	4,320,000	7,015,000	3,680,000	1,984,000	86,927,000
7	AMURIA	119,776,000	20,880,000	13,040,000	4,320,000	16,990,000	3,680,000	2,480,000	181,166,000
8	AMURU	19,640,000	10,480,000	8,400,000	4,320,000	23,880,000	3,680,000	2,480,000	72,880,000
9	APAC	111,488,000	18,640,000	11,600,000	4,320,000	16,340,000	3,680,000	1,984,000	168,052,000
10	ARUA	106,472,000	22,800,000	15,840,000	4,320,000	30,625,000	3,680,000	2,976,000	186,713,000
11	Arua Madi Okollo	66,528,000	14,800,000	10,240,000	4,320,000	22,230,000	3,680,000	1,984,000	123,782,000
12	BUDAKA	68,552,000	16,400,000	10,720,000	4,320,000	13,865,000	3,680,000	3,472,000	121,009,000
13	BUDUDA	224,152,000	34,480,000	20,320,000	4,320,000	14,720,000	3,680,000	4,464,000	306,136,000
14	BUGIRI	113,648,000	22,160,000	14,560,000	4,320,000	22,870,000	3,680,000	2,976,000	184,214,000
15	BUGWERI	48,864,000	9,840,000	6,080,000	4,320,000	11,335,000	3,680,000	992,000	85,111,000
16	BUHWEJU	38,560,000	11,440,000	7,760,000	4,320,000	13,385,000	3,680,000	2,480,000	81,625,000
17	BUIKWE	55,656,000	15,280,000	11,360,000	4,320,000	28,030,000	3,680,000	1,984,000	120,310,000
18	BUKEDEA	218,224,000	30,480,000	17,200,000	4,320,000	11,430,000	3,680,000	2,976,000	288,310,000
19	BUKOMANSIMBI	29,888,000	7,600,000	5,040,000	4,320,000	9,925,000	3,680,000	992,000	61,445,000
20	BUKWO	84,968,000	15,440,000	9,440,000	4,320,000	11,815,000	3,680,000	1,984,000	131,647,000
21	BULAMBULI	167,208,000	28,720,000	17,680,000	4,320,000	17,460,000	3,680,000	4,464,000	243,532,000
22	BULIISA	47,008,000	9,840,000	6,080,000	4,320,000	9,755,000	3,680,000	1,488,000	82,171,000
23	BUNDIBUGYO	165,600,000	29,520,000	18,560,000	4,320,000	20,690,000	3,680,000	4,464,000	246,834,000
24	BUNYANGABU	51,032,000	11,760,000	7,440,000	4,320,000	11,110,000	3,680,000	1,984,000	91,326,000
25	BUSHENYI	67,880,000	17,520,000	12,640,000	4,320,000	26,940,000	3,680,000	2,976,000	135,956,000
26	BUSIA	72,464,000	18,960,000	13,520,000	4,320,000	25,850,000	3,680,000	3,472,000	142,266,000
27	BUTALEJA	86,800,000	17,680,000	11,520,000	4,320,000	18,400,000	3,680,000	2,480,000	144,880,000
28	BUTAMBALA	24,984,000	6,960,000	4,480,000	4,320,000	9,220,000	3,680,000	992,000	54,636,000
29	BUTEBO	30,120,000	8,560,000	5,760,000	4,320,000	13,530,000	3,680,000	1,488,000	67,458,000

NO	DISTRICT	1.1.4 Support the districts to implement additional outreaches	5.2.5.B Hold quarterly one day district stakeholders performance review meeting on EPI targeting: (DHO, ADHO-MCH, DHEO), Chairpersons (LCV and LCIII), Sub county Chiefs ,, RDC, DISO.	5.2.5.C Hold Health Sub District Quarterly Performance review meetings; Targeting Sub county chiefs, HSD in charges, Health facility in charges, Health Assistants	3.1.2 Support Data Improvement Teams (DITs) to conduct Follow –up Mentorships of Health Workers in data quality improvement (of EPI/HMIS programs) at all levels in districts	Support to implement ICHDs in April and October	Support supervision for DHT	Vaccines and supplies distribution	Grand Total
30	BUVUMA	69,328,000	10,000,000	6,240,000	4,320,000	21,460,000	3,680,000	1,488,000	116,516,000
31	BUYENDE	92,608,000	16,720,000	10,160,000	4,320,000	11,270,000	3,680,000	2,480,000	141,238,000
32	DOKOLO	90,512,000	16,880,000	10,480,000	4,320,000	13,385,000	3,680,000	2,480,000	141,737,000
33	GOMBA	50,464,000	11,120,000	7,280,000	4,320,000	14,315,000	3,680,000	1,488,000	92,667,000
34	GULU	59,744,000	17,680,000	13,280,000	4,320,000	32,580,000	3,680,000	2,976,000	134,260,000
35	HOIMA	61,944,000	15,280,000	10,720,000	4,320,000	21,140,000	3,680,000	2,480,000	119,564,000
36	IBANDA	43,664,000	15,440,000	11,920,000	4,320,000	31,090,000	3,680,000	2,480,000	112,594,000
37	IGANGA	45,616,000	13,040,000	9,600,000	4,320,000	23,015,000	3,680,000	1,984,000	101,255,000
38	ISINGIRO	137,016,000	29,360,000	20,240,000	4,320,000	34,870,000	3,680,000	4,464,000	233,950,000
39	JINJA	43,920,000	14,160,000	13,280,000	4,320,000	52,475,000	3,680,000	1,984,000	133,819,000
40	KAABONG	75,384,000	14,480,000	9,120,000	4,320,000	14,225,000	3,680,000	1,984,000	123,193,000
41	Karenga	62,616,000	12,240,000	7,520,000	4,320,000	10,245,000	3,680,000	1,984,000	102,605,000
42	KABALE	55,248,000	15,920,000	12,000,000	4,320,000	30,225,000	3,680,000	2,480,000	123,873,000
43	KABAROLE	82,448,000	19,120,000	12,960,000	4,320,000	20,915,000	3,680,000	3,472,000	146,915,000
44	KABERAMAIDO	30,440,000	10,640,000	7,280,000	4,320,000	12,055,000	3,680,000	2,480,000	70,895,000
45	Kalaki	28,432,000	9,520,000	6,480,000	4,320,000	11,815,000	3,680,000	1,984,000	66,231,000
46	KAGADI	135,768,000	25,840,000	16,400,000	4,320,000	19,200,000	3,680,000	4,464,000	209,672,000
47	KAKUMIRO	115,440,000	20,880,000	12,800,000	4,320,000	13,080,000	3,680,000	3,472,000	173,672,000
48	KALANGALA	33,616,000	6,160,000	4,560,000	4,320,000	24,120,000	3,680,000	1,488,000	77,944,000
49	KALIRO	103,216,000	18,640,000	11,520,000	4,320,000	14,170,000	3,680,000	2,480,000	158,026,000
50	KALUNGU	34,456,000	9,520,000	6,720,000	4,320,000	16,350,000	3,680,000	1,488,000	76,534,000
51	KAMPALA	131,472,000	35,440,000	30,000,000	4,320,000	105,805,000	3,680,000	17,360,000	328,077,000
52	KAMULI	86,112,000	22,640,000	16,640,000	4,320,000	35,175,000	3,680,000	3,968,000	172,535,000
53	KAMWENGE	45,632,000	11,600,000	7,840,000	4,320,000	16,590,000	3,680,000	1,984,000	91,646,000
54	Kamwenge Kitagwenda	44,760,000	10,320,000	6,560,000	4,320,000	11,575,000	3,680,000	1,488,000	82,703,000
55	KANUNGU	80,760,000	18,160,000	12,320,000	4,320,000	21,380,000	3,680,000	2,976,000	143,596,000
56	KAPCHORWA	106,024,000	19,440,000	12,320,000	4,320,000	16,990,000	3,680,000	2,480,000	165,254,000
57	KAPELEBYONG	43,480,000	9,200,000	5,600,000	4,320,000	9,300,000	3,680,000	1,488,000	77,068,000
58	KASESE	171,408,000	43,760,000	33,200,000	4,320,000	77,345,000	3,680,000	6,448,000	340,161,000
59	KASSANDA	107,568,000	17,200,000	10,080,000	4,320,000	11,655,000	3,680,000	1,984,000	156,487,000
60	KATAKWI	142,288,000	24,880,000	15,440,000	4,320,000	18,095,000	3,680,000	3,472,000	212,175,000

NO	DISTRICT	1.1.4 Support the districts to implement additional outreaches	5.2.5.B Hold quarterly one day district stakeholders performance review meeting on EPI targeting: (DHO, ADHO-MCH, DHEO), Chairpersons (LCV and LCIII), Sub county Chiefs ,, RDC, DISO.	5.2.5.C Hold Health Sub District Quarterly Performance review meetings; Targeting Sub county chiefs, HSD in charges, Health facility in charges, Health Assistants	3.1.2 Support Data Improvement Teams (DITs) to conduct Follow –up Mentorships of Health Workers in data quality improvement (of EPI/HMIS programs) at all levels in districts	Support to implement ICHDs in April and October	Support supervision for DHT	Vaccines and supplies distribution	Grand Total
61	KAYUNGA	81,896,000	16,560,000	10,960,000	4,320,000	18,240,000	3,680,000	2,480,000	138,136,000
62	KIBAALE	66,240,000	12,720,000	7,600,000	4,320,000	7,585,000	3,680,000	1,984,000	104,129,000
63	KIBOGA	62,192,000	14,800,000	10,000,000	4,320,000	18,320,000	3,680,000	2,480,000	115,792,000
64	KIBUKU	123,880,000	22,800,000	14,080,000	4,320,000	14,025,000	3,680,000	3,968,000	186,753,000
65	KIKUUBE	12,488,000	6,960,000	5,360,000	4,320,000	18,680,000	3,680,000	992,000	52,480,000
66	KIRUHURA	67,912,000	14,160,000	9,120,000	4,320,000	14,635,000	3,680,000	1,984,000	115,811,000
67	Kiruhura Kazo	60,200,000	12,240,000	7,680,000	4,320,000	11,655,000	3,680,000	1,984,000	101,759,000
68	KIRYANDONGO	37,264,000	11,760,000	8,400,000	4,320,000	17,535,000	3,680,000	2,480,000	85,439,000
69	KISORO	45,048,000	15,280,000	11,280,000	4,320,000	22,950,000	3,680,000	3,472,000	106,030,000
70	KITGUM	100,464,000	21,360,000	14,160,000	4,320,000	19,665,000	3,680,000	3,968,000	167,617,000
71	KOBOKO	60,360,000	12,080,000	7,600,000	4,320,000	12,280,000	3,680,000	1,488,000	101,808,000
72	KOLE	64,624,000	12,880,000	8,000,000	4,320,000	11,030,000	3,680,000	1,984,000	106,518,000
73	KOTIDO	106,976,000	20,720,000	13,280,000	4,320,000	17,685,000	3,680,000	3,472,000	170,133,000
74	KUMI	188,304,000	27,120,000	15,600,000	4,320,000	13,385,000	3,680,000	2,480,000	254,889,000
75	KWANIA	56,416,000	12,400,000	7,920,000	4,320,000	13,145,000	3,680,000	1,984,000	99,865,000
76	KWEEN	129,672,000	22,320,000	13,600,000	4,320,000	14,410,000	3,680,000	2,976,000	190,978,000
77	KYANKWANZI	144,544,000	24,560,000	15,040,000	4,320,000	16,605,000	3,680,000	3,472,000	212,221,000
78	KYEGEGWA	102,736,000	19,120,000	11,760,000	4,320,000	12,295,000	3,680,000	2,976,000	156,887,000
79	KYENJOJO	203,552,000	34,000,000	21,040,000	4,320,000	23,510,000	3,680,000	4,464,000	294,566,000
80	KYOTERA	78,792,000	16,080,000	10,960,000	4,320,000	24,435,000	3,680,000	2,480,000	140,747,000
81	LAMWO	81,008,000	17,680,000	11,680,000	4,320,000	18,560,000	3,680,000	2,976,000	139,904,000
82	LIRA	131,664,000	23,920,000	15,440,000	4,320,000	22,165,000	3,680,000	2,976,000	204,165,000
83	LUUKA	35,648,000	10,960,000	8,080,000	4,320,000	22,070,000	3,680,000	1,488,000	86,246,000
84	LUWEERO	62,928,000	19,760,000	15,840,000	4,320,000	47,145,000	3,680,000	2,480,000	156,153,000
85	LWENGO	55,616,000	11,760,000	7,600,000	4,320,000	11,655,000	3,680,000	1,984,000	96,615,000
86	LYANTONDE	25,696,000	8,400,000	5,840,000	4,320,000	13,610,000	3,680,000	1,488,000	63,034,000
87	MANAFWA	167,800,000	27,120,000	15,840,000	4,320,000	9,250,000	3,680,000	3,968,000	231,978,000
88	MARACHA	115,600,000	20,240,000	12,480,000	4,320,000	14,250,000	3,680,000	2,976,000	173,546,000
89	MASAKA	41,672,000	12,400,000	9,360,000	4,320,000	24,970,000	3,680,000	1,488,000	97,890,000
90	MASINDI	43,360,000	14,320,000	10,640,000	4,320,000	23,415,000	3,680,000	2,976,000	102,711,000
91	MAYUGE	88,496,000	19,600,000	14,160,000	4,320,000	35,170,000	3,680,000	2,976,000	168,402,000

NO	DISTRICT	1.1.4 Support the districts to implement additional outreaches	5.2.5.B Hold quarterly one day district stakeholders performance review meeting on EPI targeting: (DHO, ADHO-MCH, DHEO), Chairpersons (LCV and LCIII), Sub county Chiefs ,, RDC, DISO.	5.2.5.C Hold Health Sub District Quarterly Performance review meetings; Targeting Sub county chiefs, HSD in charges, Health facility in charges, Health Assistants	3.1.2 Support Data Improvement Teams (DITs) to conduct Follow –up Mentorships of Health Workers in data quality improvement (of EPI/HMIS programs) at all levels in districts	Support to implement ICHDs in April and October	Support supervision for DHT	Vaccines and supplies distribution	Grand Total
92	MBALE	167,488,000	33,360,000	22,640,000	4,320,000	37,770,000	3,680,000	4,960,000	274,218,000
93	MBARARA	43,040,000	13,200,000	9,760,000	4,320,000	23,800,000	3,680,000	1,984,000	99,784,000
94	Mbarara Rwampara	50,960,000	10,640,000	6,480,000	4,320,000	8,130,000	3,680,000	1,984,000	86,194,000
95	MITOOMA	77,968,000	15,440,000	9,680,000	4,320,000	12,680,000	3,680,000	2,480,000	126,248,000
96	MITYANA	69,464,000	19,760,000	14,960,000	4,320,000	36,890,000	3,680,000	2,976,000	152,050,000
97	MOROTO	48,216,000	8,880,000	5,440,000	4,320,000	10,140,000	3,680,000	992,000	81,668,000
98	MOYO	23,832,000	9,040,000	6,800,000	4,320,000	19,875,000	3,680,000	1,488,000	69,035,000
99	Moyo Obongi	21,200,000	5,840,000	4,480,000	4,320,000	14,780,000	3,680,000	992,000	55,292,000
100	MPIGI	37,800,000	12,880,000	10,080,000	4,320,000	29,905,000	3,680,000	1,488,000	100,153,000
101	MUBENDE	101,248,000	22,000,000	15,360,000	4,320,000	29,215,000	3,680,000	2,976,000	178,799,000
102	MUKONO	66,928,000	18,960,000	14,720,000	4,320,000	40,970,000	3,680,000	2,976,000	152,554,000
103	NABILATUK	24,272,000	5,520,000	3,040,000	4,320,000	4,830,000	3,680,000	992,000	46,654,000
104	NAKAPIRIPIRIT	43,952,000	9,040,000	5,680,000	4,320,000	10,300,000	3,680,000	1,488,000	78,460,000
105	NAKASEKE	77,384,000	17,200,000	11,680,000	4,320,000	21,220,000	3,680,000	2,480,000	137,964,000
106	NAKASONGOLA	49,216,000	13,840,000	10,320,000	4,320,000	27,540,000	3,680,000	1,984,000	110,900,000
107	NAMAYINGO	42,208,000	10,960,000	7,840,000	4,320,000	22,080,000	3,680,000	1,984,000	93,072,000
108	NAMISINDWA	182,664,000	28,240,000	16,480,000	4,320,000	12,205,000	3,680,000	3,968,000	251,557,000
109	NAMUTUMBA	23,176,000	12,080,000	9,280,000	4,320,000	22,710,000	3,680,000	2,976,000	78,222,000
110	NAPAK	32,280,000	10,320,000	7,040,000	4,320,000	12,975,000	3,680,000	2,480,000	73,095,000
111	NEBBI	60,272,000	14,320,000	9,440,000	4,320,000	13,545,000	3,680,000	2,976,000	108,553,000
112	NGORA	88,432,000	15,120,000	8,960,000	4,320,000	9,620,000	3,680,000	1,984,000	132,116,000
113	NTOROKO	47,416,000	9,680,000	5,760,000	4,320,000	7,015,000	3,680,000	1,984,000	79,855,000
114	NTUNGAMO	108,888,000	26,160,000	17,920,000	4,320,000	25,400,000	3,680,000	5,456,000	191,824,000
115	NWOYA	21,520,000	8,240,000	5,600,000	4,320,000	10,325,000	3,680,000	1,984,000	55,669,000
116	OMORO	22,376,000	11,440,000	8,720,000	4,320,000	21,220,000	3,680,000	2,480,000	74,236,000
117	OTUKE	27,952,000	8,560,000	5,760,000	4,320,000	11,575,000	3,680,000	1,488,000	63,335,000
118	OYAM	59,528,000	15,760,000	11,120,000	4,320,000	22,005,000	3,680,000	2,976,000	119,389,000
119	PADER	40,376,000	15,120,000	11,360,000	4,320,000	26,395,000	3,680,000	2,976,000	104,227,000
120	PAKWACH	33,264,000	9,040,000	5,840,000	4,320,000	9,540,000	3,680,000	1,984,000	67,668,000
121	PALLISA	56,560,000	16,080,000	11,120,000	4,320,000	17,470,000	3,680,000	3,472,000	112,702,000
122	RAKAI	47,072,000	12,560,000	8,800,000	4,320,000	19,490,000	3,680,000	1,984,000	97,906,000

NO	DISTRICT	1.1.4 Support the districts to implement additional outreaches	5.2.5.B Hold quarterly one day district stakeholders performance review meeting on EPI targeting: (DHO, ADHO-MCH, DHEO), Chairpersons (LCV and LCIII), Sub county Chiefs ,, RDC, DISO.	5.2.5.C Hold Health Sub District Quarterly Performance review meetings; Targeting Sub county chiefs, HSD in charges, Health facility in charges, Health Assistants	3.1.2 Support Data Improvement Teams (DITs) to conduct Follow –up Mentorships of Health Workers in data quality improvement (of EPI/HMIS programs) at all levels in districts	Support to implement ICHDs in April and October	Support supervision for DHT	Vaccines and supplies distribution	Grand Total
123	RUBANDA	37,016,000	11,280,000	8,320,000	4,320,000	21,445,000	3,680,000	1,488,000	87,549,000
124	RUBIRIZI	59,720,000	12,240,000	7,680,000	4,320,000	10,325,000	3,680,000	1,984,000	99,949,000
125	RUKIGA	15,712,000	7,760,000	6,080,000	4,320,000	19,090,000	3,680,000	992,000	57,634,000
126	RUKUNGIRI	82,520,000	18,800,000	13,280,000	4,320,000	25,530,000	3,680,000	2,976,000	151,106,000
127	SERERE	25,032,000	9,840,000	7,280,000	4,320,000	17,750,000	3,680,000	1,984,000	69,886,000
128	SHEEMA	51,728,000	14,640,000	10,560,000	4,320,000	21,925,000	3,680,000	2,480,000	109,333,000
129	SIRONKO	165,096,000	31,280,000	20,160,000	4,320,000	24,910,000	3,680,000	5,456,000	254,902,000
130	SOROTI	49,080,000	14,640,000	10,400,000	4,320,000	18,640,000	3,680,000	2,976,000	103,736,000
131	SSEMBABULE	31,152,000	12,080,000	8,720,000	4,320,000	16,445,000	3,680,000	2,976,000	79,373,000
132	TORORO	92,632,000	25,040,000	17,920,000	4,320,000	30,255,000	3,680,000	5,456,000	179,303,000
133	WAKISO	120,688,000	35,920,000	29,600,000	4,320,000	89,630,000	3,680,000	4,464,000	288,302,000
134	YUMBE	121,608,000	23,600,000	15,360,000	4,320,000	23,030,000	3,680,000	3,472,000	195,070,000
135	ZOMBO	59,544,000	13,840,000	9,280,000	4,320,000	16,125,000	3,680,000	2,480,000	109,269,000
									18,154,141,000

Sub annex 3b. Summary of UGIFT IPFs for facility upgrades for LGs for FY 2020/21

Vote	DISTRICT	COUNTY	SUB COUNTY	FACILITY NAME	CONSTRUCTION	EQUIPPING	TOTAL ALLOCATION
611	Agago District	Agago North	Parabongo	Pacer HC II	650,000,000	210,937,500	860,937,500
588	Alebtong District	Moroto	Abia	Moroto Abia HC II	650,000,000	210,937,500	860,937,500
564	Amolatar District	Kioga	Agikdak	Awonangiro HC II	650,000,000	210,937,500	860,937,500
		Kioga	Namasale TC	Biko HC II	650,000,000	210,937,500	860,937,500
502	Apac District	Maruzi	Chegere	Kidilani HC II	650,000,000	210,937,500	860,937,500
		Maruzi	Akokoro	Kungu HC II	650,000,000	210,937,500	860,937,500
579	Bududa District	Lutsheshe	Nalwanza	Bumusi HC II	650,000,000	210,937,500	860,937,500
610	Buhweju District	Buhweju	Kyahenda	Kiyanja HC II	650,000,000	210,937,500	860,937,500
578	Bukedea District	Bukedea	Kamutur	Tajar HC II	650,000,000	210,937,500	860,937,500
		Bukedea	Kocheka	Kocheka HC II	650,000,000	210,937,500	860,937,500
567	Bukwo District	Kongasis	Chepkwasta	Chepkwasta HC II	650,000,000	210,937,500	860,937,500
		Kongasis	Riwo	Brim HC II	650,000,000	210,937,500	860,937,500
589	Bulambuli District	Elgon	Bumugibole	Bumugibole HC II	650,000,000	210,937,500	860,937,500
505	Bundibugyo District	Bughendera	Ntotoro	Mantoroba HC II	650,000,000	210,937,500	860,937,500
		Bwamba	Mirambi	Mirambi HC II	650,000,000	210,937,500	860,937,500
622	Bunyangabu District	Bunyangabu	Rubona TC	Rubona HC II	650,000,000	210,937,500	860,937,500
507	Busia District	Samia Bugwe South	Masinya	Bumunji HC II	650,000,000	210,937,500	860,937,500
		Samia Bugwe South	Sikuda	Tiira HC II	650,000,000	210,937,500	860,937,500
619	Butebo District	Butebo	Kabwangasi	Kachuru HC II	650,000,000	210,937,500	860,937,500
575	Dokolo District	Dokolo	Amwoma	Amwoma HC II	650,000,000	210,937,500	860,937,500
		Dokolo	Okwalongwen	Abalang HC II	650,000,000	210,937,500	860,937,500
558	Ibanda District	Ibanda	Kikyenkye	Kihani HC II	650,000,000	210,937,500	860,937,500
512	Kabale District	Ndorwa East	Maziba SC	Kahondo HC II	650,000,000	210,937,500	860,937,500
		Ndorwa West	Rubaya	Kitooma HC II	650,000,000	210,937,500	860,937,500
513	Kabarole District	Burahya	Hakibale	Kitule HC II	650,000,000	210,937,500	860,937,500
		Burahya	Mugusu	Nyabuswa HC II	650,000,000	210,937,500	860,937,500
613	Kagadi District	Buyaga West	Kyakabadiima	Kyakabadiima HC II	650,000,000	210,937,500	860,937,500
614	Kakumiro District	Bugangaizi East	Kibijo	Kabuubwa HC II	650,000,000	210,937,500	860,937,500
		Bugangaizi West	Kijangi	Kigando HCII	650,000,000	210,937,500	860,937,500
561	Kaliro District	Bulamogi	Buyinda	Buyinda HC II	650,000,000	210,937,500	860,937,500
517	Kamuli District	Buzaaya	Magogo	Bubago HC II	650,000,000	210,937,500	860,937,500
519	Kanungu District	Kinkizi	Butogota TC	Ntungamo HC II	650,000,000	210,937,500	860,937,500
521	Kasese District	Busongora North	Buhuhira	Buhuhira HC II	650,000,000	210,937,500	860,937,500
625	Kassanda District	Kassanda	Manyogaseka	Kyasansuwa HC II	650,000,000	210,937,500	860,937,500
523	Kayunga District	Ntenjeru-North	Kayunga	Busaale HC II	650,000,000	210,937,500	860,937,500
605	Kibuku District	Kibuku	Kakutu	Lyama HCII	650,000,000	210,937,500	860,937,500
562	Kiruhura District	Nyabushozi	Sanga	Rwabarata HC II	650,000,000	210,937,500	860,937,500
		Nyabushozi	Kinoni	Rwentamu HC II	650,000,000	210,937,500	860,937,500
607	Kole District	Kole South	Kole TC	Okole HC II	650,000,000	210,937,500	860,937,500
626	Kwania District	Kwania	Akali	Akali HC II	650,000,000	210,937,500	860,937,500
		Kwania	Ayabi	Owiny HC II	650,000,000	210,937,500	860,937,500
612	Kween District	Kween	Moyok	Moyok HC II	650,000,000	210,937,500	860,937,500
		Kween	Atar	Atar HC II	650,000,000	210,937,500	860,937,500
530	Kyenjojo District	Mwenge North	Bufunjo	Kataraza HC II	650,000,000	210,937,500	860,937,500
621	Kyotera District	Kyotera	Nangoma	Nangoma HC II	650,000,000	210,937,500	860,937,500

Vote	DISTRICT	COUNTY	SUB COUNTY	FACILITY NAME	CONSTRUCTION	EQUIPPING	TOTAL ALLOCATION
531	Lira District	Erute North	Adekokwok	Anyangatir HC II	650,000,000	210,937,500	860,937,500
577	Maracha District	Maracha East	Drambu	Liko HC II	650,000,000	210,937,500	860,937,500
535	Mayuge District	Bunya West	Imanyiro	Nkombe HC II	650,000,000	210,937,500	860,937,500
601	Mitooma District	Ruhinda	Mayanga	Mayanga HC II	650,000,000	210,937,500	860,937,500
568	Mityana District	Mityana South	Busunju TC	Busunju HCII	650,000,000	210,937,500	860,937,500
539	Moyo District	West Moyo	Alur	Lama HC II	650,000,000	210,937,500	860,937,500
541	Mubende District	Kasambya	Bagezza	Mubende Gayaza HC II	650,000,000	210,937,500	860,937,500
569	Nakaseke District	Nakaseke South	Semuto	Semuto HC II	650,000,000	210,937,500	860,937,500
546	Ntungamo District	Kajara	Kagarama TC	Ihunga (Ntungamo) HCII	650,000,000	210,937,500	860,937,500
		Rushenyi	Rubare	Nyanga HC II	650,000,000	210,937,500	860,937,500
606	Nwoya District	Nwoya	Anaka	Todora HC II	650,000,000	210,937,500	860,937,500
615	Omoro District	Tochi	Aremo	Tekulu HC II	650,000,000	210,937,500	860,937,500
		Omoro	Abuja	Abwoch HC II	650,000,000	210,937,500	860,937,500
572	Oyam District	Oyam South	Myene	Acimi HC II	650,000,000	210,937,500	860,937,500
		Oyam North	Aleka	Abela HC II	650,000,000	210,937,500	860,937,500
602	Rubirizi District	Bunyaruguru	Magambo	Butoha HC II	650,000,000	210,937,500	860,937,500
596	Serere District	Kasilo	Kasilo TC	Kamod HC II	650,000,000	210,937,500	860,937,500
609	Sheema District	Sheema South	Kitagata	Kyeibanga HC II	650,000,000	210,937,500	860,937,500
552	Sironko District	Budadri West	Nalusaala	Buyaya HC II	650,000,000	210,937,500	860,937,500
	Total				**41,600,000,000**	**13,500,000,000**	**55,100,000,000**

Sub annex 3d. Summary of Global fund IPFs to LGs for FY 2020/21

	Districts	IMM	Facility Clinical Audits	Training Vector Control Officers	EQA	District Malaria Epidemic review and response coordination meetings	Total
1	Abim		9,543,214		-	2,720,000	12,263,214.29
2	Agago		9,543,214		15,659,200	2,720,000	27,922,414.29
3	Amudat		9,714,643		-	2,720,000	12,434,642.86
4	Amuria				-	2,720,000	2,720,000.00
5	Amuru		11,870,000		15,429,028	2,720,000	30,019,028.00
6	Apac				14,868,800	2,720,000	17,588,800.00
7	Arua		9,714,643		-		9,714,642.86
8	Budaka		8,514,643		-		8,514,642.86
9	Bududa	24,246,500	9,028,929		-	2,720,000	35,995,428.57
10	Bugiri	24,075,071	11,124,286		14,412,800	2,720,000	52,332,157.14
11	Bugweri				-	2,720,000	2,720,000.00
12	Buhweju	19,988,900	12,495,714		17,872,572		50,357,186.29
13	Buikwe	24,017,929	10,667,143		-	2,720,000	37,405,071.43

	Districts	IMM	Facility Clinical Audits	Training Vector Control Officers	EQA	District Malaria Epidemic review and response coordination meetings	Total
14	Bukedea				-	2,720,000	2,720,000.00
15	Bukomansimbi	79,955,600	8,686,071		-		88,641,671.43
16	Bukwo	24,303,643	7,122,000		-		31,425,642.86
17	Bulambuli		12,495,714		-		12,495,714.29
18	Bullisa		9,714,643		-		9,714,642.86
19	Bundibugyo		9,543,214		-		9,543,214.29
20	Bushenyi	24,303,643	9,200,357		14,749,716		48,253,716.00
21	Busia				-	2,720,000	2,720,000.00
22	Butabika Hospital		2,638,214		-		2,638,214.29
23	Butaleja	19,988,900	9,496,000		-	2,720,000	32,204,900.00
24	Butambala	23,995,071			-	2,720,000	26,715,071.43
25	Buvuma	24,017,929	-		-	2,720,000	26,737,928.57
26	Buyende	24,017,929	8,514,643		-	2,720,000	35,252,571.43
27	Entebbe		2,666,786		-		2,666,785.71
28	Fort Portal	24,303,643	5,905,000		-		30,208,642.86
29	Gomba	24,017,929	8,171,786		-	2,720,000	34,909,714.29
30	Gulu		3,038,214		14,834,400		17,872,614.29
31	Hoima	24,017,929	8,686,071		-		32,704,000.00
32	Ibanda	24,303,643	11,810,000		16,267,200		52,380,842.86
33	Iganga	24,075,071			-	2,720,000	26,795,071.43
34	Isingiro	24,303,643	11,638,571		15,098,972		51,041,186.29
35	Jinja	24,017,929	10,667,143		13,724,800	2,720,000	51,129,871.43
36	Kaabong				-	2,720,000	2,720,000.00
37	Kabale	24,417,929	12,495,714		15,507,200	2,720,000	55,140,842.86
38	Kabarole		8,857,500		-		8,857,500.00
39	Kagadi	24,017,929	11,581,429		-		35,599,357.14
40	Kalangala	24,017,929	5,562,143		-		29,580,071.43
41	Kaliro	24,017,929	5,676,429		-	2,720,000	32,414,357.14
42	Kalisizo	24,075,071	8,514,643		-		32,589,714.29
43	Kalungu	24,075,071	8,343,214		-		32,418,285.71
44	Kampala	48,921,571	7,743,214		-		56,664,785.71
45	Kamuli	24,075,071	11,124,286		14,437,028	2,720,000	52,356,385.14
46	Kamwenge	24,075,071	12,038,571		14,858,284	2,720,000	53,691,926.86
47	Kanungu	24,303,643			19,665,484	2,720,000	46,689,126.86
48	Kapchorwa	24,303,643			14,615,084		38,918,726.86
49	Kapelebyong				-	2,720,000	2,720,000.00
50	Karenga				-	2,720,000	2,720,000.00
51	Kasanda	24,303,643	11,352,857		-		35,656,500.00
52	Kasese	24,417,929	12,495,714		15,355,200	2,720,000	54,988,842.86
53	Katakwi				-	2,720,000	2,720,000.00
54	Kayunga	24,303,643	8,171,786		-	2,720,000	35,195,428.57

	Districts	IMM	Facility Clinical Audits	Training Vector Control Officers	EQA	District Malaria Epidemic review and response coordination meetings	Total
55	Kazo	24,303,643	9,200,357		-		33,504,000.00
56	Kibale		9,371,786		-	2,720,000	12,091,785.71
57	Kibuku		8,514,643		-	2,720,000	11,234,642.86
58	Kikuube	24,303,643	12,038,571		-	2,720,000	39,062,214.29
59	Kiruhura				14,493,484	2,720,000	17,213,484.00
60	Kiryandongo				-	2,720,000	2,720,000.00
61	Kisoro	9,371,786	12,495,714		15,440,228	2,720,000	40,027,728.00
62	Kitagwenda	24,303,643	9,028,929		-		33,332,571.43
63	Kitgum		9,543,214		15,249,144	2,720,000	27,512,358.29
64	Koboko				-	2,720,000	2,720,000.00
65	Kole		9,028,929		15,264,000	2,720,000	27,012,928.57
66	Kotido		9,714,643		-	2,720,000	12,434,642.86
67	Kumi		9,114,643		-	2,720,000	11,834,642.86
68	Kwania		9,200,357		-	2,720,000	11,920,357.14
69	Kween		7,122,000		-	2,720,000	9,842,000.00
70	Kyankwanzi	24,303,643	8,857,500		-	2,720,000	35,881,142.86
71	Kyegegwa	24,246,500			-	2,720,000	26,966,500.00
72	Kyenjojo	24,303,643			-	2,720,000	27,023,642.86
73	Kyotera	24,303,643	8,686,071		-	2,720,000	35,709,714.29
74	Lamwo		9,714,643		15,249,143	2,720,000	27,683,785.70
75	Lira		9,200,357		14,823,544		24,023,901.14
76	Luuka	24,075,071	8,686,071		-	2,720,000	35,481,142.86
77	Luwero	24,017,929	8,000,357		-		32,018,285.71
78	Lwengo	24,075,071	8,171,786		-		32,246,857.14
79	Madi-Okollo				-	2,720,000	2,720,000.00
80	Manafwa		8,857,500		-	2,720,000	11,577,500.00
81	Maracha				-	2,720,000	2,720,000.00
82	Masaka		8,171,786		-		8,171,785.71
83	Mayuge				13,872,456	2,720,000	16,592,456.00
84	Mbale	24,303,643	5,790,714		14,337,144		44,431,501.14
85	Mbarara	24,303,643	5,790,714		14,899,200		44,993,557.14
86	Mitooma	24,303,643			15,248,800		39,552,442.86
87	Mityana				-	2,720,000	2,720,000.00
88	Moroto		6,476,429		15,362,056	2,720,000	24,558,484.57
89	Moyo				-	2,720,000	2,720,000.00
90	Mubende	24,303,643	11,124,286		-	2,720,000	38,147,928.57
91	Mukono	24,017,929	11,124,286	28,443,374	-		63,585,588.29
92	Mulago Hospital	48,921,571	10,210,000		-		59,131,571.43

	Districts	IMM	Facility Clinical Audits	Training Vector Control Officers	EQA	District Malaria Epidemic review and response coordination meetings	Total
93	Nabilatuk				-	2,720,000	2,720,000.00
94	Nakapiripiriti				-	2,720,000	2,720,000.00
95	Nakaseke				-	2,720,000	2,720,000.00
96	Nakasongola				-	2,720,000	2,720,000.00
97	Namayingo		11,581,429		-	2,720,000	14,301,428.57
98	Namisindwa		9,028,929		-	2,720,000	11,748,928.57
99	Namutumba	24,189,357			-		24,189,357.14
100	Napak				-	2,720,000	2,720,000.00
101	Nebbi				-	2,720,000	2,720,000.00
102	Ngora	24,303,643			-	2,720,000	27,023,642.86
103	Ntoroko				-	2,720,000	2,720,000.00
104	Ntungamo	24,303,643	12,038,571		18,282,400		54,624,614.29
105	Nwoya				15,248,800	2,720,000	17,968,800.00
106	Obongi				-	2,720,000	2,720,000.00
107	Omoro				-	2,720,000	2,720,000.00
108	Otuke				-	2,720,000	2,720,000.00
109	Oyam		6,019,286		15,007,772	2,720,000	23,747,057.71
110	Pader				16,231,200	2,720,000	18,951,200.00
111	Pakwach	24,303,643	9,200,357		-		33,504,000.00
112	Pallisa		8,686,071		-		8,686,071.43
113	Rakai				-	2,720,000	2,720,000.00
114	Rubanda	24,475,071	9,371,786		-	2,720,000	36,566,857.14
115	Rubirizi				20,644,228	2,720,000	23,364,228.00
116	Rukiga	24,475,071	9,371,786		-	2,720,000	36,566,857.14
117	Rukungiri	24,475,071	9,200,357		20,661,600	2,720,000	57,057,028.57
118	Sembabule				-	2,720,000	2,720,000.00
119	Serere				-	2,720,000	2,720,000.00
120	Sheema				14,667,200		14,667,200.00
121	Soroti		9,200,357	22,999,495	-	2,720,000	34,919,852.14
122	Soroti Hospital		6,076,429		-		6,076,428.57
123	Tororo			19,057,481	14,276,344		33,333,825.00
124	Wakiso	47,921,571	10,438,571		10,573,828		68,933,970.86
125	Yumbe				-	2,720,000	2,720,000.00
126	Zombo				-	2,720,000	2,720,000.00
					-		-
	Grand Total	**1,485,486,329**	**719,618,571**	**70,500,350**	**557,188,339**	**225,760,000**	**3,058,553,588.84**

SUB ANNEX 3E: TRANSITIONAL DEVELOPMENT AD HOC ALLOCATION AND BENEFICIARIES

N0	FACILITY NAME	DISTRICT	AMOUNT
1.	Kasana General Hospital	Luwero District	600,000,000
2.	Koboko General Hospital	Koboko District	500,000,000
3.	Mukono General Hospital	Mukono District	500,000,000
4.	Buwenge General Hospital	Jinja District	700,000,000
5.	Kahondo HC IV	Kabale District	500,000,000
6.	Rurambira HC II	Kiruhura District	500,000,000
7.	Jehovah Rapha HC II	Buikwe District	500,000,000
8.	Palama HC III	Katakwi District	500,000,000
9.	Patongo HC III	Agago District	500,000,000
10.	Kawomya HC II	Kayunga District	300,000,000
11.	Kaserem HC III	Kapchorwa District	500,000,000
12.	Mpigi HC IV	Mpigi District	400,000,000
13.	Kitindo HC III	Ntungamo District	300,000,000
	TOTAL		**6,300,000,000**

SUBANNEX 4: Planning and Budget Calendar for LG Institutions

Timing	Activity/event	Responsibility centre	Output
15th Sep	1st Budget Call Circular with GOU priorities and MTEF is issued	MoFPED	MTEF
Late Sep	Local Government Budget Committee agrees the rules, conditions & flexibility of the coming planning & budgetary process	LGBC	Agreement about the overall planning &budgetary framework before start of budget process
Early Oct	Joint review mission	Hon. MoH	Aide Memoire
Mid Oct	Health Sector Planning Committee drafts health sector plan for the year	Health Sector Planning Committee	Draft Health Sector Plan
Mid Oct	MoH carries out regional planning meetings	MoH	Final Health Sector Plans
Late Oct	Holding of Regional Local Governmen Budget Framework paper workshops	Ministry of Finance, Planning, & Economic Development	Recurrent and development grants ceilings communicated to local governments, alongside changes to sector policies and guidelines.
Early Nov	Executive Committee meets to determine inter-sectoral priorities as identified in previous DDP and to fix Intersectoral allocation %	District Executive Committee	Intersectoral priorities identified For potential budget reallocations & flexibility
Early Nov			Draft activity & time schedule for the entire budget process, and indicative budget allocations for LLGs & HoDs, etc.
Mid Nov			Health Sector Plan
Late Nov			Draft inputs to budget framework paper to be presented to sector (social services) committees and development plans to be considered by LLG councils
1st week Dec			Draft budget framework paper and development plan ready to be presented to Executive Committee
Beginning 2nd Week of Dec			Draft budget framework paper and development plan ready for Budget Conference
End 2nd week of Dec			Budget input (i.e. priorities, re-allocations & preliminary budget estimates) ready for incorporation in draft budget by the Budget Desk
Mid Dec			Final budget framework paper and draft budget ready to be presented to Finance- or Executive Committee Draft budget ready for submission to MoFPED
20th Dec			National BFP
10th Jan			OBT with Revised MTEF
Mid Jan			Final draft budget and work plan ready to be presented to sector

Timing	Activity/event	Responsibility centre	Output
			committees
Late Jan		Sector Committees	Final Input from sector committees to annual work plan & budget
Early Feb		Finance or Exec. Committee	Final Draft budget including annual work planready to be read by council
Mid Feb		**Budget Estimates**	Budget desk
1st March		**Budget Estimates**	MoFPED
Before 1st April	Reading and approval of the budget	Full council	Approved budget to be signed by chairperson and submitted to MoFPED/MoLG/LGFC & Auditor General
1st April	Reading of the national budget speech	MoFFED	National Budget Speech
31st May	Budget estimates approved	Parliament	Approved Budget Estimates
1st July	Budget execution	All votes	Outputs

SUBANNEX 5. The Main Grievances Avenues for Local Governments

The following notice should be posted on the LG Notice board, with details specific to the Local Government to be completed by the Local Government DHO. A similar version is prepared for facilities and included in the facilities guidelines.

Avenue	Type of Grievance	Contact details
Local Government level		
Councilor	• Violence against and abuse of children and adults by staff, contracted labor • Selection of health infrastructure not in line with guidelines • Quality of health care and absenteeism	
Health Officer	• Quality of works delivered by contractors • Condition of school infrastructure and facilities • Quality of teaching • Functioning of the School Management Committee • Corruption and misuse of funds	
District land board	• Complaints about land associated with health facilities and health infrastructure	
National level		
Police	• Corruption and misuse of funds • Other criminal activity	Telephone: 112/999 CP ANTI-CORRUPTION 0717 121 110 CP ANTI HUMAN TRAFFIC MINISTRY OF INTERNAL AFFAIRS 0715 411 677 CP SEXUAL & GBV 0713 534 713 CP SEXUAL OFFENCES 0718 642 477 Email: info@upf.go.ug Address: https://www.upf.go.ug/key-uganda-police-phone-contacts/
Uganda Patients Protection	• Emotional, physical or sex abuse • Human trafficking • Child neglect esp. by parents or guardian	
Uganda Child Helpline	• Emotional, physical or sex abuse • Child trafficking • Child neglect esp. by parents or guardian	Web: http://uchl.mglsd.go.ug/ Phone: 116
NITA Helpline	• Data protection issues	TBC. Legislation just assented.
Uganda Budget Hotline	• Quality of works delivered by contractors • Missing and misuse of funds	Call for free: 0800 229 229 Feedback: www.budget.go.ug Email: budget@finance.go.ug
IGG Hotline	• Corruption and misuse of funds	Report: https://www.igg.go.ug/complaints/ Call: +256 414 347387 Email: kampala@igg.go.ug (other regions addresses at https://www.igg.go.ug/contact/)

SUBANNEX 6: Outputs and Indicators

Programme: 0881 Primary Health Centre and Sanitation Services
Output: 088101 Public Health Promotion
Output: 088104 Medical Supplies for Health Facilities
- Indicator: Number of health facilities reporting no stock out of the 6 tracer drugs.
- Indicator: Value of essential medicines and health supplies delivered to health facilities by NMS
- Indicator: Value of health supplies and medicines delivered to health facilities by NMS

Output: 088106 Promotion of Sanitation and Hygiene
Output: 088153 NGO Basic Healthcare Services (LLS)
- Indicator: Number of children immunized with pentavalent vaccine in the NGO Basic health facilities
- Indicator: No. and proportion of deliveries conducted in the NGO Basic health facilities
- Indicator: Number of outpatients that visited the NGO Basic health facilities
- Indicator: Number of inpatients that visited the NGO Basic health facilities

Output: 088154 Basic Healthcare Services (HCIV-HCII-LLS)
- Indicator: Number of trained health workers in health Centres
- Indicator: No. of trained health related training sessions held.
- Indicator: Number of outpatients that visited the Govt. health facilities.
- Indicator: Number of inpatients that visited the Govt. health facilities.
- Indicator: No. and proportion of deliveries conducted in the Govt. health facilities
- Indicator: % of approved posts filled with qualified health workers
- Indicator: %of Villages with functional (existing, trained, and reporting quarterly) VHTs.
- Indicator: No. of children immunized with pentavalent vaccine

Output: 088155 Standard Pit Latrine Construction (LLS.)
- Indicator: No. of new standard pit latrines constructed in a village
- Indicator: No. of villages which have been declared Open Defecation Free (ODF)

Output: 088156 Hand Washing facility installation (LLS.)
- Indicator: No of standard hand washing facilities (tippy tap) installed next to the pit latrines

Output: 088159 Multi sectoral Transfers to Lower Local Governments
Output: 088175 Other Service Delivery Capital Investments
Output: 088180 Health centre construction and rehabilitation
- Indicator: No of health centres constructed
- Indicator: No of health centres rehabilitated

Output: 088181 Staff houses construction and rehabilitation
- Indicator: No of staff houses constructed
- Indicator: No of staff houses rehabilitated

Output: 088182 Maternity ward construction and rehabilitation
- Indicator: No of maternity wards constructed
- Indicator: No of maternity wards rehabilitated

Output: 088183 OPD and other ward construction and rehabilitation
- Indicator: No of OPD and other wards constructed
- Indicator: No of OPD and other wards rehabilitated

Output: 088184 Theatre construction and rehabilitation
- Indicator: No of theatres constructed
- Indicator: No of theatres rehabilitated

Output: 088185 Specialist health equipment and machinery
- Indicator: Value of medical equipment procured

Programme: 0882 District Hospital Services
Output: 088251 District Hospital Services (LLS.)
Output: 088275 Other Service Delivery Capital Investment
Output: 088280 Hospital construction and rehabilitation
Output: 088281 Staff houses construction and rehabilitation
Output: 088282 Maternity ward construction and rehabilitation
Output: 088283 OPD and other ward construction and rehabilitation
Output: 088284 Theatre construction and rehabilitation

Output: 088285 Specialist health equipment and machinery

Programme: 0883 Health Management and Supervision
Output: 088301 Healthcare Management Services
Output: 088302 Healthcare Services Monitoring and Inspection
Output: 088303 Sector Capacity Development
Output: 088372 Administrative Capital Investment

SUBANNEX 7: Infrastructure Requirements Per Facility Level

LEVEL OF HEALTH CARE	BASIC BUILDING REQUIREMENTS
Hospital	Medical building - Out patient department - Administration offices - Operating theatre (2 rooms) - Female ward(at least 15 beds) - Paediatric ward(at least 15 beds) - Maternity ward (at least 15 beds) - Male ward (at least 15 beds) - Mortuary - Placenta pit and medical waste pit Staff houses - 80 NO. housing units
Health Centre IV	Medical buildings - Out patient department - Drug store with HSD office - Operation theatre - General ward - Maternity ward - Mortuary - Placenta pit and medical waste pit Staff houses - 18 NO. housing units
Health Centre III	Medical Buildings - Out patient department - Maternity ward - General ward - Placenta pit and medical waste pit Staff houses - 10 NO. Housing units
Health Centre II	Medical buildings - Out patient department - Emergency delivery - Placenta pit - Medical waste pit Staff houses - 4 NO. housing units

The following infrastructure is therefore required for upgrading HC IIs to HC IIIs:

- Out-patient department
- Maternity ward
- General ward
- Placenta pit and medical waste pit
- Toilets/VIP latrines & bathrooms
- 10 housing units (can start with 4)
- Power supply-connection to electricity grid or solar power installation
- Water source
- Fencing