MINISTRY OF HEALTH

HEALTH SECTOR PLAN FOR TRANSITIONING OF PARTNER FACILITIES TO GOVERNMENT PLANNING AND MANAGEMENT (HSTP)





February, 2025

TABLE OF CONTENTS

Table of Contents i
List of Tables iii
Table of Figures iii
Acronyms and Abbreviations iv
Executive Summary vi
1 Introduction And Background 1
1.1 Introduction 1
1.2 Background 1
1.3 Purpose of the Plan 2
1.4 Plan Development Process 2
2 Situational Analysis 3
2.1 Understanding of Transition in the Health Sector 3
2.2 Status of Transitioning of health Facilities 4
2.3 Current Interventions 6
2.4 Status of Health Service Delivery 7
2.4.1 Key Service Delivery Gaps and Challenges Affecting Transitioning 8
2.4.2 Lessons Learned 13
3 Transition Plan Strategic Direction and Roadmap 15
3.1 Alignment of the Plan with National and International Planning Frameworks 15
3.2 Vision, Mission, Goal and Objectives 15
3.3 Guiding Principles 16
3.4 Theory of Change for the Health Sector Transition Plan 18
3.5 Strategic interventions and Actions 19
3.5.1 Key Strategic Interventions 19
4 Implementation Framework of the Plan 23
4.1 Governance and Management 23
4.1.1 Health Sector Integrated Refugee Response Steering Committee 24
4.1.2 District Transition Committee (DTC) 24
4.1.3 Refugee Welfare Councils' Committee 25
4.2 Capacity Building and Capability Development 26
4.3 Partnership, Collaboration and Coordination 27
4.3.1 Role and Responsibilities of different Stakeholders 27
4.4 Information Management 32
4.5 Financing Harmonization 32
4.6 Risk Management 33

4.7 Phases of Transition and Timelines 34
5 Financing and Cost Estimates 36
5.1 Resource Mobilisation and Financing 36
5.2 Costing of the Plan 36
5.3 Cost Estimates 37
5.3.1 Summary Financing Plan 2025 -2035 Based on Old Staffing Norms 37
5.3.2 Detailed Budget 2025-2035 Based on the New Staffing Norms 38
5.3.3 Health Sector Budget for Transitioning of Partner Facilities to Government Planning and Management 40
6 Monitoring, Evaluation and Learning (MEL) 50
7 References 55
Annex 56
Annex I: Staffing Gap Analysis Matrix 56
Annex II: Infrastructure Gap Analysis Matrix 60
Annex III: Equipment Gap Analysis Matrix 67

LIST OF TABLES

Table 1: Health facility coding status - as at April 1, 2024 4
Table 2: Government Vs. Development Partner Support to the Health Workforce in the Settlements 5
Table 3: Composition of the District Transition Committee 24
Table 4: Role and Responsibilities of different Stakeholders 27
Table 5: Health Sector Risk Assessment and Mitigation 33
Table 6: Public HR Gaps in RHDs 56
Table 7: Public Health Infrastructure Gaps in RHDs 60

TABLE OF FIGURES

Figure 1: Transition Phases and Process for Health Sector Transition Plan x
Figure 2: Human Resource Gaps in the Health Facilities in the Settlements 5
Figure 3: Step by step transition process in the health sector (Source: MoLG, MOH and OPM (2020). Integration Guidelines for Refugee Health Services) 6
Figure 4: Budget performance for the health sector in RHDs during FY 2022/23 (Source: MoFPED) 12
Figure 5: Theory of Change for the Health Sector Transition Plan 18
Figure 6: Transition Phases and Process for Health Sector Transition Plan 35

ACRONYMS AND ABBREVIATIONS

CBO	Community Based Organisations
CRRF	Comprehensive Refugee Response Framework
CSR	Corporate Social Responsibilities
DHIS	District Health Information System
DHMT	District Health Management Team
DHO	District Health Officer
DLG	District Local Governments
DROC	District Refugee Oversight Committee
DTC	District Transition Committee
EMHS	Essential Medicines and Health Supplies
FBOs	Faith Based Organisations
GBV	Gender Based Violence
GoU	Government of Uganda
HC	Health Centre
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HSTP	Health Sector Transition Plan
INGOs	International Non-Governmental Organizations
IP	Implementing Partners
KII	Key Informant Interviews
LG	Local Government
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MEL	Monitoring, Evaluation and Learning
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoWT	Ministry of Works and Transport
MWE	Ministry of Water and Environment
NDP	National Development Plan
NGOs	Non-Governmental Organisation
NMS	National Medical Stores
NPA	National Planning Authority
NTS	National Transition Strategy
OPM	Office of the Prime Minister
PHC	Primary Health Care
PPP	Public Private Partnerships
REF	Refugee Engagement Forum
RELONS	Refugee Lead Organizations
RHDs	Refugee Hosting Districts
RLO	Refugee-Led Organizations
RRP	Refugee Response Plan
RWC	Refugee Welfare Councils
SPARS	The Supervision, Performance Assessment, and Recognition Strategy
UBOS	Ugandan Bureau of Statistics

UCRRP	Uganda Country Refugee Response Plan
UgIFT	Uganda Intergovernmental Fiscal Transfers Program for Results
UN	United Nations
UNHCR	United Nations High Commission for Refugees

EXECUTIVE SUMMARY

The large-scale and protracted refugee situation, combined with a natural population growth of 3% annually, places a significant burden on the healthcare system, leading to challenges such as underfunding, limited infrastructure, and an overburdened workforce. The inadequate infrastructure, shortages of medical staff and essential medicines affect the overall quality of health care for refuges and host communities. Due to the additional refugee population, putting a high strain on already limited resources, refugee-host districts (RHDs) are among the poor performing districts in the country. According to the MoH Annual Health Sector Performance Report 2023/24, District League Table performance for all the 145 districts, against several selected health indicators for the five years of the National Health Strategy, majority of RHDs were performing poorly.

In order to enhance refugee health services, the Ugandan government, in collaboration with the United Nations High Commission for Refugees (UNHCR) and various international and local partners, has been working to integrate refugee health services into the mainstream national health system and foster a more sustainable and equitable healthcare framework that benefits both refugees and host communities. It is against this background, that this Plan has been prepared through a very highly consultative process to ensure that refugees and host communities receive high-quality healthcare during and post transition period.

The Health Sector Transition Plan is a key component of the National Transition Strategy (NTS) for Transitioning of partner facilities in refugee settlements in Uganda to Government planning and management. The purpose of the Plan is to provide the strategic direction for transitioning of partner facilities to government planning and management, ensuring quality, equitable, and sustainable healthcare services for all refugee and host communities, aligned with national health goals and standards. It provides a roadmap for a coordinated and phased transition of partner financed refugee health services and systems to government planning and management on jointly agreed standards, detailing key strategic interventions, key milestones and resource needs to support this process.

The plan identifies clear strategic objectives guiding the integration of refugee health services into the national system, ensuring equity, quality, and sustainability. It also outlines key interventions and specific actions to address current gaps, such as inadequate infrastructure and health workforce, essential medicines and medical supplies, leadership and governance and resource allocation, while aligning with national health systems and standards. Ultimately, the plan aims to gradually integrate refugee health services into Uganda's national health system, ensuring government ownership, sustainability, and equitable access to quality healthcare for both refugees and host communities.

The Health Sector Transition Plan encompasses:

- **Situational Analysis,** highlights the status of transition in the health sector within Uganda's refugee response. The analysis identifies key challenges, and lessons learned during the transition process as well as recommendations. These findings and recommendations have informed the Transition Plan direction, establishing a foundation for the health sector roadmap.
- **Transition Plan Strategic Direction**, outlines, strategic focus areas, vision, mission and goal, strategic objectives and interventions as well as guiding principles for Transition Plan
- **Implementation Framework of the Plan,** outlines essential components that will drive effective execution, ensuring alignment with the plan's objectives and the overall transition strategy. The

framework prioritizes governance and management to ensure effective decision-making and accountability

- **Financing and Cost Estimates,** entails a resource mobilization and financing strategy establishing reliable, long-term funding streams to ensure that services for both refugee and host communities are consistently funded, accessible, and can adapt to changing healthcare demands over time.
- **Monitoring, Evaluation and Learning (MEL),** outlines a robust monitoring and evaluation framework has been established to facilitate tracking of progress to guide informed decision making and planning to ensure a resilient, coordinated responsive transition process providing quality, equitable sustainable services for both refugee and host communities during the transition process

Status of Transitioning of Health Facilities and Service Delivery

Overall, the process of transitioning health facilities from partner managed to government management and planning has been rather slow. While 95% (82 facilities) have been officially coded, reported as transitioned, and are receiving government support, many of these facilities face significant gaps in infrastructure, health workforce, and essential medicines and supplies, which are limiting their ability to deliver quality services. The health sector is heavily donor dependent with 80% (Table 2) of the health workforce in refugee settlements supported by partners. The heavy reliance on donor support for the refugee healthcare workforce hinders long-term sustainability and integration into national health systems. It also creates uncertainty in continuity of care, undermines eligibility for transition and system stability. To provide clarity in the transition process, the Plan provides a clear definition and criteria for determining the status of transition (**eligible, partial, and full transition**) as outlined under the different phases of transition. The eligibility for transition of the health facilities will be determined based on MOH service standards and service delivery standards for the health sector.

Despite the slow pace, some progress has been made with a number of interventions initiated to support the transition process in the refugee health sector. The Uganda Intergovernmental Fiscal Transfer Programme (UgIFT) financed the transition of health facilities from humanitarian partners financing to the Local Government (LG) system, including both salary and operational costs via sector conditional grants. Integration has enabled access to regular drug supplies from the National Medical Stores (NMS), leading to more effective service delivery and increased uptake of healthcare services. Furthermore, MoH has enhanced healthcare services in refugee-hosting districts by deploying additional and senior to offer emergency and specialized services, such as adolescent health programs, enhancing the accessibility and quality of care for women and the youth. MoH deployed 30 midwives to health facilities in refugee-hosting districts, contributing to improved maternal and child health outcomes (UNFP, 2023). Equally facilities have been equipped to handle a larger patient load and more complex cases that would have otherwise required referral to HC IVs or district hospitals. Infrastructure has been improved with the introduction of Blood banks, e.g. the Hoima District Blood Bank that will ensure a steady supply of blood for medical emergencies in Kyangwali refugee settlement, Kikuube district. In order to facilitate the transition process, the MoH has put in place guidelines for refugee health services. These guidelines aim to integrate refugee health services into Uganda's national health system.

Transition Plan Strategic Direction and Roadmap

The health sector transition plan strategic direction and roadmap outlines, the vision, mission, goal and strategic objectives to facilitate progressive and systematic transfer of the health facilities,

responsibilities, resources, and oversight to government management. Central to the plan are strategic interventions and key activities focused on improving and expanding the infrastructure and equipment, enhancing human resource capacity in the refugee hosting districts, strengthening health management information system, enhancing financing for sustainable refugee healthcare service delivery, as well as strengthening leadership, management and coordination for effective health service delivery.

The health sector transition plan proposes strong institutional arrangements, essential for effective implementation of the plan fostering, coordinated decision-making and planning as well as ensuring accountability across all stakeholders. Financial sustainability is another critical component of the plan, outlining key strategic interventions and activities to enhance financing for sustainable refugee healthcare service delivery. Finally, the plan establishes implementation phases with specific timelines and milestones to guide structured, progressive transition process and facilitate effective monitoring and learning.

Vision

A resilient refugee healthcare system that aligns with national health goals, fully managed by government, ensuring quality, equitable and sustainable healthcare care for all refugee and host communities.

Mission

To deliver quality, equitable and sustainable healthcare services for refugees and host communities.

Goal

To transition partner managed health facilities to government management by 2035, ensuring quality, equitable and sustainable healthcare services to all refugee and host communities, aligned with national health goals and standards.

Objectives

The Plan outlines five (5) key objectives aiming to achieve the desired goal of transitioning partner health facilities to government managed facilities that provide quality, equitable and sustainable healthcare to refugees and host communities, aligned with national health goals and standards. The objectives include:

1. Integrate refugee healthcare into national systems, ensuring a harmonized, sustainable financing approach.
2. Improve health infrastructure to increase access to quality and equitable healthcare services for refugees and host communities.
3. Strengthen human resource capacity for improved healthcare delivery, and better health outcomes for refugees and host communities.
4. Enhance access to essential medicines and medical supplies for improved patient care and health outcomes for refugees and host communities.
5. Strengthen governance and management systems to enhance coordination, accountability, and resource utilization for efficient and effective healthcare delivery

Implementation Framework of the Plan

The implementation framework outlines essential components that will drive effective execution, ensuring alignment with the plan's objectives and the overall transition strategy. Governance, leadership and Management underpins the framework. This will involve orienting leaders on their roles to lead decision-making and accountability. The Plan prioritizes capacity building to enhance the health sector readiness, by investing in recruitment, training and skills development, ensuring that the health workforce has the knowledge and tools needed to sustain quality of service delivery. Partnership and collaboration are central in fostering strong relationships and strategic partnerships among stakeholders, promoting coordinated efforts, shared ownership, and efficient resource utilization.

To support evidence-based decision-making, a robust a robust (M&E) system, using Key Performance Indicators and various feedback platforms will be established for data collection, analysis, and dissemination, ensuring timely and accurate insights to help refine strategies and sustain momentum for transition in the health sector. The framework also prioritizes a harmonized financing mechanism, creating a sustainable funding model, ensuring transparent resource allocation and clear accountability for resource usage. Finally, the plan envisages addressing uncertainties, through a risk management approach that identifies potential challenges and establishes mitigation plans, ensuring adaptability and resilience through the transition process.

At the national level, the MoH will provide overall leadership working closely with local governments, development partners, NGOs and to ensure effective coordination of refugee healthcare services during the transition period. Governance and management will be delivered through the District Transition Committee (DTC) operating as integrated coordination entity at subnational level, where stakeholders regularly meet to assess progress, provide expert input, share updates, and address challenges and refine strategies to ensure that transition in the health sector is on course. The DTC will operate within already existing structures to ensure complementarity and avoid duplication of efforts and will report progress to the District Refugee Forum. The leadership structures will include:

Phases of Transition and Timelines

The Plan envisions a phased implementation approach that outlines three different phases of the transition with clear timelines and key milestones for each phase as outline in Figure 5. These phases and take into account activities planned in MoH, Transition Guidelines for Refugee Health Services, 2023. Adopting a phased approach during transition is key to allow the government to build the necessary infrastructure, gradually absorb the partner supported staff, recruit additional staff and build the necessary capacity to ensure continuity of quality health care services through a multisectoral approach. Phased transition would also allow time for resource mobilization, making the necessary budget allocations, and alignment, ensuring the continuity, quality, and equity of healthcare services throughout the transition and after. Cognizant of the extensive investment required for infrastructure development, along with the huge wage and non-wage operational costs, the plan is planned over a 10-year period, aligned with Uganda Vision 2040, the National Development planning cycles and the Health Sector Development Plan. The will be implemented over the next two National Development Plan cycles (NDP IV and NDP V)

Phase I: Short-term (1-4yrs)	Phase 2: Mid-term (5-8yrs)	Phase 3: Long-term (9-10yrs)
1. Establish governance structures to oversee the transition process 2. Undertake comprehensive baseline assessment of health infrastructure, workforce, funding, and service delivery gaps 3. Prepare Inventory of health facilities eligible for transitioning to government ownership based on MOH service standards and service delivery standards for the health sector 4. Integrate refugee health services into national health systems 5. Include all coded health facilities in the District Development Plan 6. Accreditation and Upgrading 7. Land acquisition and titling 8. Construction and Equipping 9. Strengthen procurement and logistics management 10. Health System Strengthening 11. Capacity building of LGs to take over	1. Scale up Construction, Renovation and Equipping 2. Closure of temporary facilities 3. Monitoring and Evaluation and publish outcomes to guide policy 4. Partial transition of facilities and take-over of management 5. Building capacities of referral sites (district and regional)	1. Construction and Equipping 2. Full integration refugee health services into national health systems 3. Full transition of facilities and take-over of management responsibility and handover of inventory 4. Publicise Uganda model for refugee healthcare transition and seek Global Collaboration 5. Develop a strong Monitoring, Supervision and Coordination (MSC) framework to improves health system performance

Cross-Phase Actions (ongoing)

Resource Mobilization; Recruitment of Staff; Training of Staff; Strengthen Stakeholder Engagement, Construction, Renovation and Equipping

Community Engagement and Sensitization

On going Monitoring and Evaluation: Performance Monitoring and Reporting

Figure 1: Transition Phases and Process for Health Sector Transition Plan

***Eligible for transition –** A facility is considered eligible for transition when it fulfils MOH service standards and service delivery standards for the health sector

***Partial transition –** Partial transition involves shared management between the government and partners, while infrastructure development, human resource capacity building, and the integration of facilities and systems into the government health system are still in progress.

***Full transition –** Full transition occurs when the government assumes full management responsibility, with partner support, and all facilities and systems are fully integrated into the national health system.

1 INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

This transition plan for the health sector is part of the *National Transition Strategy (NTS) for Transitioning Partner Facilities in Refugee Settlements in Uganda to Government Planning and Management.* It provides a roadmap for a coordinated and phased transition of partner financed refugee health services and systems to government planning and management on jointly agreed standards, detailing key strategic interventions, key milestones and resource needs to support this process. The plan focuses on addressing key challenges related to infrastructure, human resources and medical supplies, financing, health information systems, and leadership and governance. Ultimately, the plan aims to gradually integrate refugee health services into Uganda's national health system, ensuring government ownership, sustainability, and equitable access to quality healthcare for both refugees and host communities.

This plan is designed to be user friendly and for use by Ministry of Health (MoH) management, local governments, partners, and all stakeholders involved in refugee healthcare service delivery, to guide them in their planning processes and operations during the transition process. The plan identifies clear strategic objectives guiding the integration of refugee health services into the national system, ensuring equity, quality, and sustainability. It also outlines strategic interventions and specific actions to address current gaps, such as inadequate infrastructure and workforce, medical supplies, and resource allocation, while aligning with national health policies and standards.

The plan aims to establish and maintain strategic partnerships and collaboration with key stakeholders, including government agencies, humanitarian actors, donors, and Non-Governmental Organisations (NGOs) to ensure ongoing support and effective coordination. A robust monitoring and evaluation framework has been established to facilitate tracking of progress to guide informed decision making and planning to ensure a resilient, coordinated responsive transition process providing quality, equitable sustainable services for both refugee and host communities during the transition process.

1.2 BACKGROUND

For a long time, the provision of health services to refugees by the partners was planned, resourced and provided separately from that of the host communities, leading to parallel service provision in the Refugee Hosting Districts (RHDs) relative to the mainstream government health programming. However, over time, there has been significant of involvement of the government, the Ministry of Health and the District Local Governments (DLGs) in the planning and management of refugee health services and system. The influx of refugees places a significant burden on the healthcare system, leading to challenges such as underfunding, limited infrastructure, and an overburdened workforce. The inadequate infrastructure, shortages of medical staff and essential medicines affect the overall quality of health care. In order to enhance refugee health services, the Ugandan government, in collaboration with the United Nations High Commission for Refugees (UNHCR) and various international and local partners, has been working to integrate refugee health services into the mainstream national health system. This is being achieved through coding of health facilities

so that they can be included and budgeted for within the Government systems. To date 95% (82 facilities) have been officially coded and are receiving government support. This transition is crucial as a means of fostering a more sustainable and equitable healthcare framework that benefits both refugees and host communities. It is against this background, that this plan has been prepared to ensure that refugees and host communities receive high-quality healthcare during and post transition period.

1.3 PURPOSE OF THE PLAN

To provide the strategic direction for transitioning of partner facilities to government planning and management, ensuring quality, equitable, and sustainable healthcare services for all refugee and host communities, aligned with national health goals and standards.

1.4 PLAN DEVELOPMENT PROCESS

The plan was developed through a highly consultative process involving various stakeholders at national, district, settlement and community levels. A situational analysis was conducted to assess the current state of transition, identify critical gaps, resource requirements, and set key milestones. Based on the situational analysis findings, the transition plan was crafted through a consultative process to determine the vision, mission, objectives, and strategic interventions, setting the strategic direction and clear roadmap for sustainable transitioning of partner facilities to government planning and management. To ensure a smooth, systematic and gradual implementation, the plan includes flexible and complementary phases with key milestones for each phase, allowing flexibility for adaptation and smooth handover as the transition progresses. An integrated Monitoring and Evaluation (M&E) framework was developed to enable MoH and stakeholders to track progress, address emerging issues, and make necessary adjustments as needed to ensure a smooth and successful transition.

2 SITUATIONAL ANALYSIS

The purpose of the situational analysis was to establish the current status of transition of refugee health services, identifying gaps, resource needs and key milestones in the process, to inform the development of a comprehensive Health Sector Transition Plan (HSTP) with a clear roadmap for sustainable transitioning of partner health facilities to government planning and management based on jointly agreed standards. Specifically, the situational analysis assessed the current understanding of transition and status of health service delivery to identify gaps in the health infrastructure, health workforce, essential medicine and supplies as well as financing for refugee healthcare in the refugee hosting districts.

2.1 UNDERSTANDING OF TRANSITION IN THE HEALTH SECTOR

There has been substantial progress with regard to the coding of health facilities, which refers to the process of allocating a unique identification code for health facilities, so that they can be included in Government systems and budgeted for. It also means that these facilities report to Government systems, including through Government Information Systems. The coding system ensures that each facility is distinctively identified, which facilitates effective communication, resource allocation (e.g. primary health care (PHC) funds), and monitoring of services. However, even though facilities have been coded, costs for wages of health workers and running costs are still largely covered by partners.

District stakeholders emphasize the need for phasing and careful handling of the transition process, stressing the need to avoid rushing which might lead to disruption of services. Furthermore, they emphasize the need to improve, expand and equip the existing health infrastructure, as well as recruitment of adequate medical staff to replace partner-supported staff as necessary steps in transitioning, and ensuring continued access to quality healthcare for both refugees and host communities. In the absence of substantial investment in health infrastructure, human resources as well as sustainable financing and good governance, the government may struggle to maintain the necessary level of care during and after the transition. District stakeholders emphasize the need for increased reliable healthcare financing from both government and donors to sustain health services for refugees and host communities and ensure the transition's success.

At local government level, transition is not yet well understood by all stakeholders. There are concerns about the transition process being top-own and there are fears by some district stakeholders who perceive transition as an uncoordinated exit strategy by partners, leaving the burden of health service provision to government alone. It is therefore crucial that the transition process must ensure transparent, gradual and full transition of leadership and management of facilities and services from partner to government management at all levels to avoid duplication of roles and gaps in oversight, which could result in reduced service quality at health facilities.

To bridge the current information gaps regarding transition, the plan should prioritise inclusive stakeholder engagement, with the view to enhance awareness and participation in the transition process by all stakeholders at national, district, and community levels including both refugees and host communities. The plan should adopt tailored communication strategies to ensure that district and community-level stakeholders clearly understand the objectives, phased approach and recognize the long-term benefits of transition. District officials, local leaders, and community

representatives must be involved early in planning, aligning local government priorities, timelines, and the need for local adaptation to avoid disruptions in service delivery. There is also need for continued dialogue and feedback, ensuring that each stakeholder's concerns, particularly around staffing, financing, and infrastructure, are addressed transparently and collaboratively.

To foster trust, the plan should communicate clear roles and responsibilities for local governments and community leaders, ensuring they play active roles in supporting and managing health facilities during transition. This approach will bridge perception gaps and promote a unified, long-term vision for government led healthcare for refugees, both during and after the transition.

2.2 STATUS OF TRANSITIONING OF HEALTH FACILITIES

Overall, the process of transitioning health facilities from partner managed to government management and planning has been rather slow. Whereas 95% (82 facilities) have been officially coded and reported to be fully transitioned, and already receiving government support, most of these are experiencing significant gaps in infrastructure, health workforce, and essential medicines and supplies, hindering the delivery of quality services.

Table 1: Health facility coding status - as at April 1, 2024

Region	Settlement	Permanent	Temporary (Not in district plan)	To be coded	Total HFs	Coded	% Coded
West Nile	Adjumani	17	0		17	17	100%
	Bidibidi	10	0	3	16	13	81%
	Imvepi	4	4	1	4	3	75%
	Lobule	4			4	4	100%
	Palorinya	9	0		9	9	100%
	Rhino	5	0	1	5	5	100%
Mid-West	Kiryandongo	3	0		3	3	100%
	Kyangwali	8	2	2	10	8	80%
Southwest	Kyaka II	3	2	1	5	4	80%
	Rwamwanja	6	0		6	6	100%
	Nakivale	6	0		6	6	100%
	Oruchinga	2	0		2	2	100%
North	Palabek	3	0		3	3	100%
	Grand Total	**80**	**8**	**8**	**86**	**82**	**95%**

Source: UNHCR Assessment 2023

Whereas coding of facilities has been done, and facilities are receiving support from Government, the health sector is still heavily donor-dependent. Eighty percent (80%) of the health workforce in refugee settlements is supported by partners as demonstrated in Table 2. Heavy reliance on donor funding for the refugee healthcare workforce hinders long-term sustainability and integration into national health systems. It also creates uncertainty in service delivery, undermines system stability, and disrupts continuity of care.

Although terms like **'partial'** and **'ready for transition'** were being used to describe the status of transition based on the coding exercise, the analysis revealed that these facilities were far from

meeting national standards and eligibility criteria for transition. Clear definitions and criteria for determining the status of transition (**eligible, partial, and full transition**) have been outlined under the different phases of transition. The eligibility for transition of the health facilities will be determined based on MOH service standards and service delivery standards for the health sector.

Table 2: Government Vs. Development Partner Support to the Health Workforce in the Settlements

Settlement	Total – Development Partners Support	Total Government Support	Grand Total	Development Partners Support
Adjumani	345	98	443	77.9%
Bidibidi	370	79	449	82.4%
Imvepi	106	36	142	74.6%
Kiryandongo	56	62	118	47.5%
Kyaka	182	8	190	95.8%
Kyangwali	260	22	282	92.2%
Nakivale	240	44	284	84.5%
Oruchinga	46	16	62	74.2%
Palabek	89	8	97	91.8%
Palorinya	178	95	273	65.2%
Rhino	184	69	253	72.7%
Rwamwanja	166	10	176	94.3%
Total	**2,222**	**547**	**2,769**	**80.3%**

Furthermore, the sector is experiencing huge staffing gaps as demonstrated in Figure 1. These have serious consequences on healthcare delivery, including reduced access to essential medical services, longer waiting times, and increased workload for the existing few health workers, resulting in compromised care quality. Critical services such as maternal and child health and other medical emergencies are particularly affected, increasing the risk of poor health outcomes. These gaps undermine efforts of transition from humanitarian to government management. Addressing staff shortages is crucial to ensuring sustainable, equitable, and quality healthcare for both refugee and host communities.

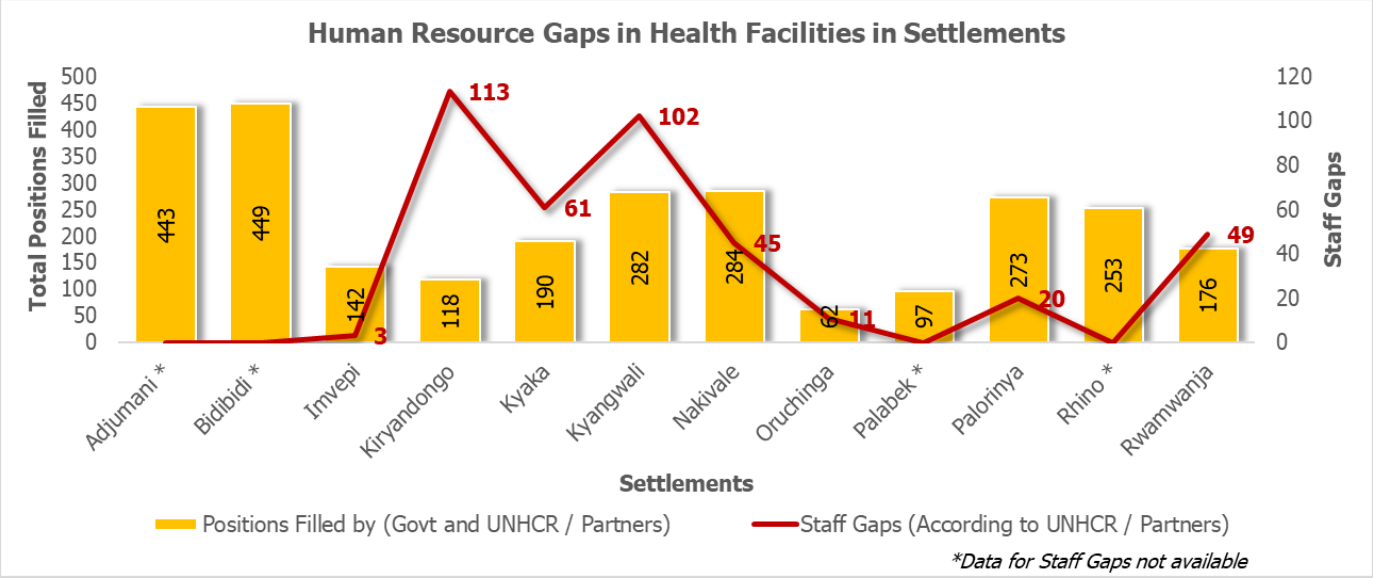


Figure 2: Human Resource Gaps in the Health Facilities in the Settlements

Whereas staffing gaps were established from secondary data, it was not possible to determine the detailed infrastructural, human, and financial resource needs as well as eligibility and stages of transition. This was due to the absence of reliable data, as further highlighted in Section 2.4.1.

2.3 CURRENT INTERVENTIONS

A number of interventions have been initiated to support the transition process in the refugee health sector. The Uganda Intergovernmental Fiscal Transfer Programme (UgIFT) financed the transition of health facilities from humanitarian partners financing to the Local Government (LG) system, including both salary and operational costs via sector conditional grants. The transition involved identifying and coding the facilities, identifying staff for recruitment onto the government payroll, supporting non-wage recurrent grants and absorbing staff previously supported by humanitarian actors at identified facilities.

In order to facilitate the transition process, the MoH has put in place guidelines for refugee health services. The guidelines facilitate coordination of health services provision in the refugee settlements. They also guidelines aim to integrate refugee health services into Uganda's national health system, adopting a three- phase approach; 1) Phase 1: Emergency Phase; 2) Phase 2: Stabilization; and 3) Phase 3: Conventional as illustrated in the Figure 3. The guidelines also provide specific criteria for transitioning health facilities and services, ensuring that only facilities meeting national standards are integrated into government management. The roles and responsibilities section outlines roles if different stakeholders, including MoH, DLGs, UNHCR and health development partners. The health services integration and transition for refugees focuses on ensuring refugees' health care is part of the Ministry of Health programmes and management structures.

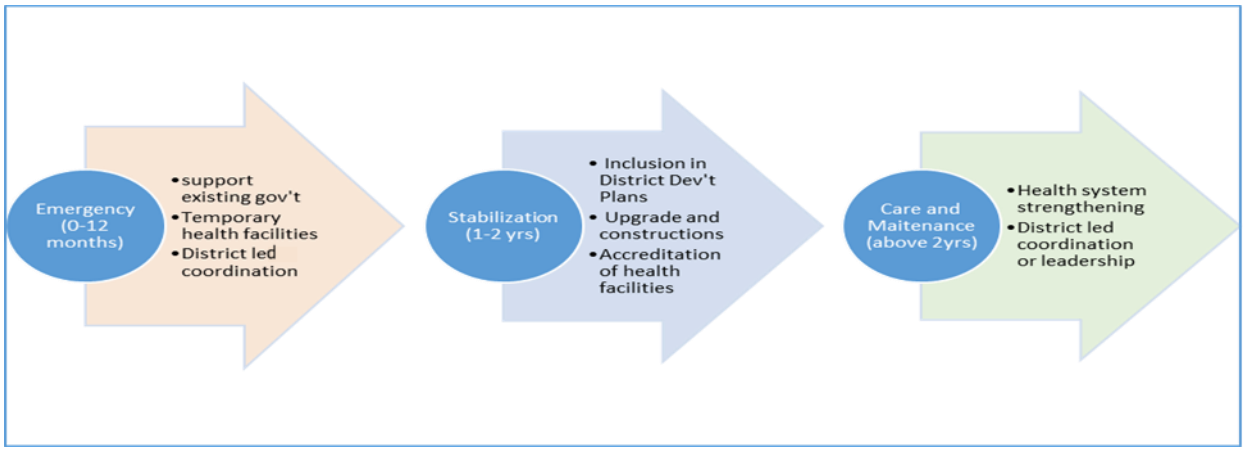


Figure 3: Step by step transition process in the health sector (Source: MoLG, MOH and OPM (2020). Integration Guidelines for Refugee Health Services)

These guidelines are facilitating better coordination across various actors, ensuring that partners work collaboratively in the delivery of refugee health services rather than relying solely on humanitarian aid. Currently, several health key players (development and humanitarian) are represented at Health Development Partners, Health Policy Advisory Committee and Technical Working Groups at the national level and Extended District Health Team at the District level, all of which provide an opportunity for refugee integration and transition, in process and decisions. Equally, refugees are represented in the oversight committees of Global Fund, National

Coordination Committees for Malaria, Tuberculosis, etc. The Ministry of Health has established a Directorate of Health Governance and Regulation with a Commissioner for Health Sector Partners and Multi-Sectoral Coordination under which the secretariat of the Health Sector Integrated Refugee Response Plan is hosted.

One of the gaps of the current guidelines is that they don't have a resource mobilisation strategy and plan for sustainable funding. They rely heavily on continued financial support from health development partners. The expectation that development partners will finance 60% of the recurring budget may not be sustainable, especially given the overall decline in funding and recent changes in the donor landscape.

2.4 STATUS OF HEALTH SERVICE DELIVERY

This section describes the status of health service delivery during the transition period, identifying gaps in health infrastructure, health workforce, essential medical supplies and financing for refugee healthcare in the refugee hosting districts.

Despite the slow pace, the transition process has led to some improvements in health service delivery at government managed facilities in some districts, driven by their integration into the national health system. Integration has enabled access to regular drug supplies from the National Medical Stores (NMS), leading to more effective service delivery and increased uptake of healthcare services. In Bidibidi settlement, Yumbe District, integration into the national health system has led to some improvements in staffing and the expansion of health facilities and services. Government managed facilities have recruited more senior staff and introduced specialized services, such as adolescent health programs, enhancing the accessibility and quality of care for women and the youth. As a result, these facilities are now better equipped to handle a larger patient load and more complex cases that would have otherwise required referral to HC IVs or district hospitals.

In addition, the Ministry of Health (MoH) in Uganda has enhanced healthcare services in refugee-hosting districts by establishing blood banks, deploying additional health staff and emergency healthcare facilities e.g. the established Hoima District Blood Bank, will ensure a steady supply of blood for medical emergencies in Kyangwali refugee settlement, Kikuube district. Additionally, the MoH deployed 30 midwives to health facilities in refugee-hosting districts, contributing to improved maternal and child health outcomes (UNFP, 2023). These initiatives have strengthened the healthcare infrastructure, the quality and accessibility of medical services in refugee-hosting districts for both refugees and host communities. Subsequently, some HC IVs in the RHDs such as Bujubuli HC IV, Rwamwanja HC IV and Kyangwali HC IV have consistently been the best performing HC IVs in the whole country.

Furthermore, the transition process has led to health facilities benefiting from national health reporting system fostering informed decision making for better health service delivery by the ministry and at the district level. For instance, the zoning and coordination of refugee ambulance service in settlements, following the mapping done by the districts has led to improved transportation and optimal use of ambulances serving both refugees and host communities. This approach also facilitated well-coordinated responses during the epidemic response and inspired peaceful coexistence between the refugee and host communities. This kind of innovation should be integrated into the transition management.

Notwithstanding the reported improvements, the RHDs are among the poor performing districts in the country due to the additional refugee population, putting a high strain on already limited resources. According to the MoH Annual Health Sector Performance Report 2023/24, District League Table performance for all the 145 districts, against several selected health indicators for the five years of the National Health Strategy, majority of RHDs were performing poorly.

2.4.1 Key Service Delivery Gaps and Challenges Affecting Transitioning

Overall, the transition of health facilities and services is experiencing challenges across all refugee host districts, hindered by inadequate funding, limited infrastructure, insufficient staff and medical supplies.

Inadequate Human Resources – As highlighted earlier under Section 2.2, the human resource gap remains a very big challenge for all health facilities in RHDs. A staffing gap analysis matrix presented under Annex I, provides a detailed comparison of current performance against desired standards to identify areas needing improvement. Since the health workforce is highly donor dependent, the phasing out of partner-supported staff during transition is likely to widen the staffing gaps, affecting essential health services, as most government managed health centres might lack sufficient staff to meet the demands of the increasing refugee populations.

The inadequate human resource is further aggravated by delayed recruitment of healthcare personnel. This is due to prolonged delays in obtaining clearance from the Ministry of Public Service. Additionally, the current wage bill is insufficient to meet the demands of transitioning facilities and growing refugee populations. This shortfall makes it difficult for the government to recruit the required number of staff in accordance with the new staffing norms for HC III and IV facilities. Consequently, the government heavily relies on partner supported medical staff for service delivery. For instance, at Rwamwanja HC IV in Kamwenge district, only 11 (11%) out of 103 staff are employed by the government, while in Kyangwali HC IV, the partner supported 96% of the total health workforce, highlighting the need for increased government staffing and resources to meet the growing refugee healthcare demands. These challenges hinder efforts to address critical staffing gaps and impact the overall efficiency of quality healthcare service delivery. If not addressed, these challenges will hinder the transition to full government control and management.

Relatedly, health facilities are experiencing high turnover and retention challenges, especially, in remote refugee-hosting districts like Yumbe, where working conditions are challenging, and the remuneration does not include hard-to-reach allowances. As a result, many healthcare workers leave for better opportunities, and remain unreplaced, leaving health facilities understaffed. Conversely, as part of the transition process, government needs to consider offering incentives such as allowances and career development opportunities to attract health workers to remote refugee hosting districts.

Besides the low staffing levels due to the low wage bill, there are challenges associated with limited training and capacity building opportunities. Health workers in the transitioning facilities lack training and capacity building opportunities, which are essential to empower them to effectively manage unique challenges of refugee hosting districts such as psychosocial needs, malnutrition, reproductive health care and referral support which are currently not adequately addressed due to

lack of skilled manpower, comprehensive policies and guidelines addressing specific health needs of refugees.

Staff capacity development for health workers in refugee communities, through Continuing Professional Development, orientation and mentorship are critical to enable them to understand the complex and unique needs and challenges. Equally, it will help to reduce cultural barriers, foster trust and improve attitudes among health workers as well as clients, leading to enhanced inclusivity and increased uptake of health services among the refugee communities. On the contrary, insufficient training and lack of capacity building initiatives can result in staff incompetence, contributing to medical errors and undermining confidence and morale. This, in turn, hinders their ability to address emerging medical challenges, ultimately leading to diminished healthcare and poor patient outcomes.

Inadequate Infrastructure and Equipment - Limited infrastructure and equipment is hindering the transition process. The continuous influx of refugees puts significant pressure on the limited health infrastructure in refugee hosting districts. Currently there are major infrastructure gaps, including, among others temporary and semi-permanent structures, that must be upgraded to suit the national standards to ensure smooth transition. The MoH's guidelines acknowledge that 28% of health facilities are temporary or semi-permanent. The infrastructure gap analysis matrix presented under Annex II, provides a detailed comparison of current performance against desired standards to identify areas needing improvement.

Health facilities in refugee settlements often lack adequate space to serve the large refugee populations. For instance, in Palorinya settlement in Obongi district alone, they require at least 10 admission wards and equipment to improve the health infrastructure. There is urgent need to construct and upgrade temporary structures to permanent structures as a long-term commitment to improving health services. Without this infrastructure, health services will remain compromised, making it difficult to provide adequate quality care. Infrastructure should be prioritized, to ensure that refugee-hosting districts have adequate facilities to meet the increased demand for services.

The limited infrastructure, combined with inadequate equipment, significantly hinders healthcare delivery. This is likely to result in poor diagnosis and treatment outcomes, as well as delays in medical interventions, particularly for complex diseases that require specialized diagnostic equipment, tools and treatment facilities. This ultimately results in overall poor health outcomes the increasing vulnerability of refugee populations.

Weak Referral Systems - Inadequate referral mechanism support is a major barrier to healthcare access for refugees, as many cannot afford self-transportation to far off general, regional and national referral centres. The limited ambulance services prevent timely access to emergency care, which is crucial for addressing life threatening conditions and other health complications. Rwamwanja HC IV, which supports five health facilities within the settlement and surrounding host communities, operates with only four ambulances, all of which are funded by partners. Similarly, Kyangwali HC IV in Kyangwali settlement, serving a refugee population of over 130,000 (excluding the host community) and nine lower health facilities, faces the same challenge of relying entirely on partner supported ambulances. The lack of timely transport, due to limited ambulances, results in delayed emergency care for refugees with life threatening conditions, thus increasing the risk of complications which may lead to fatalities, especially in maternal and child health. Some pregnant women in need of obstetric care are unable to access ambulances, forcing

them to deliver at home. This significantly increases the risk of maternal and infant mortality, negatively impacting national health indicators.

In settlements like Nakivale in Isingiro District and Lobule in Koboko District, where several ambulances are assigned for refugee communities but none for host communities, the districts have implemented a zoning strategy that has helped to ensure ambulances effectively serve both refugee populations and host communities. This approach should be adopted by other districts to promote equitable use of available resources and enhance access to services for both refugees and host communities.

The highlighted infrastructure and equipment gaps underscore the urgent need for infrastructure development during the transition period, without substantial investment to address these challenges, the government may struggle to deliver quality healthcare to refugees and host communities during and after the transition period.

Inadequate essential medicines and supplies - While partner supported facilities have been more efficient in ensuring a consistent supply of essential medicines, delays in procurement and supply of health commodities remain significant challenges in the refugee health care system. This affects the 95% (82 facilities) of the facilities in the RHDs, that have been officially coded and are considered fully transitioned and are entitled to grants funding and Essential Medicines and Health Supplies (EMHS) bi-monthly, supplemented by UNHCR and other implementing partners. Consequently, many facilities across the refugee host districts experience stockouts of essential medicines and other supplies such as, vaccines and HIV kits, compromising the delivery of critical healthcare services. Facilities like Bidibidi HC III, have experienced drug stockouts lasting over two months, leading to treatment delays and compromised quality of care, which ultimately exacerbates health risks for refugee populations. The challenge of essential medicines and supplies is more acute at referral centres, where additional medical, diagnostic services, and resources are required to adequately care for the many referred refugees who were not initially accounted for in the resource planning.

The inadequacy of essential medicines and supplies is primarily attributed to the weak supply chain management system within the RHDs. This undermines service delivery, by causing delays in procurement, distribution, and monitoring, leading to frequent stockouts and limited access to essential medicines and supplies. Consequently, the transition process should prioritize strengthening procurement systems and supply chain management by enhancing planning, streamlining procurement processes, and ensuring the timely delivery of essential medical supplies. These measures are critical to preventing stockouts and maintaining consistent, high-quality healthcare services for refugee and host communities. Failure to address these challenges could lead to chronic shortages of essential medicines, compromising healthcare delivery and jeopardizing the success of the transition process.

Weak Health Management Information System (HMIS) - Whereas efforts have been made to improve HMIS in RHDs, with all refugee coded facilities now reporting into DHIS2, ensuring comparability across regions and facilities for effective centralized monitoring and evaluation, RHDs still face significant gaps in data collection, analysis, reporting, and utilization resulting in fragmented health information systems, causing inefficiencies in decision-making, planning, monitoring, and evaluation. The supply of HMIS tools like registers remains severely inadequate affecting routine data collection. Additionally, HFs within the Refugee settlements provide a wider

scope of services e.g. laboratory services up to HC II yet are not provided with the tools for data collection except when partners print and distribute. This is further compound by the staffing gap and lack of capacity development on use of these data collection tools affects quality of the data and analysis for decision-making.

Furthermore, there is limited stakeholder involvement in data collection and management, resulting in significant data gaps that hinder effective planning and implementation for refugee health care. While District Planning Offices are crucial for coordinating information systems and leading implementation of programs tailored to local needs, they are not involved in collecting and management of refugee healthcare data. This has led to poor coordination among government agencies, healthcare providers, partners, and NGOs, hindering the ability to effectively monitor health trends, address the specific health needs of the refugee population, and allocate resources for targeted interventions and planning. This ultimately compromises the quality of care for refugees.

In order to improved health information system to effectively, plan, coordinate and monitor progress and assess the success of transition, there is a need to develop and implement a robust M&E framework with clear indicators and baseline data to track progress of refugee service provision under the different phases of transition and make necessary adjustments to improve performance. All transitioned health facilities must report through DHIS2, the official government reporting tool for all districts in the country. Furthermore, transitioned health facilities should be able to analyze, report, and utilize data for informed decision making, planning and coordination. Additionally, there is need to build capacity of health workers on proper data handling and analysis to ensure accurate reporting, and utilization of data for better decision-making and resource allocation. District Planning Offices should be effectively engaged to offer the necessary technical expertise and support coordination of the refuge health information system. Whereas some indicators in the HMIS have been disaggregated to include refugee populations, there is a need to integrate this across all health indicators in DHIS2.

Inadequate Health financing for Refugee healthcare services - The situational analysis reveals that the health sector continues to face under funding across all the RHDs. All the five (5) of the 13 RHDs sampled, receive less than 25% of the planned total budget in the health sector. The funding gap, which is over 75%, translates into poor quality health services delivery in the districts.

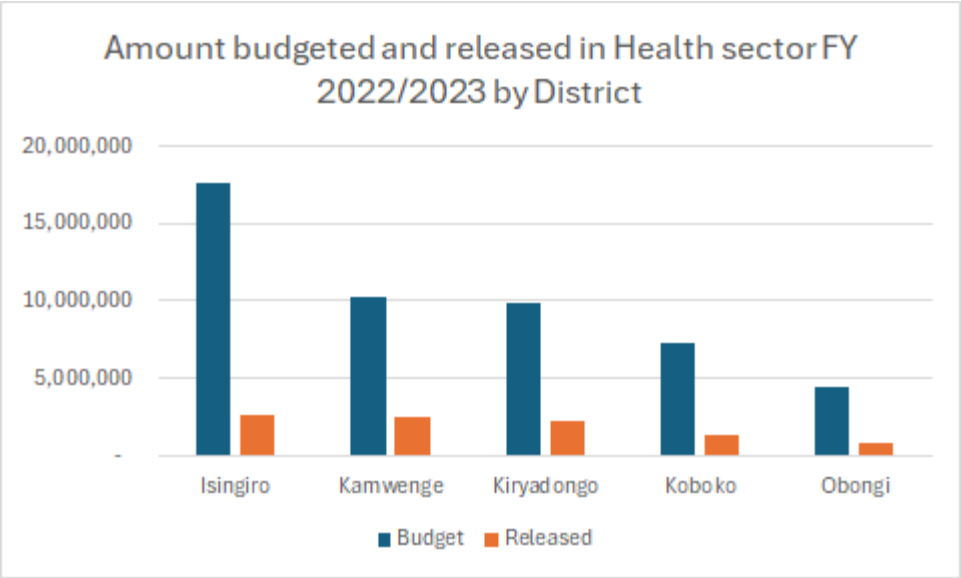


*Figure 4: Budget performance for the health sector in RHDs during FY 2022/23 (*Source: MoFPED)

The inadequate funding of health services has led to limited access to essential medical care, reduced quality of services in both refugee and host communities. There is a shortage of healthcare professionals, medical supplies and equipment across the health facilities, hindering the delivery of timely and effective care.

This financial shortfall can exacerbate existing healthcare delivery challenges and increase the vulnerability of refugee populations, particularly in addressing chronic diseases and mental health needs requiring specialized care. Ultimately, inadequate health financing undermines the overall health outcomes of refugees, jeopardizing the transition process and ability to integrate refugee healthcare into the national system. This situation underscores the need for better funding and coordination to ensure that the government can fully take over management. There is need to come up with a reliable, sustainable and equitable health financing strategy for the transition.

To address persistent underfunding of the health sector, projections have been made over a 10-year period showing gradual, increased funding for the sector.

Weak Collaboration and Coordination – Whereas efforts have been made to improve coordination of refugee health services for delivery of common results, coordination challenges persist due to differing priorities among partners, government agencies, and NGOs, leading to overlapping responsibilities and duplication of efforts, which ultimately hinders the efficiency of service delivery. The health sector response coordination at the district levels is weak. While there are some institutional structures in place, there are no dedicated personnel, clear terms of reference, and financial support for coordination of refugee healthcare, actors, and partnerships. In consequence, some critical decision-making and health sector planning happens outside Local Government health service delivery arrangements. This results in duplication of efforts and resource wastage.

Whereas districts through the extended District Health Management Team (DHMT) provides guidance and oversight at the district level, for effective implementation, supervision, monitoring and coordination of healthcare services, there are still coordination gaps and challenges.

There is lack of clarity regarding mandates and reporting lines for Implementing Partners (IPs) involved in the refugee healthcare. NGOs often lack clarity on their specific roles and responsibilities, resulting in overlapping responsibilities and duplication of efforts, which ultimately undermines delivery, efficiency and impact as well as the transition process.

While community engagement is essential for enhancing local level coordination and aligning healthcare interventions with local needs, funding for these programs is limited, leading to insufficient community involvement and a disconnect between government initiatives and local priorities. Failure to effectively engage communities on health matters undermines the success and sustainability community health interventions. If not, addressed this can lead to resistance or apathy towards government-managed health services and above all, will affect the sustainability of the transition.

Effective coordination at all levels is essential for the successful transition of refugee healthcare services to government management. There is a need for comprehensive stakeholder engagement and consultation, especially during the planning stages of the transition, to allow stakeholders to identify and agree on what needs to be done and ensure a smooth transition. This highlights the need to foster collaborative partnerships among government agencies, partners, NGOs, and local communities to improve outcomes in refugee healthcare management and facilitate a smoother transition process. Inter alia, coordination and collaboration can be enhanced through joint planning and reviews, ensuring alignment and harmonization of priorities among government agencies, partners and NGOs. This calls for regular meetings, performance reviews, joint support supervision visits, and inter district visits for promotion of peer learning and sharing of best practices.

While government is making efforts to expand infrastructure and recruit additional staff, there are significant operational challenges related to drug supply, staff performance, and the availability of critical services such as ambulances. The inadequate human resources coupled with insufficient infrastructure, further limits the refugee health care system's ability to effectively manage the increasing health needs of the refugee population and ensure quality of service during the transition process and post transition. For a successful transition, government must invest in health infrastructure and human resource development. Specifically, government should increase the wage bill and prioritize staffing in refugee-hosting districts and reduce its reliance on partners. Additionally, training and capacity building for health workers should be prioritized to ensure that health workers are equipped to effectively handle complex health needs of refugees.

Data limitation: There is absence of reliable data regarding the status of facilities in terms of infrastructural, human and financial resource needs as well as eligibility and stages of transition. Whereas, efforts were made by Office of the Prime Minister (OPM) to collect this data, the exercise was constrained by data shortfalls.

2.4.2 Lessons Learned

From the situational analysis findings, there are a number of lessons learned to guide informed decisions, to streamline the transition processes and increase preparedness for government to take over management of refugee healthcare services.

(i) **Capacity Building for quality service delivery:** Sustaining quality service delivery requires increasing investment in capacity building for Local Governments, particularly for healthcare

workers to build the skills, knowledge, and competencies focused on healthcare governance, strategic planning, resource mobilization and utilization. Targeted training for health and medical staff will be crucial for enhancing their ability to manage and adapt to emerging refugee healthcare needs to deliver quality, sustainable healthcare to both refugee and host communities. This is key for those charged with leading and managing LG services and health facilities.

(ii) **Partnerships and Collaboration:** Partnerships and collaboration are critical in sustaining healthcare services, as they leverage diverse expertise, resources, and networks to address the complex healthcare needs of the refugee populations. Under humanitarian managed healthcare services, collaborative efforts among partners, humanitarian donors, development partners, NGOs, local governments, and local communities have been central in strengthening local health systems and enhancing the sustainability of interventions. During transitioning to government-managed refugee health services, it is essential to continue these partnerships and collaboration to maintain service quality and ensure resource availability to support the integration of refugees into national health systems, creating a more sustainable and inclusive refuge healthcare system.

(iii) **Sustained Engagement with Humanitarian Actors:** As the transition shifts management of refugee health services toward government, humanitarian actors remain vital in ensuring sustained quality of services through delivering expertise, resources and technical support as well as emergency services throughout this period. Conversely, the transition plan should promote sustained engagement and collaboration, ensuring a clearly defined and adaptable role for humanitarian actors as they support integration of refugee healthcare into national health systems, while enhancing the government's capacity for long-term, sustainable management.

(iv) **Adopting a phased approach** - Considering the complex nature of transition, the process must adopt a phased transition including the transition of medical staff from partner management to government control including, absorption of the existing committed partner supported staff. This approach would allow the government to gradually absorb staff, ensuring, there is minimal disruption of services. A phased transition would also allow time for the necessary budget allocations, infrastructure improvements, and capacity building to be put in place, ensuring that healthcare services remain uninterrupted during the transition.

(v) **Ensuring flexibility and adaptability** - The transition process must ensure flexibility and adaptability by incorporating flexibility into the Transition Guidelines for Refugee Health Services-MoH 2023, to allow for adjustments in response to changing circumstances, such as new refugee inflows or unexpected resource shortfalls.

3 TRANSITION PLAN STRATEGIC DIRECTION AND ROADMAP

This section describes the health sector transition plan strategic direction and roadmap outlining, the vision, mission, goal and strategic objectives to facilitate progressive and systematic transfer of the health facilities, responsibilities, resources, and oversight to government management. Central to the plan are strategic interventions and key activities focused on improving and expanding the infrastructure and equipment, enhancing human resource capacity in the refugee hosting districts, strengthening health management information system, enhancing financing for sustainable refugee healthcare service delivery, as well as strengthening leadership, management and coordination for effective health service delivery.

The health sector transition plan proposes strong institutional arrangements, essential for effective implementation of the plan fostering, coordinated decision-making and planning as well as ensuring accountability across all stakeholders. Financial sustainability is another critical component of the plan, outlining key strategic interventions and activities to enhance financing for sustainable refugee healthcare service delivery. Finally, the plan establishes implementation phases with specific timelines and milestones to guide a structured, progressive transition process and facilitate effective monitoring and learning.

3.1 ALIGNMENT OF THE PLAN WITH NATIONAL AND INTERNATIONAL PLANNING FRAMEWORKS

The Health Sector Transition Plan strategic interventions are premised on a number of international, policies, plans and frameworks. The Plan's priorities align the with the national health goals and standards, promoting equitable, high-quality care for all, as articulated in the Health Sector Strategic Plan (2020/21 - 2024/25), which emphasises integration of refugee response activities into the government health systems, while preserving the historical gains of peaceful co-existence of refugees and host communities. Equally, the Plan's objectives are aligned with the objective of the National Essential Health Care Package for Uganda 2024, which emphasizes equitable access to quality primary, secondary, tertiary, and quaternary health services that meet priority needs of the population at different stages of the life cycle. Furthermore, the Plan aligns with the vision of Health Sector Integrated Refugee Response Plan (2019-2024), aspiring to achieve a coordinated, integrated, and district-led health service delivery for both refugees and host communities.

The Plan's alignment with the national planning framework is crucial to ensure that refugee healthcare integration supports national health priorities, fosters equitable care, and contributes to the national health goals and standards of high-quality care for all while ensuring, peaceful coexistence between refugees and host communities.

3.2 VISION, MISSION, GOAL AND OBJECTIVES

Vision

A resilient refugee healthcare system that aligns with national health goals, fully managed by government, ensuring quality, equitable and sustainable healthcare care for all refugees and host communities.

Mission

To deliver quality, equitable and sustainable healthcare services for refugees and host communities.

Goal

To transition partner-managed health facilities to government management by 2035, ensuring quality, equitable and sustainable healthcare services to all refugee and host communities, aligned with national health goals and standards.

Objectives

The plan outlines five (5) key objectives to be implemented during the transition to achieve the desired goal of transitioning to government managed facilities that provide quality, equitable and sustainable healthcare to refugees and host communities, aligned with the national health goals and standards. The objectives include:

i. Integrate refugee healthcare into national systems, ensuring a harmonized, sustainable financing approach.
ii. Improve health infrastructure to increase access to quality and equitable healthcare services for refugees and host communities.
iii. Strengthen human resource capacity for improved healthcare delivery, and better health outcomes for refugees and host communities.
iv. Enhance access to essential medicines and medical supplies for improved patient care and health outcomes for refugees and host communities.
v. Strengthen governance and management systems to enhance coordination, accountability, and resource utilization for efficient and effective healthcare delivery

3.3 GUIDING PRINCIPLES

Integrated service provision: Ensuring a holistic approach in refugee healthcare, where different services and programs are integrated to provide comprehensive care. Such integration is designed to improve accessibility, reduce redundancies, better address complex health needs, and ensure efficient use of resources to enhance patient outcomes.

Shared Responsibility: Emphasizing collective responsibility and commitment from government, humanitarian organizations, development partners, local authorities, and communities to ensure sustainable, accessible, and effective healthcare for refugees. Ensuring coordinated collaboration with each stakeholder having a distinct role to play.

Cultural Sensitivity: Respecting cultural differences for both refugee and host communities throughout the transition process, ensuring the plan aligns with local beliefs and practices and gains community support.

Equity, Quality and Inclusivity: Committing to providing equal access to quality healthcare for all refugee and host communities, prioritizing vulnerable populations and addressing health disparities as part of the implementation process.

Accountability and Transparency: Maintaining good leadership and management at all levels, open and transparent communication channels among partners, and stakeholder participation with clear roles, responsibilities, and reporting mechanisms.

Collaboration and Partnerships: Fostering collaboration among all actors, government agencies, partners, private sector, refugees and host communities, to ensure meaning participation and collaborative working for synergy and complementarity to leverage resources for shared success.

Evidence Based Decision Making: Utilising reliable data, research, and proven best practices to guide decision making and planning, ensuring that actions are informed, effective, and aligned with the needs of the refugee and host communities and meet the requirements of national health standards

Sustainability and Resilience: Establishing reliable funding streams and building the government's capacity for continued quality service delivery ensuring, long-term sustainability of all transitioned facilities and services. Additionally, ensuring government ownership and building capacity for prudent use of human, financial, and material resources helps the system remain responsive to evolving healthcare needs and sustainable in the long-term.

3.4 Theory of Change for the Health Sector Transition Plan

The Theory of Change for the Health Sector Transition Plan outlines a clear, strategic pathway through which the government, led by the Ministry of Health, envisions building a resilient refugee healthcare system. This system will be fully integrated into national health structures, aligned with national goals, and managed by the government to ensure the delivery of quality, equitable, and sustainable healthcare for both refugees and host communities.

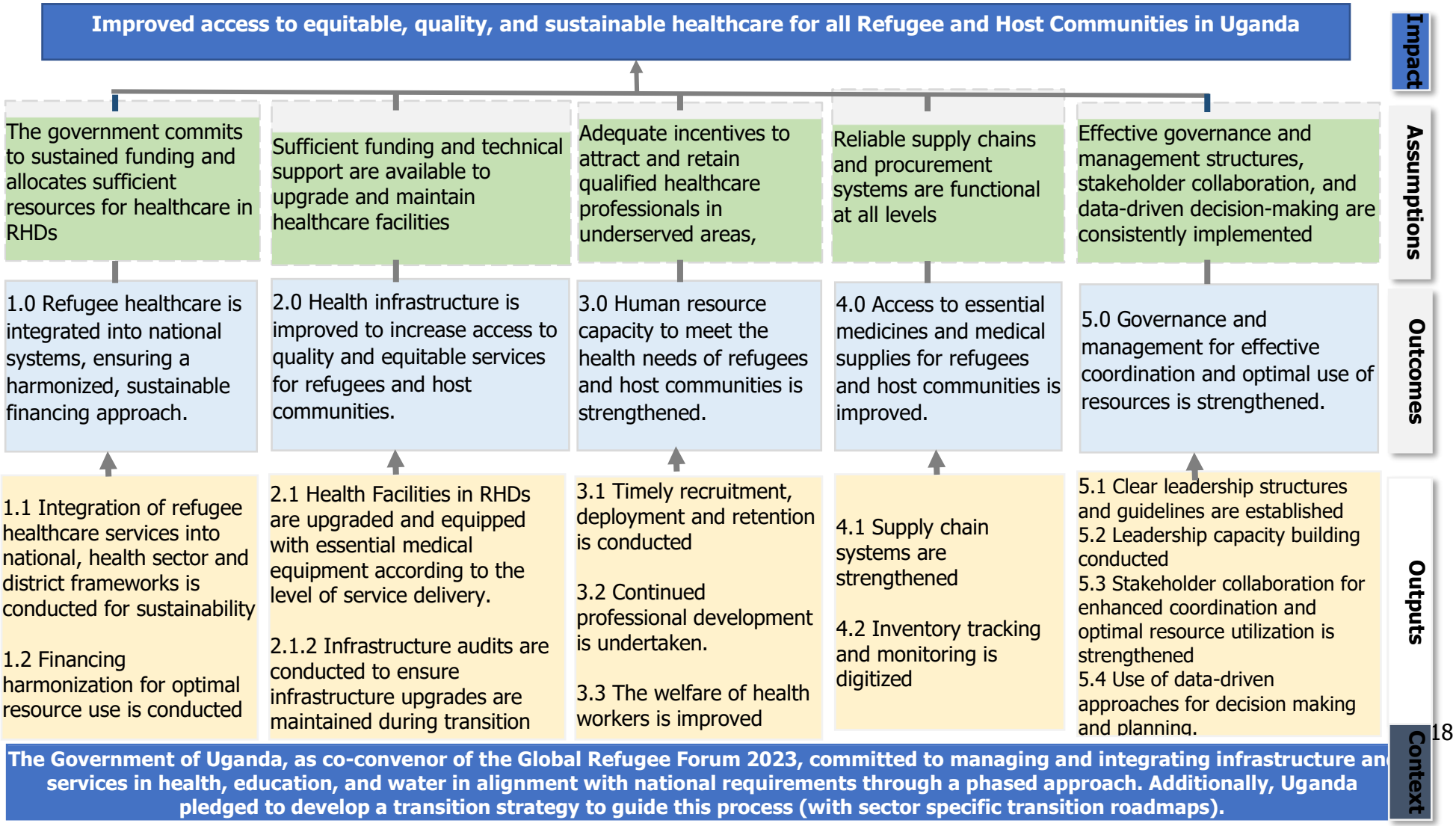


Figure 5: Theory of Change for the Health Sector Transition Plan

3.5 STRATEGIC INTERVENTIONS AND ACTIONS

The plan outlines key strategic interventions under each objective, and targeted actions essential for supporting a successful transition to a government managed refugee healthcare system, ensuring quality, equity, and sustainability in healthcare for refugees and host communities. The proposed actions aim to address identified challenges and gaps and support the integration of refugee healthcare services into Uganda's national health system.

3.5.1 Key Strategic Interventions

(i) Integration of services for sustainability.
(ii) Financing harmonization for optimal resource use.
(iii) Upgrading and equipping the health infrastructure for increased access to services.
(iv) Ensuring timely recruitment, deployment and retention of health workers for enhanced human resource capacity for service delivery.
(v) Continued professional development and improvement of the welfare of health workers.
(vi) Strengthening supply chain systems for increased access to essential medicines and supplies.
(vii) Establishing clear leadership structures and guidelines, and capacity building for strengthened governance and management.
(viii) Enhancing stakeholder collaboration for enhanced coordination and optimal resource utilization.
(ix) Use of data-driven approaches for decision-making.

Integrate refugee healthcare into national systems, ensuring a harmonized, sustainable financing approach

Strategic Interventions	Key Activities	Responsibility
Integration of services for sustainability	i. Conduct a comprehensive baseline of refugee healthcare services in the country.	MoFPED, MoH, OPM, DLGs, & partners
	ii. Integration of refugee healthcare into national, health sector and district frameworks (policies, strategies, plans and budgets).	MoH, DLG, OPM, MoFPED.
	iii. Train health workers in integrated planning, ensuring unique needs of refugees are incorporated including mainstreaming protection and gender in health programming.	MoH, DLG, & OPM.
	iv. Engage refugee and host communities in planning and decision-making to ensure services are relevant and effective.	OPM, DLG, Partners, & NGOs.
	v. Assess progress in service integration under the different phases of transition.	MoH, DLG, OPM, & Partners.
Financing harmonization for	i. Conduct resource mapping to assess current financial flows in refugee healthcare and identify gaps to guide equitable allocation across the RHDs and settlements.	MoH, DLG, OPM & Partners.

Strategic Interventions	Key Activities	Responsibility
optimal resource use.	ii. Implement transparent budgeting, procurement, and reporting mechanisms to optimize resource allocation	MoH, DLG, MoLG, MoFPED &Partners.
	iii. Lobby government and development partners for increased refugee healthcare funding.	MoH, DLG, MoLG, MoFPED, Partners
	iv. Advocate for a joint financing mechanism combining donor contributions with government to ensure a unified and predictable funding pool to support transition of refugee health services.	Parliament, OPM, MoFPED, & MoH.
	v. Advocate for high-level government support to prioritize resource allocation for refugee healthcare.	OPM, MoFPED, MOH, & Partners
	vi. Seek out new international funding sources, including global health partnerships.	MoH, DLG, OPM & Partners.
	vii. Advocate for refugee health insurance schemes to facilitate access to services during the transition phase.	MoH, DLG, OPM & Partners.
	viii. Establish public-private partnership arrangements to mobilize additional resources to sustain services during transition.	MoH, DLG, Partners, Private Sector, & PSFU.
	ix. Assess progress in financial harmonization under the different phases of transition.	MoH, DLG, OPM, MoFPED & Partners

Improve the health infrastructure to increase access to quality and equitable services for refugees and host communities

Strategic Interventions	Key Activities	Responsibility
Upgrading and Equipping	i. Construct and upgrade health facilities	MoH, DLG, Partners.
	ii. Equip health facilities with essential medical equipment according to the level of service delivery.	MoH, DLG, Partners,
	iii. Conduct infrastructure audits to ensure infrastructure upgrades and equipment are maintained during transition and inventory is updated and maintained regularly.	MoH, MoWT, DLG,

Strengthen human resource capacity for improved healthcare delivery, and better health outcomes for refugees and host communities

Strategic interventions	Key activities	Responsibility
Ensuring timely recruitment, deployment and retention	i. Advocate for expedited clearance, recruitment and deployment processes.	MoPS, MoH, MoFPED, OPM
	ii. Facilitate integration of partner supported refugee health workers into the national health workforce through affirmative action.	MoPS, MoH, MoFPED, OPM & DLG.
	iii. Advocate for the recruitment of qualified refugee health professionals into the national workforce where possible.	MoPS, MoH, MoFPED, OPM
Continued professional development	i. Conduct training needs assessment among refugee healthcare workers to identify skill gaps.	MoH, DLG
	ii. Develop a targeted capacity building plan to address identified skill gaps and enhance service delivery during transition.	MoH, DLG, & partners.

Strategic interventions	Key activities	Responsibility
	iii. Conduct tailored training of healthcare workers to address refugee health needs and transition demands.	MoH, DLG, & partners.
	iv. Train and deploy refugee and host CHWs to raise awareness for transition and deliver basic health services in the settlements and host communities.	DLG, NGOs
	v. Conduct support supervision, mentorship and coaching to support the transition process.	MoH, DLG, & Partners
Improving welfare	i. Provide decent accommodation.	MoH, DLG, & Partners
	ii. Provide incentives such as allowances and career advancement for health workers in refugee districts considered hard-to-reach.	MoH, DLG, Partners

Enhance access to essential medicines and medical supplies for improved patient care and health outcomes for refugees and host communities

Strategic interventions	Key activities	Responsibility
Strengthening Supply Chain Systems	i. Assess the existing supply chain to identify key gaps, bottlenecks, and inefficiencies.	MoH, DLG, Partners,
	ii. Develop a procurement plan for a sustainable supply of medicines and other commodities for refugee healthcare	MoH, DLG, Partners,
	iii. Secure agreements with reliable prequalified suppliers for better coordination and ensuring a steady flow of essential commodities.	MoH, DLG
	iv. Provide timely transport for efficient distribution and redistribution of medical supplies in refugee settlements.	MoH, DLG
Digitalizing inventory tracking and monitoring	i. Establish an inventory tracking software or system for efficient inventory tracking and distribution.	MoH, DLG, Partners,
	ii. Train staff in digital inventory management, demand forecasting, and efficient distribution	MoH, DLG,
	iii. Conduct regular inventory audits to assess the performance of the supply chain management system and take corrective action to reduce stockouts, wastage, and inefficiencies.	MoH, DLG, Partners,
	iv. Engage refugee and host communities to monitor and ensure medicines and supplies meet local needs and are used appropriately.	DLG, RWCs, Partners

Strengthen governance and management systems to enhance coordination, accountability, and resource utilization for efficient and effective healthcare delivery

Strategic Interventions	Key Activities	Responsibility
Leadership capacity building	i. Orientate the established coordination structures on their roles and responsibilities to streamline decision making processes at various levels.	MOH, MoLG, DLGs, Partners
	ii. Conduct leadership and management training for technical staff, Political leaders, Local leaders, Religious	DLG, Partners, NGOs.

Strategic Interventions	Key Activities	Responsibility
	leaders, , Refugee foundations, Cultural leaders... etc. in various leadership skills, governance, planning, resource management, advocacy, community mobilization, conflict resolution and mediation, land acquisition and management.	
	iii. Develop grievance and dispute resolution mechanisms to address any conflicts that arise during the transition.	DLG, MoGLSD, Partners, NGOs.
Enhancing Stakeholder collaboration for enhanced coordination and optimal resource utilization	i. Assess coordination mechanisms to guide the review of MoH guidelines for refugee health services to ensure effective participation of all relevant stakeholders in planning and management of refugee healthcare services ensuring a unified approach to service delivery	OPM, MoLG, OPM, MoH, DLG.
	ii. Support district level coordination structures such as the Extended District Health Team, the District Refugee Oversight Committee and District Integrated Health Sector Coordination Committee to ensure their functionality	MoLG, OPM, MoH, DLG, Partners
	iii. Develop a communication strategy to streamline inter-agency communication among partners to align efforts	OPM, MoH
	iv. Create coordination platforms to promote governance practices and trust to ensure continuous feedback at all levels.	MoLG, OPM, MoH, DLG, Partners, NGOs
	v. Support regular coordination meetings bringing together various stakeholders to review implementation progress at various levels.	MoLG, OPM, MoH, DLG, Partners, NGOs
Use of data-driven approaches for decision making and planning	i. Implement robust M&E systems to track progress, assess impact, and adjust strategies based on evidence for better outcomes.	MoH, DLGs, MoLG, OPM
	ii. Strengthen capacity in data management, ensuring linkage of refugee health related data with national health systems for comprehensive planning, monitoring and resource allocation	MoH, DLG, Partners.
	iii. Conduct joint reviews involving both government and partners to assess progress of the transition process.	MoH, DLG, OPM Partners

To achieve the objectives of the Plan, will require strong stakeholder engagement and collaboration, involving various key actors to secure buy-in and collective ownership, as outlined in the implementation framework of Plan. Equally important, is mobilizing the necessary resources, including skilled personnel, infrastructure and essential medicines and supplies. Monitoring progress consistently through effective M&E system and ensuring flexibility to adaptive management to address unforeseen challenges and refine strategies will be crucial. Above all, good governance, effective leadership, and sustained partnerships are fundamental to maintaining momentum and achieving successful outcomes of the transition Plan.

4 IMPLEMENTATION FRAMEWORK OF THE PLAN

The implementation framework outlines essential components that will drive effective execution, ensuring alignment with the plan's objectives and the overall transition strategy. Governance and Management as the backbone of the framework, will involve orienting leaders on their roles to lead decision-making and accountability. The Plan prioritizes capacity building to enhance the health sector readiness, by investing in recruitment, training and skills development, ensuring that the health workforce has the knowledge and tools needed to sustain quality of service delivery. Partnership and collaboration are central to fostering strong relationships and strategic partnerships among stakeholders, promoting coordinated efforts, shared ownership, and efficient resource utilization.

To support evidence-based decision-making, a robust (M&E) system, using Key Performance Indicators and various feedback platforms will be established for data collection, analysis, and dissemination, ensuring timely and accurate insights to help refine strategies and sustain momentum for transition in the health sector. This will be complemented by a comprehensive Communication Plan that ensures timely, clear, and consistent information sharing through regular updates to continuously engage stakeholders, foster transparency and ownership throughout the transition plan implementation process. The framework also prioritizes a harmonized financing mechanism, creating a sustainable funding model, ensuring transparent resource allocation and clear accountability for resource usage. Finally, the plan envisages addressing uncertainties, through a risk management approach that identifies potential challenges and establishes mitigation plans, ensuring adaptability and resilience through the transition process.

4.1 GOVERNANCE AND MANAGEMENT

Effective governance and management will be crucial during the transition process, to ensure accountability, transparency, and effective coordination, ultimately leading to sustainable, quality services that meet the needs of both refugees and host communities. The plan prioritizes leadership and governance as essential pillars for driving effective execution of the Plan. Ensuring effective governance and management will involve; establishing relevant leadership structures with clearly defined roles and responsibilities to oversee the implementation of the plan, provide technical support and guidance, and monitor progress to ensure effective execution and the optimal use of resources. Members of the leadership structures will be oriented on their roles and responsibilities to ensure that they are aligned and equipped to contribute effectively to the objectives of the transition Plan.

At the national level, the MoH will provide overall leadership working closely with local governments, development partners, NGOs and to ensure effective coordination of refugee healthcare services during the transition period. Governance and management will be delivered through the District Transition Committee (DTC) operating as integrated coordination entity at subnational level, where stakeholders regularly meet to assess progress, provide expert input, share updates, and address challenges and refine strategies to ensure that transition in the health sector is on course. The DTC will operate within already existing structures to ensure complementarity and avoid duplication of efforts and will report progress to the District Refugee Forum. The leadership structures will include:

4.1.1 Health Sector Integrated Refugee Response Steering Committee

At the national level, the Health Sector Integrated Refugee Response Steering Committee, a multi-stakeholder committee will provide strategic guidance and oversight of the Health Sector Transition Plan (HSTP). The Committee will report to the MoH Top Management and will feed into the Health Policy Advisory Committee (HPAC). It will work closely with the District Transition Committee to ensure alignment with the Uganda Country Refugee Response Plan.

Key roles and responsibilities

i. Providing oversight and guidance to government and partners on the implementation of the transition plan to maintain compliance with identified priorities.
ii. Ensuring transparency and accountability to the Government of Uganda and its partners on funds allocated towards the Health Sector Transition Plan.
iii. Undertaking resource mapping to identify funding gaps, support resource mobilization and ensure harmonized resource allocation and utilization.
iv. Capacity-building for the refugee health workforce to enhance their ability to take over responsibility and effectively manage refugee programs sustainably.
v. Strengthening linkages between various stakeholders enabling them to work collaboratively and harmonize efforts.
vi. Advocate for sustained political commitment and resource support from national and international stakeholders to support the transition process in the health sector.
vii. Conduct periodic monitoring of implementation of the HSTP, including reviews and evaluations related to the plan and its implementation.
viii. Prepare and submit quarterly progress reports to the Transition Steering Committee.

4.1.2 District Transition Committee (DTC)

At the local government level, the District Transition Committee (DTC) a multi-stakeholder committee that will play a pivotal role in guiding and overseeing the transition process at the district level. Embedding the transition strategy within local governance and community structures fosters localization, enhances accountability, promotes social cohesion, and strengthens resilience in key sectors such as water, health, and education. The DTC will report to the District Engagement Forum on the progress of the implementation of the transition strategy and sector plans in the district.

Table 3: Composition of the District Transition Committee

	Representative	Input
1.	District Local Government • Chief Administrative Officer (CAO) - Chairperson • District Planner - Secretary • District Health Officer (DHO) • District Education Officer (DEO) • District Water Engineer • District Community Development Officer (DCDO) • District Finance Officer • LC V Chairperson	To provide technical and political leadership and, coordination, and ensure alignment of the transition process with district priorities and plans
2.	Facility Representatives • Government schools, hospitals and Health Center In-Charges	Technical expertise and representing the interests and needs of healthcare facilities.

	• Private Sector Service Providers	
3.	Implementing Partners (INGOs and NNGOs)	Technical expertise, policy advocacy and resource mobilization to cover gaps during the transition period
4.	Refugee and Community Leaders	Represent refugees and host community interests and ensure inclusivity
5.	Private Sector	Represent the private sector and explore investments and partnerships for enhancing sustainable service delivery in the district

Key roles and responsibilities

i. Providing strategic oversight in planning, budgeting, implementation and monitoring of the NTS through District-Level Transition Plans and addresses challenges by recommending improvements.
ii. Ensure alignment and integration of transition-related activities into District Development Plans (DDPs).
iii. Spearhead resource mobilization efforts to secure and optimally utilize financial, human, and material resources needed to achieve objectives of transition objectives and sustainable impactful outcomes
iv. Strengthening collaboration and coordination among stakeholders at district-level to ensure harmonized efforts and, avoid duplication and promote efficient resource use.
v. Monitoring the progress of the NTS activities, ensuring that milestones and objectives are achieved and provides feedback to partners for improvement.
vi. Advocating for adequate funding and resource allocation from the government and other stakeholders to support the transition process and sustain water, health, and education services for refugees and host communities.

4.1.3 Refugee Welfare Councils' Committee

At the settlement level, the Refugee Welfare Councils' Committee comprised of representatives of the different Refugee Welfare Councils at the zonal levels, will play a leading role in implementing the Health Sector Transition Plan by providing leadership, coordination, and accountability at the settlement level, ensuring that, the Plan is effectively implemented, fostering sustainable and inclusive healthcare systems for refugees.

Key roles and responsibilities

i. Community mobilization and sensitization to educate refugees and host communities on the objectives and benefits of the transition plan and encourage community participation in transition activities.
ii. Participating in the planning and implementation of settlement-level health interventions together with the district authorities.
iii. Monitoring the delivery of healthcare services to ensure quality and responsiveness and providing regular feedback on the effectiveness of services and identifying areas for improvement.
iv. Monitoring the flow of health resources to ensure transparency and equitable resource distribution and utilization at the settlement level.
v. Addressing grievances related to healthcare services as a result of transition.

To further strengthen leadership and governance, MoH will review the guidelines for refugee health services to ensure effective participation of all relevant stakeholders in planning and management of refugee healthcare services through representation and participation in various coordination structures at national and sub national levels such as; the Health Sector Integrated Refugee Response Steering Committee, Health Development Partners Group, Health Policy Advisory Committee and Technical Working Groups. Equally, refugees should be represented in the oversight committees of various health programs at national and sub national levels.

District level coordination structures such as the Extended District Health Team, the District Refugee Oversight Committee and District Integrated Health Sector Coordination Committee will be supported and strengthened to ensure their functionality, enabling meaningful participation of relevant stakeholders and refugees to provide an opportunity for their input in refugee integration and transition process. Equally, the District Disaster Management meetings should be supported to continue to address emergencies as part of the transition process. DHOs and Health Sector Refugee Focal Desks should be supported and facilitated to coordinate and monitor refugee healthcare services in the refugee host districts.

To effectively contribute to the Uganda Country Comprehensive Refugee Response Plan, this Plan shall be implemented in harmony with the Water and Education Sector Transition Plans to ensure complementarity and increased impact. The Strategy identifies strong synergies to be coordinated under the Transition Steering Committee as highlighted in the Strategy Implementation Framework.

4.2 CAPACITY BUILDING AND CAPABILITY DEVELOPMENT

Capacity building has been identified as a major undertaking during the transition process, essential for strengthening the ability of central and local government for continuity, and quality of healthcare to refugee and host communities as donor support and management diminishes. Accordingly, the Health Sector Transition Plan outlines a number of actions aimed at capacity building for enhancing service delivery to meet the health needs of the refugee and host communities. Capacity building will involve recruitment of new staff to replace partner supported staff and increase the numbers to meet required staffing levels according to facility delivery level.

Training programs will be undertaken to build the necessary skills, knowledge, and competencies of healthcare staff focused on healthcare delivery, strategic planning and health governance, resource mobilization and management, aligning with national health standards. Continuous professional development programs, mentorship as well as incentives will be included as part of capacity development program to ensures that the workforce is equipped, motivated, and capable of adapting to emerging healthcare needs to deliver quality, sustainable healthcare to both refugee and host communities.

Additionally, the plan provides for training of leaders (Technical staff, Political leaders, Local leaders, Religious, Founders Refugee, Cultural leaders and any other relevant key stakeholders in leadership skills, governance, planning, and resource management, community mobilization, mediation, advocacy, land acquisition and management, and crisis management while creating mechanisms to ensure accountability and transparency.

Capacity building will also involve upgrading, expanding and equipping of health facilities to meet national standards and effectively address the growing needs of the refugee population. Upgrading of buildings will be done to ensure access to clean water, electricity, and sanitation. Infrastructure development will also entail strengthening the Supply Chain Management System for timely procurement and delivery of essential medicines, equipment such as diagnostic tools, laboratory equipment and supplies to enable comprehensive and quality care.

4.3 PARTNERSHIP, COLLABORATION AND COORDINATION

Partnership and collaboration are crucial for engendering effective coordination essential for successful transition, as they will ensure, unifying efforts across government and partners for continuity of services. The plan outlines targeted actions to strengthen partnerships, foster collaboration, and enhance effective coordination among stakeholders.

A comprehensive review of existing coordination mechanisms will be undertaken to identify coordination gaps and inform the development of a new coordination framework and guidelines defining clear roles and responsibilities, fostering the inclusion of various stakeholders at national, regional, district, and settlement levels. Table 3 outlines the roles and responsibilities of different stakeholders. Additionally, a comprehensive communication strategy will be developed to streamline inter-agency communication, helping to align efforts and minimize duplication of services, thus enhancing overall efficiency in healthcare delivery for refugees.

Regular coordination meetings will be organized to bring together various stakeholders, allowing for the review of transition progress at different levels and fostering an environment of collaboration, shared learning, transparency, and accountability, ensuring that resources are directed where they are most needed. Community sensitization meetings and dialogues will play a crucial role in fostering collaboration between refugees and local communities. By engaging them in joint planning, implementation, and monitoring, these efforts will help ensure that healthcare services are integrated and tailored to effectively address the unique needs of refugees and host communities.

4.3.1 Role and Responsibilities of different Stakeholders

The MoH will provide oversight and technical support supervision ensuring adherence to standards and guidelines. The ministry will also be responsible for accreditation of health facilities, and regulation of professional practice. The implementation of the Plan will be district-led, involving various stakeholders, including Humanitarian partners, UN Agencies, Multilateral and Bilateral Agencies, National and International NGOs, local communities, the private sector, community-based, faith-based, cultural organizations and other non-state actors as key stakeholders with clear roles and responsibilities as outline in Table 3.

Table 4: Role and Responsibilities of different Stakeholders

No.	Stakeholder	Roles and Responsibilities
Government Ministries, Departments and Agencies (MDAs)		
1.	Office of the Prime Minister (OPM)	▪ Act as the lead coordinating body for the transition, ensuring alignment with national policies and frameworks such as Uganda's Refugee Response Plan (RRP) and the CRRF.

No.	Stakeholder	Roles and Responsibilities
		▪ Provide high-level policy guidance to ensure refugee health services are fully integrated into national and local planning frameworks. ▪ Ensure that the transition is aligned with national development priorities and facilitate communication between stakeholders (UNHCR, DLGs, line ministries). ▪ Oversee the monitoring of progress in collaboration with the MOH, and RHDs, ensuring that refugee health services are incorporated into national health data and reporting systems. ▪ Support efforts to mobilize resources from national and international partners to fund health infrastructure development and capacity-building for LGs in RHDs. ▪ Serve as the primary government liaison with partners and donors.
2.	Ministry of Finance, Planning and Economic Development (MoFPED)	▪ Allocate and manage financial resources for the transition of health services in RHDs ▪ Develop budget frameworks that incorporate refugee health needs ▪ Track committed resources to the districts and ensure that financial support for the refugee response is effectively managed and aligned with national priorities under NDP IV and subsequent development plans. ▪ Monitor financial sustainability of transitioned health services.
3.	Ministry of Health (MoH)	▪ Provide technical leadership for the planning, implementation, and monitoring of healthcare services in refugee-hosting districts. ▪ Ensure the integration of services into national health systems, including data collection and reporting. ▪ Provide technical support and capacity-building to local governments to manage healthcare in refugee-hosting districts ▪ Oversee the development and rehabilitation of health infrastructure in refugee-hosting districts, ensuring sustainability beyond the transition period. ▪ Ensure quality and sustainable healthcare service delivery and management during and post transition. ▪ Coordinate the transition of all health facilities and ensure adherence to national standards. ▪ In collaboration with MoFPED, mobilize resources to ensure that the transition roadmap is implemented.
4.	Ministry of Local Government (MoLG)	▪ Oversee the integration of health services within local government structures ▪ Support DLGs in establishing coordination mechanisms to manage transitioned services. ▪ Facilitate decentralization of resources and responsibilities. ▪ Support capacity building for effective transition.
5.	Ministry of Public Service	▪ Provide guidelines for recruitment, retention, and remuneration of government staff, including qualified refugees. ▪ Manage public sector wage bill and job classifications. ▪ Ensure alignment of partner supported staff with government structures.
District Local Governments (DLGs)		
6.	District Local Governments	▪ Responsible for the overall management and delivery of healthcare services transition at the local level, ensuring equitable access for both refugees and host communities. ▪ Ensure that refugee health needs are integrated into district-level development plans and budgets. ▪ Collect health related data from refugee settlements and host communities, submitting it to national systems (MOH) and the CRRF Steering Committee for regular reviews. ▪ Build local capacity, including health services management, infrastructure maintenance, and data reporting systems. ▪ Engage with refugee and host communities to ensure the effective delivery of health services and resolve any challenges related to access, distribution, or service delivery.

No.	Stakeholder	Roles and Responsibilities
		▪ Coordinate between sectors (education, health, water) at the local level. ▪ Account for results and resources to the Central Government and partners. ▪ Ensure that land is allocated for the construction of the facilities and also for other use by the refugees.
7.	District Service Commission	▪ Recruit and appoint staff for government-managed health facilities (district staff under health) ▪ Ensure fair and timely hiring processes. ▪ Address human resource gaps in the health sector in RHDs.
8.	District Health Officers (DHOs)	▪ Monitor and maintain health facilities during and after transition. ▪ Coordinate heath service delivery with partners and local stakeholders. ▪ Ensure sustainable health supply and infrastructure. ▪ Data Collection and Technical Guidance: Gathering accurate information on the state of health facilities, offering expertise, and guiding interventions for proper health management in refugee settlements. ▪ Coordination of Partners: Leading the coordination of partners to ensure transparency, proper planning, and alignment of activities with district priorities, particularly in relation to health management and resource sustainability. ▪ Collaboration with OPM: Working closely with the OPM to manage social services for refugees, integrating district-level activities with broader government frameworks for cohesive health service delivery. ▪ Long-term Planning and Sustainability: Advocating for long-term partnerships with organizations that have sustainable goals, particularly for projects like tree planting, to ensure continuity and health resource sustainability.
Development Partners (DPs) and Humanitarian Partners		
9.	Development Partners	▪ Provide financial resources to support the development of health infrastructure ▪ Provide technical assistance and capacity building support toward health services management during and after the transition in RHDs. ▪ Support MoH and LGs with technical expertise, ensuring that health programs are sustainable and aligned with international best practices. ▪ Assist in monitoring and evaluating the transition process by supporting the development of indicators, data collection methods, and reporting systems. ▪ Engage in joint planning and coordination with MoH, DLGs in RHDs for health service delivery. ▪ Support the development and review of relevant policies, strategies, and programs that facilitate transition, ensuring alignment with national priorities and international standards.
10.	Humanitarian Actors	▪ Provide funding and financial support for transition activities in the health sector within RHDs. ▪ Provision of Essential Services: Deliver critical services in the short term, such as health care, education, and water, where gaps exist, until these services are fully integrated into the government system. ▪ Facilitate capacity-building programs.
11.	International Non-Governmental Organizations (INGOs)	▪ Provide technical assistance and financial resources to DLGs in RHDs to deliver health services to refugees and the host communities. ▪ Facilitate community participation in health programs, particularly focusing on refugee and host community engagement to ensure inclusiveness and demand-driven service delivery. ▪ Advocate for the rights of refugees and vulnerable host community members, ensuring that health services are accessible and equitable. ▪ Provide training to community health committees and service providers on managing health points, latrines, and promoting hygiene practices. ▪ Work closely with DLGs and partners to monitor service delivery and identify and report on any gaps or challenges related to access to health services for refugees.

No.	Stakeholder	Roles and Responsibilities
		▪ Collaborate with DLGs to transfer knowledge and best practices in health management. ▪ Establish partnerships with local NGOs for sustainability.
12.	Non-Governmental Organizations (NGOs and CBOs)	▪ Advocate for local and refugee community needs during the transition period within the health sector. ▪ Implement community-level projects in partnership with local governments specifically in the health sector. ▪ Provide supplementary services in the health sector. ▪ Build the capacity of refugees and host communities to enhance self-reliance through vocational training, education programs, and business development services.
Refugees and Host Communities		
13.	Host Communities	▪ Collaborate with local governments and partners during the transition and post transition within the health sector. ▪ Actively participate in the management of health services, including the formation of health user committees. ▪ Provide feedback through local governments and partners on the quality of health services, reporting issues such as non-functional health points. ▪ Support the integration of refugees into the community. ▪ Participate in community meetings and provide input on health services delivery discussions. ▪ Collaborate with partners and local governments to support the transition of health services. ▪ Advocate for quality and accessible health services.
14.	Refugee-Led Organizations (RLOs)	▪ Advocate for the rights and needs of refugees during the transition within the health sector. ▪ Facilitate community-level projects related to health. ▪ Build capacity of refugees and their leadership structures in peaceful co-existence, gender based violence (GBV), livelihoods, environment, literacy among others. ▪ Provide a communication channel between refugees and other stakeholders.
15.	Refugee Engagement Forum (REF)	▪ Participate in planning and coordination and provide input regarding priority actions and budgets during the transition. ▪ Facilitate dialogues between refugees, government, and partners in the health sector. ▪ Promote continued involvement of refugees in national decision-making processes in relation to the transition process. ▪ Collect and present relevant data related to health transitioned facilities for informed decision-making. ▪ Ensure that refugee voices are included in decision-making processes. ▪ Monitor health service delivery in refugee communities. ▪ Provide regular feedback from the refugee communities to the government and implementing partners and service delivery and propose practical solutions.
16.	Refugee Camp Commandants	▪ Implementation of Government Policy: Enforcing government policy in refugee operations by overseeing its execution and ensuring adherence to established standards and guidelines within the health sector. ▪ Coordination of Stakeholders: Collaborating with partners, district governments, and other agencies in health service delivery to refugees, facilitating cooperation among various stakeholders involved in the camps. ▪ Monitoring and Oversight: Conducting oversight of refugee operations, organizing and participating in coordination forums such as health sector working groups to ensure proper implementation of activities.

No.	Stakeholder	Roles and Responsibilities
		▪ Stakeholder Engagement and Management: Facilitating discussions with key stakeholders to align on the objectives and timelines of transition, acknowledging the diverse reactions from local and district officials.
17.	Refugee Leaders / Refugee Welfare Councils (RWC I, RWC II, and RWC III)	▪ Represent refugee communities in discussions about the transition in the health sector. ▪ Address grievances and advocate for improvements. ▪ Provide leadership and guidance during the transition process. ▪ Advocacy for Refugees and Host Communities: Acting as a representative to advocate for the needs and rights of refugees and host communities, ensuring their concerns are addressed within the health sector. ▪ Sensitization and Mindset Change: Educating and raising health awareness among the refugees and host communities, fostering better understanding and changing attitudes towards co-existence and collaboration. ▪ Bridging Communication Gaps: Serving as a mediator between service providers, local government, and the community to facilitate effective communication and collaboration during the transition. ▪ Monitoring and Evaluation: Overseeing the delivery of health services to ensure they meet the needs of both refugees and host communities, providing feedback and identifying gaps in service provision. ▪ Coordination with Stakeholders: Collaborating with partners, OPM, district officials, and other key stakeholders to share information and ensure that the transition process is understood and effectively implemented. ▪ Spokespersons for the Community: Refugee leaders are viewed as the "spokesperson and ears of the grassroots challenges," playing a vital role in representing community views to government and partners. ▪ Information Dissemination: Effective communication is a significant aspect of their role. Leaders serve to relay vital information regarding transitions, ensuring that it reaches the community accurately and effectively. ▪ Mobilization and Community Engagement: Leaders are tasked with mobilizing community members and fostering resilience. ▪ Advocacy for Community Concerns: The refugee leaders will play a critical role in advocating for community needs and concerns during transitions.
18.	Refugees	▪ Responsible for actively participating in livelihood programs, health, and community activities that promote and build their capacity for integration. ▪ Refugees are encouraged to engage positively work with host communities, contributing to social cohesion and mutual understanding. Their involvement in community activities will help build trust and collaboration under the transition process. ▪ Refugees have a role in advocating for their own rights and needs, both individually and collectively. This can include participating in decision-making processes that affect their health needs
19.	Religious Leaders / Faith Based Organisations (FBOs)	▪ Provide guidance and mobilize communities to support the transition in the health sector. ▪ Advocate for the needs of vulnerable populations regarding health services delivery. ▪ Facilitate dialogue between stakeholders within the health sector.
20.	Local Communities (refugees and host communities)	▪ Provide land for refugee healthcare establishment ▪ Participate in planning to determine healthcare priorities and services that meet the needs for both refugees and host communities ▪ Participate in governance structures including Health Management Committees to represent the interests of local communities and ensure adherence to standards ▪ Participate in monitoring healthcare services and provide feedback on service quality and accessibility and advocate for improvements and, hold service providers accountable to ensure standards are met.

No.	Stakeholder	Roles and Responsibilities
		▪ Participate in health education and community awareness campaigns to promote health literacy and preventive practices to reduce healthcare burdens. ▪ Facilitate harmonious interactions between refugee and host communities, ensuring cultural sensitivity, and address any conflicts to maintain a stable environment and promote social cohesion for healthcare delivery.
21.	The Private Sector	▪ Engage in partnerships to enhance refugee livelihoods through employment, skills training, and investment in refugee-hosting areas. ▪ Through Corporate Social Responsibilities (CSR) initiatives, private sector can support refugee communities by funding social programs, offering internships, or donating goods and services. ▪ Drive innovation in service delivery for refugees, such as developing digital financial services, mobile health applications, and online education platforms. These innovations can help bridge the gap between humanitarian aid and sustainable development. ▪ Engage in Public Private Partnerships (PPPs) with the government and NGOs to deliver services and infrastructure projects in refugee-hosting areas, such as building health facilities and health supply systems.

4.4 INFORMATION MANAGEMENT

Information management will be crucial during the transition period for maintaining reliable data, ensuring proper decision making and evidence-based planning for continuity of quality services, and facilitating effective integration into national health systems. Equally, disseminating accurate reliable data will foster transparency and trust, and improve resource mobilization and management, leading to more effective outcomes. By prioritising use of data-driven approaches to decision making, the plan establishes a foundation for sustainable, evidence-based healthcare planning that is responsive to both refugee and host community needs.

The plan focuses on implementing a robust M&E system to ensure continuous monitoring of the transition progress as well as evaluation and learning (MEL), enabling evidence-based decision making and timely adjustments to strategies for improved outcomes. The systems will collect, analyze, and regularly present data that inform all stakeholders about the effectiveness of interventions, fostering transparency and accountability. The plan prioritises strengthening capacity of local governments in data management. This includes integrating refugee health data with national health systems to create a unified data ecosystem. This will facilitate integration of services, comprehensive planning and monitoring, ensuring that refugee health needs are effectively addressed within broader national frameworks.

Joint reviews involving government and partners will provide a platform to collectively assess the progress of the transition process, identify challenges, realign strategies and co-develop solutions. Fostering open, continuous dialogue and collaboration, will ensure alignment of efforts and promote shared ownership of the transition process and outcomes. The detailed Monitoring, Evaluation and Learning (MEL) is presented in presented under Section 6 of the strategy.

4.5 FINANCING HARMONIZATION

The Plan will be funded within the Government funding system as outlined in the National Transition Strategy. Accordingly, the Plan will benefit from the "Transition Partnership Fund" arrangement to finance its activities. This funding modality minimizes fragmentation, improves

funding predictability, and ensures transparent collaboration among stakeholders to achieve shared objectives in supporting implementation of planned transition activities. Comprehensive resource mapping will be undertaken to get a clear picture of current financial flows and identify gaps, enabling informed decision-making for resource mobilization and equitable allocation for healthcare delivery.

This "Transition Partnership Fund" arrangement will ensure that resources are directed to areas of greatest need, reducing duplication and inefficiencies. Ultimately, a joint financing mechanism will create a harmonized financing ecosystem that supports sustainable, equitable, and efficient refugee healthcare services. It builds trust among stakeholders, including donors, government, and local communities, enhances accountability and optimize resource allocation, ensuring funds are used effectively and achieve maximum impact. Regular assessments of financial harmonization progress across will be conducted across the different transition phases of transition to provide valuable insights to refine strategies, address emerging challenges, and ensure alignment with the objectives of the fund.

Additionally, the Plan advocates for increased funding from the government and development partners to address existing financial gaps and secure sustainable funding streams. Lobbying will be done at highest political levels to ensure that refugee healthcare becomes a national priority, in the National Development Plan (NDP IV). It also explores other funding sources such as health insurance, PPPs to diversify financial support and bridge funding gaps, reducing over-reliance on donors. These efforts will strengthen resilience and sustainability in refugee healthcare financing.

4.6 RISK MANAGEMENT

This section outlines key risks associated with financial, political, environmental, and operational challenges, along with proposed mitigation strategies.

The shift from partner managed to government managed health facilities and services presents several risks, including delays in medical supplies, inadequate medical staffing, declines in referral systems, leading to compromised quality of care. These challenges stem from funding constraints, inefficient supply chains, and reduced capacity to handle specialized care. To mitigate these risks, measures such as strengthening supply chain management, recruiting more medical staff, maintaining partner support in services, and securing long-term financial commitments are essential, among others as detailed in the Table 4.

Table 5: Health Sector Risk Assessment and Mitigation

Risk Observed or Anticipated	Risk Contributors / Factors	Probability of Occurrence	Impact of Risk	Risk Mitigation Measures
Delays in Medical Supplies and Stockouts	Inefficient supply chain, delayed procurement processes, reduced funding	High	Increased morbidity and mortality, decline in trust in healthcare services	Strengthen supply chain management, ensure timely procurement, maintain emergency stock levels
Inadequate Medical Staffing and Increased Workload	Reduced wage bill, high turnover, lack of specialized medical personnel	High	Overburdened health workers, decline in quality	Recruit more medical staff, offer competitive wages, improve working conditions for healthcare workers

			of care, increased patient wait times	including housing and incentives
Decline in Medical Referral Systems and Ambulance Services	Poor emergency response, lack of specialized care, high transport costs	Medium	Limited access to specialized care, increase in preventable deaths, poor health outcomes	Maintain partner support in referral systems, secure funding for ambulance services, strengthen emergency response
Compromise in Quality of Health Services	Poor infrastructure, substandard diagnostics, reduced funding for specialized care	High	Increased health complications, poor diagnosis, decline in overall healthcare quality	Invest in health infrastructure, strengthen diagnostic facilities, maintain quality control measures
Financial Constraints and Funding Challenges	Decline in donor funding, limited government budget, delay in resources disbursement due to government bureaucracy and fear of corruption, high operational costs	High	demands, decline in health infrastructure maintenance, Reduced healthcare services, inability to meet healthcare	Explore alternative funding sources, secure long-term government financial commitments, encourage cost-sharing and PPPs

4.7 PHASES OF TRANSITION AND TIMELINES

The Plan envisions a phased implementation approach that prioritizes building the necessary infrastructure and equipping of the health facilities with appropriate medical and diagnostic equipment, and recruiting, and building capacity of the required personnel to enable the delivery of quality, equitable services during the transition. Additionally, it prioritizes strengthening health facility governance structures to ensure they are functional, effective, efficient, and resilient.

This Plan outlines the different phases of the transition, including timelines and key milestones for each phase. These phases are based on MoH, Transition Guidelines for Refugee Health Services, 2023 and take into account the planned activities in these guidelines, which have been integrated in the proposed phases of the Plan.

Adopting a phased approach during transition is key to allow the government to build the necessary infrastructure, gradually absorb the partner supported staff, recruit additional staff and build the necessary capacity to ensure continuity of quality health care services through a multisectoral approach. A phased transition would also allow time for resource mobilization, making the necessary budget allocations, and alignment, ensuring the continuity, quality, and equity of healthcare services throughout the transition and after.

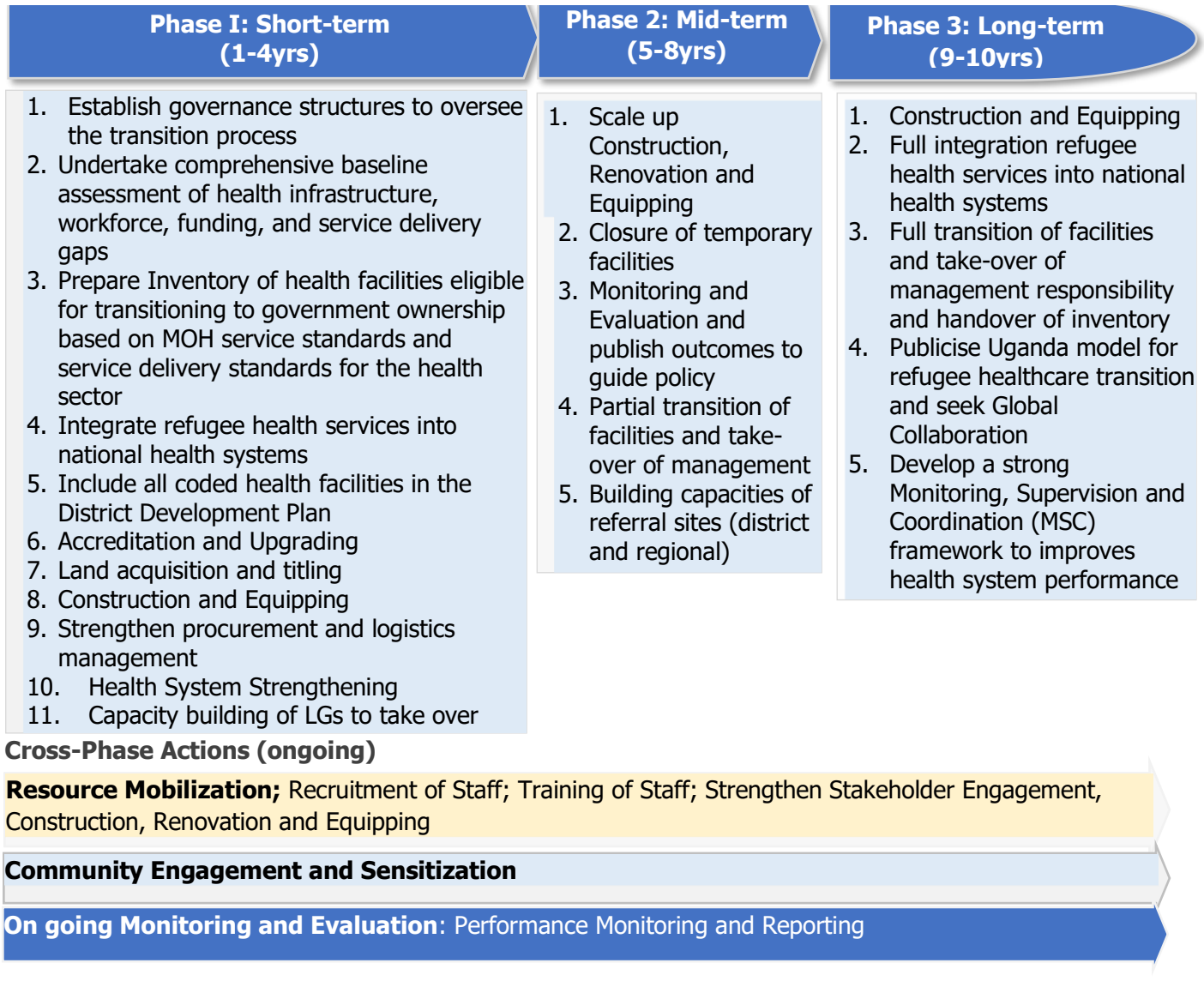
Cognizant of the extensive investment required for infrastructure development, along with the huge wage and non-wage operational costs, the plan is structured into three phases over a 10-year period. These phases are aligned with Uganda Vision 2040, the National Development plan, the Global Refugee compact, the Health Sector Development Plan, UNHCR strategic direction and the Health Sector Integrated Refugee Response Plan II and will be implemented over the next two National Development Plan (NDP) cycles: NDP IV and NDP V.

Phase I: Short-term: 1-4 years - This will involve start up activities, including baseline assessments, infrastructure and human resource development and capacity building, and intensive resource mobilization. Humanitarian partners will continue to support both government and temporary health facilities

Phase 2: Mid-term: 5-8 years – Partial transition involving shared management between government and partners with continued infrastructure, and human resource development, capacity building and resource mobilization.

Phase 3: Long-term 9-10 years - Full Transition with government taking over full management responsibility with the support of partners.

Figure 6: Transition Phases and Process for Health Sector Transition Plan



***Eligible for transition –** A facility is considered eligible for transition when it fulfils MOH service standards and service delivery standards for the health sector

***Partial transition –** Partial transition involves shared management between the government and partners, while infrastructure development, human resource capacity building, and the integration of facilities and systems into the government health system are still in progress.

***Full transition –** Full transition occurs when the government assumes full management responsibility, with partner support, and all facilities and systems are fully integrated into the national health system.

5 FINANCING AND COST ESTIMATES

5.1 RESOURCE MOBILISATION AND FINANCING

Sustainable financing for continuity and quality healthcare under government management will necessitate establishing reliable, long-term funding streams to ensure that services for both refugee and host communities are consistently funded, accessible, and can adapt to changing healthcare demands over time. This process will involve integrating refugee healthcare into the National Development Plan (NDP IV) and national health budget, to guarantee funding for both capital development and operational costs as well as emergency needs for refugee healthcare.

The main sources of financing for the implementation Plan will come from various sources including Government, the UN, Bilateral and Multilateral organisations and humanitarian and development partners and the private sector. The Plan outlines a number of financing options and strategies aimed at enhancing resource mobilisation to support implementation of the Plan and ensure successful transition. The plane establishes expenditure tracking, and accountability systems to ensure prudent use of resources. Efforts will focus on diversifying funding sources through partnerships to mobilize additional financial support to bridge the funding gap and reduce reliance on humanitarian aid.

The Government will disburse funds through the MOH and local governments for the development of infrastructure and securing of human resources for health, medicine and health supplies, information systems and technologies. Effective management of resources through transparent budgeting, expenditure tracking, and accountability systems will be critical to ensure cost-effective solutions and efficient utilization of resources as well as building trust among stakeholders. Additional training for government officials including healthcare managers in financial management, along with regular audits, will be undertaken to ensure responsible and efficient use of resources.

Cognisant of the continued emergency and influx of refugees, humanitarian donors and some partners may continue to directly fund implementing partners to respond to emergencies. However, such a funding modality will be considered in consultation with Government and monitored to ensure alignment with the Transition Strategy and the HSIRRP.

5.2 COSTING OF THE PLAN

The costing of the Plan is based on the assessed current and projected needs and provides indicative estimates of resource requirements for its implementation over the planned period of transition. It takes into consideration the critical gaps identified in infrastructure, human resource and medical supplies that need to be addressed urgently to ensure a successful transition. Key

areas of focus include improving staffing of health facilities to meet recommended government staffing norms; upgrading, expanding and equipping of health facilities; capacity building of facility based and community health extension workers; and medicine and health supplies. Specific costs have been provided for each component establishing clear cost breakdowns. The Plan is estimated to cost about UGX 707,095,713,294 (Uganda Shillings seven hundred seven billion, ninety-five million seven hundred thirteen thousand two hundred ninety-five) equivalent of USD 205,122,126 (Two hundred and five million, one hundred twenty-two thousand one hundred twenty-six United states dollars) during the 15-year period of transition.

5.3 COST ESTIMATES

5.3.1 Summary Financing Plan 2025 -2035 Based on Old Staffing Norms

HEALTH SECTOR BUDGET FOR TRANSITIONING OF PARTNER FACILITIES TO GOVERNMENT PLANNING AND MANAGEMENT (HSPTPF)			
Summary Financing Plan 2025 -2035			
Budget Code	**Description**	**Total Budget in Uganda Shillings**	**Total Budget in USD**
1	Medical Supplies	78,288,000,000	22,368,000
2	Investments (Infrastructure)	15,578,353,789	4,450,958
3	Equipment	14,403,814,642	4,091,376
4	Personnel Costs	408,960,000,000	116,845,714
5	Operation and Maintenance	62,100,000,000	17,742,857
6	Governance	24,900,000,000	7,114,286
7	Training Health Management	16,170,000,000	4,620,000
8	Monitoring and Evaluation	12,540,000,000	3,582,857
9	Referrals Costs	11,190,000,000	3,197,143
10	Financing Costs	100,330,363	2,866,102
11	Overhead	62,865,214,500	18,242,833
Total		**707,095,713,294**	**205,122,126**

The estimated provided are based on the current structures and not the newly approved structures where staffing at Health Centre III is expected to be approximately 55 persons in number compared to the 20 persons in the old structure. And approximately 155 persons for the new structure compared to 50 in the old structure at the Health Centre IV. The new structures are three times more compared to the old structure's and if we adopted the new structures where costs are expected to triple and would settle for an estimated cost of **UGX 2,121,287,139,883** Equivalent of **USD 615,366,379**

		USD
Total for New Structures	**UGX 2,121,287,139,883**	**615,366,379**

The costings have taken into account the standard approach used by the Government of Uganda to compute costs of the health unit establishments. We also know that health services require substantial funding and a standard has been applied to derive the costs of the health service establishments and taking into account the population.

Estimate's Used have been derived as Follows:

- Essential Medicines HC III @ at UGX 58.4 Pa and at Health Center 1v at UGX 166M pa
- Wages HC III @ UGX 296M Pa and Wages at HC IV at UGX 522M pa
- While non-wages at HC III @ UGX 38M Pa and Wages at HC IV at UGX 150M pa
- Estimates for Equipment's have been estimated as listed in the cost estimated budget
- See Tables for Detailed budget and Cost estimates on pages 41 and 43.

5.3.2 Detailed Budget 2025-2035 Based on the New Staffing Norms

HEALTH SECTOR BUDGET FOR TRANSITIONING OF PARTNER FACILITIES TO GOVERNMENT PLANNING AND MANAGEMENT (HSPTPF)

Detailed Budget 2025-2035

Budget Code	Description	Total Budget in Uganda Shillings	Total Budget in USD
1	**Medical Supplies**		
1001	**Essential Medicine and Supplies**		
100100	Essential Medical Supplies	78,288,000,000	22,368,000
	SUB TOTAL FOR MEDICAL SUPPLIES	**78,288,000,000**	**22,368,000**
2	**Investments**		
2001	**Infrastructure and Equipment**		
200101	Settlement Infrastructure	15,578,353,789	4,450,958
	SUB TOTAL FOR INFRUSTRUCTURE	**15,578,353,789**	**4,450,958**
3	**Equipment**		
3001	**Motor vehicles**		
3001101	Coordination Vehicles	2,729,245,202	779,784
3001102	Ambulances	5,573,089,440	1,592,311
3001103	Motorcycles	1,800,000,000	514,286
3002	**Other Equipment**		
300201	Hospital Equipment	4,301,480,000	1,204,994
	SUB TOTAL FOR EQUIPMENT	**14,403,814,642**	**4,091,376**
4	**Personnel Costs**		
4001	**Staff Costs**		

400102	Wages	377,640,000,000	107,897,143
400103	Non-Wage	31,320,000,000	8,948,571
	SUB TOTAL FOR STAFF COSTS	**408,960,000,000**	**116,845,714**
5	**Operational Costs**		
5001	**Operation and Maintenance Costs**		
500101	Health Governance	62,100,000,000	17,742,857
	SUB TOTAL O&M COSTS	**62,100,000,000**	**17,742,857**
6	**Governance**		
6001	**Governance and Management**		
600101	Health Governance with in the HC 111 and 1V	24,900,000,000	7,114,286
	SUB TOTAL GOVERNANCE	**24,900,000,000**	**7,114,286**
7	**Training Health Management**		
7001	**Training Health Management**		
700101	Health Training	16,170,000,000	4,620,000
	SUB TOTAL TRAINING	**16,170,000,000**	**4,620,000**
8	**Monitoring and Evaluation**		
8001	**M&E**		
800101	Monitoring and Evaluation	12,540,000,000	3,582,857
	SUB TOTAL M&E	**12,540,000,000**	**3,582,857**
9	**Referrals**		
9001	**Referrals**		
900101	**Referrals Between HC III and HC IV / General Hospital**	**11,190,000,000**	**3,197,143**
10	**Financing Costs**		
10001	**Charges**		
1000101	Bank Charges and Financing Costs 0.02%	100,330,363	2,866,102
	SUB TOTAL FINANCING COSTS	**100,330,363**	**2,866,102**
11	**Overhead**		
11001	Overhead Costs		
1100101	Overhead Costs 10%	62,865,214,500	18,242,833
	SUB TOTAL CONTINGENCY	**62,865,214,500**	**18,242,833**
Total		**707,095,713,294**	**205,122,126**

5.3.3 Health Sector Budget for Transitioning of Partner Facilities to Government Planning and Management

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
1							
1001	**Medical Supplies**						
100101	HC III	Essential Medical Supplies	78.00	58,400,000	15	68,328,000,000.00	19,522,285.71
	HC IV	Essential Medical Supplies	4.00	166,000,000	15	9,960,000,000.00	2,845,714.29
		TOTAL For Medical Supplies				**78,288,000,000.00**	**22,368,000.00**
2	**Investments**						
2001	**Infrastructure and Equipment**						
200101	Settlement Infrastructure		78.00	173,671,726	1	13,546,394,599.00	3,870,398.46
	Renovations (20%)					2,031,959,189.85	580,559.77
		Subtotal Infrastructure				**15,578,353,789**	**4,450,958**
3	**Equipment**						
3001	**Motor vehicles**						
3001101	Coordination Vehicles						
		Ivempi	2	136,462,260	2	545,849,040	155,957
		Rhino	2	136,462,260	2	545,849,040	155,957
		Obongi	1	136,462,260	2	272,924,520	77,978
		Adjumani	1	136,462,261	2	272,924,522	77,978
		Kyaka	2	136,462,260	2	545,849,040	155,957
		Nakivale	2	136,462,260	2	545,849,040	155,957
		Subtotal				**2,729,245,202**	**779,784**

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
3001102	Ambulances						
		Burial van - Arua	1	154,808,040	2	309,616,080	88,462
		Kyangwali	2	154,808,040	2	619,232,160	176,923
		Moyo	2	154,808,040	2	619,232,160	176,923
		Arua (Rhino, Ivempi)	2	154,808,040	2	619,232,160	176,923
		Koboko	1	154,808,040	2	309,616,080	88,462
		Nakivale	2	154,808,040	2	619,232,160	176,923
		Lamwo	1	154,808,040	2	309,616,080	88,462
		Kiryandongo	1	154,808,040	2	309,616,080	88,462
		Yumbe	2	154,808,040	2	619,232,160	176,923
		Kyegegwa	1	154,808,040	2	309,616,080	88,462
		Adjumani	2	154,808,040	2	619,232,160	176,923
		Kamwenge	1	154,808,040	2	309,616,080	88,462
		Subtotal				**5,573,089,440**	**1,592,311**
3001103	Motorcycles						
		Kyangwali	12	7,500,000	2	180,000,000	51,429
		Moyo	12	7,500,000	2	180,000,000	51,429
		Arua (Rhino, Ivempi)	12	7,500,000	2	180,000,000	51,429
		Nakivale	12	7,500,000	2	180,000,000	51,429
		Lamwo	12	7,500,000	2	180,000,000	51,429
		Kiryandongo	12	7,500,000	2	180,000,000	51,429
		Yumbe	12	7,500,000	2	180,000,000	51,429

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Kyegegwa	12	7,500,000	2	180,000,000	51,429
		Adjumani	12	7,500,000	2	180,000,000	51,429
		Kamwenge	12	7,500,000	2	180,000,000	51,429
		Subtotal				**1,800,000,000**	**514,286**
3002	**Other Equipment**						
300201	**Hospital Equipment**						
1	Ultrasound scan						
		Bidibidi	1	30,000,000	2	60,000,000	17,143
		Kyangwali	1	30,000,000	2	60,000,000	17,143
		Nakivale	1	30,000,000	2	60,000,000	17,143
2	Hospital beds				2	-	
		Bidibidi	50	950,000	2	95,000,000	27,143
		Ivempi	50	950,000	2	95,000,000	27,143
		Rhino	100	950,000	2	190,000,000	54,286
3	Cold Chain Fridges				2	-	
		Kyangwali	3	35,000,000	2	210,000,000	60,000
		Yumbe	5	35,000,000	2	350,000,000	100,000
		Moyo	3	35,000,000	2	210,000,000	60,000
		Lamwo	1	35,000,000	2	70,000,000	20,000
		Kyaka	2	35,000,000	2	140,000,000	40,000
		Arua	3	35,000,000	2	210,000,000	60,000
4	Cold chain boxes					-	
		Adjumani	4	600,000	2	4,800,000	1,371

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Bidibidi	8	600,000	2	9,600,000	2,743
		Parabek	4	600,000	2	4,800,000	1,371
		Kyaka	4	600,000	2	4,800,000	1,371
		Kiryandondo	4	600,000	2	4,800,000	1,371
		Kyangwali	4	600,000	2	4,800,000	1,371
		Rwamwanja	4	600,000	2	4,800,000	1,371
		Nakivale	16	600,000	2	19,200,000	5,486
		Oruchinga	4	600,000	2	4,800,000	1,371
5	Vaccines Carriers					-	
		Adjumani	8	150,000	2	2,400,000	686
		Bidibidi	16	150,000	2	4,800,000	1,371
		Parabek	8	150,000	2	2,400,000	686
		Kiryandongo	8	150,000	2	2,400,000	686
		Arua	17	150,000	2	5,100,000	1,457
		Kyangwali	8	150,000	2	2,400,000	686
		Kyaka	8	150,000	2	2,400,000	686
		Rwamwanja	8	150,000	2	2,400,000	686
		Nakivale	8	150,000	2	2,400,000	686
		Oruchinga	8	150,000	2	2,400,000	686
7	CD4 machine					-	
		Adjumani	1	42,000,000	2	84,000,000	24,000
		Parolinya	1	42,000,000	2	84,000,000	24,000
8	CBC Machine					-	

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Kyangwali	2	35,000,000	2	140,000,000	40,000
		Kyaka II	1	35,000,000	2	70,000,000	20,000
		Oruchinga	1	35,000,000	2	70,000,000	20,000
		Rwamwanja	1	35,000,000	2	70,000,000	20,000
		Imvepi	1	35,000,000	2	70,000,000	20,000
		kiryandongo	1	35,000,000	2	70,000,000	20,000
		Parolinya	1	35,000,000	2	70,000,000	20,000
		Nakivale	1	35,000,000	2	70,000,000	20,000
9	Chemistry Anaylzer				2	-	
		Kyaka II	1	10,000,000	2	20,000,000	5,714
		Rwamwanja	1	10,000,000	2	20,000,000	5,714
		Nakivale	2	10,000,000	2	40,000,000	11,429
		kyangwali	2	10,000,000	2	40,000,000	11,429
		Parolinya	1	10,000,000	2	20,000,000	5,714
						-	
10	Viral Load counter					-	
		Nakivale	1	40,000,000	2	80,000,000	22,857
		Kyaka II	1	40,000,000	2	80,000,000	22,857
		Rwamwanja	1	40,000,000	2	80,000,000	22,857
		Parolinya	1	40,000,000	2	80,000,000	22,857
11	Resuscitation Equipment (ample bags, bulb syringes, Stethoscopes)	Parolinya	10	200,000	2	4,000,000	1,143
		Nakivale/oruchinga	10	200,000	2	4,000,000	1,143

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Kyaka II	5	200,000	2	2,000,000	571
		Rwamwanja	5	200,000	2	2,000,000	571
		Imvepi	3	200,000	2	1,200,000	343
		Rhino	7	200,000	2	2,800,000	800
12	Incubators	Imvepi	3	7,000,000	2	42,000,000	12,000
		Rwamwanja	4	7,000,000	2	56,000,000	8,000
		Kyaka II	4	7,000,000	2	56,000,000	8,000
		Nakivale	4	7,000,000	2	56,000,000	8,000
		Rhino	7	7,000,000	2	98,000,000	28,000
		Parolinya	4	7,000,000	2	56,000,000	16,000
		kyangwali	1	7,000,000	2	14,000,000	4,000
						-	
13	Hemocue machines					-	
		Arua (Imvepi, Rhino Camp)	3	2,870,000	2	17,220,000	4,920
		Lobule	1	2,870,000	2	5,740,000	1,640
		Bidibidi	3	2,870,000	2	17,220,000	4,920
		Palabek	2	2,870,000	2	11,480,000	3,280
		Adjumani	3	2,870,000	2	17,220,000	4,920
		Palorinya	3	2,870,000	2	17,220,000	4,920
		Kiryandongo	2	2,870,000	2	11,480,000	3,280
		Kyaka II	3	2,870,000	2	17,220,000	4,920
		Kyangwali	3	2,870,000	2	17,220,000	4,920
		Rwamwanja	2	2,870,000	2	11,480,000	3,280

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Nakivale	3	2,870,000	2	17,220,000	4,920
		Oruchinga	1	2,870,000	2	5,740,000	1,640
14	Height boards					-	
		Kyangwali	6	520,000	2	6,240,000	1,783
		Moyo	4	520,000	2	4,160,000	1,189
		Arua (Rhino, Ivempi)	5	520,000	2	5,200,000	1,486
		Koboko	1	520,000	2	1,040,000	297
		Nakivale	6	520,000	2	6,240,000	1,783
		Lamwo	5	520,000	2	5,200,000	1,486
		Kiryandongo	3	520,000	2	3,120,000	891
		Yumbe	8	520,000	2	8,320,000	2,377
		Kyegegwa	4	520,000	2	4,160,000	1,189
		Adjumani	7	520,000	2	7,280,000	2,080
		Kamwenge	3	520,000	2	3,120,000	891
15	Electronic weighing scales					-	
		Kyangwali	12	430,000	2	10,320,000	2,949
		Moyo	8	430,000	2	6,880,000	1,966
		Arua (Rhino, Ivempi)	10	430,000	2	8,600,000	2,457
		Koboko	2	430,000	2	1,720,000	491
		Nakivale	12	430,000	2	10,320,000	2,949
		Lamwo	10	430,000	2	8,600,000	2,457
		Kiryandongo	6	430,000	2	5,160,000	1,474
		Yumbe	16	430,000	2	13,760,000	3,931

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Kyegegwa	8	430,000	2	6,880,000	1,966
		Adjumani	14	430,000	2	12,040,000	3,440
		Kamwenge	6	430,000	2	5,160,000	1,474
16	Computers						
		Adjumani	11	3000000	2	66,000,000	18,857
		Nakivale	8	3000000	2	48,000,000	13,714
		Oruchinga	3	3000000	2	18,000,000	5,143
		Imvepi	4	3000000	2	24,000,000	6,857
		Kyaka	12	3000000	2	72,000,000	20,571
		Rwamwanja	6	3000000	2	36,000,000	10,286
		kyangwali	5	3000000	2	30,000,000	8,571
		Rhino	15	3000000	2	90,000,000	25,714
		Parabek	5	3000000	2	30,000,000	8,571
		Kiryandongo	4	3000000	2	24,000,000	6,857
		Bidibidi	10	3000000	2	60,000,000	17,143
		Sub total				**4,301,480,000.000**	**1,204,994.286**
4	**Personnel Costs**						
4001	**Staff Costs**						
400101	**Wages**						
		HC III	78	296,000,000	15	346,320,000,000	98,948,571
		HC IV	4	522,000,000	15	31,320,000,000	8,948,571
		Sub-Total Wages				**377,640,000,000**	**107,897,143**

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
400102	**Non-Wages**						
	Non-Wage	**HC III**	78	38,000,000	15	44,460,000,000	12,702,857
	Non-Wage	**HC IV**	4	150,000,000	15	9,000,000,000	2,571,429
		Subtotal non-wage				**53,460,000,000**	**15,274,285.714**
5	**Operational Costs**						
5001	**Operation and Maintenance Costs**						
500101	Health Governance Within HC III and IV	HC III	78	50,000,000	15	58,500,000,000	16,714,286
		HC IV	4	60,000,000	15	3,600,000,000	1,028,571
		Sub-Total Operational Costs				**62,100,000,000**	**17,742,857**
6	**Governance**						
6001	**Governance and Management**						
600101	Health Governance	**HC III**	78	20,000,000	15	23,400,000,000	6,685,714
		HC IV	4	25,000,000	15	1,500,000,000	428,571
		Sub-Total Operational Costs				**24,900,000,000**	**7,114,286**
7	**Training**						
7001	**Training Health Management**						
700101	Health Training	**HC III**	78	13,000,000	15	15,210,000,000	4,345,714
		HC IV	4	16,000,000	15	960,000,000	274,286

Budget Code	Description		Unit	Unit price	Period	Total Cost in UGX	Total Costs in USD
		Sub-Total Operational Costs				**16,170,000,000**	**4,620,000**
8	**Monitoring and Evaluation**						
8001	**M & E**						
800101	M and E	**HC III**	78	10,000,000	15	11,700,000,000	3,342,857
		HC IV	4	14,000,000	15	840,000,000	240,000
		Sub-Total Operational Costs				**12,540,000,000**	**3,582,857**
9	**Referrals**						
9001	**Referrals**						
900101	Referrals Between HC III and HC IV/General Hospital	**HC III**	78	9,000,000	15	10,530,000,000	3,008,571
		HC IV	4	11,000,000	15	660,000,000	188,571
		Sub-Total Operational Costs				**11,190,000,000**	**3,197,143**

6 MONITORING, EVALUATION AND LEARNING (MEL)

The plan outlines a Monitoring, Evaluation, and Learning (MEL) system that is crucial for ensuring systematic tracking of the transition progress, enabling evidence-based decision making and timely adjustments to strategies and actions for improved outcomes. The M&E Framework includes objectives, strategic actions, activities, key performance indicators and targets across the different implementation phases.

The system will collect, analyze, and regularly present real-time data that inform all relevant stakeholders, providing insights into the effectiveness of interventions as well as fostering transparency and accountability. Overall, the proposed MEL will enhance accountability to stakeholders, optimize resource allocation, and facilitate continuous learning and adaptive management to drive performance improvement to maximize the long-term effectiveness of the transition actions.

Objective	Strategic Intervention	Activities	Indicators	Target	Responsibility
Integrate refugee healthcare into national systems, ensuring a harmonized, sustainable financing approach	Integration of services for sustainability	Conduct comprehensive baseline of refuge healthcare services in the country	Baseline survey report	1	OPM, MoFPED, MoH, DLG, Partners
		Integration of refugee healthcare into national, health sector and district frameworks (policies, strategies, plans and budgets)	# of refugee hosting districts with DDPs integrating refugee healthcare	13	MoH, DLG, OPM
		Train health workers in integrated planning, ensuring unique needs of refugees are incorporated	# of health workers trained on integrated planning by gender	TBD# OF	MoH, DLG.
		Engage refugee and host communities in planning and decision-making to ensure services are relevant and effective	# of refugees and host communities trained in planning and decision-making by gender	TBD	OPM, DLG, Partners, NGOs
		Assess progress in service integration under the different phases of transition	# of evaluation reports on integration	3	MoH, DLG, OPM, Partners.
	Financing harmonization for optimal resource use	Conduct resource mapping to assess current financial flows in refugee healthcare and identify gaps to guide equitable allocation across the RHDs and settlements.	# resource mapping report	1	MoH, DLG, Partners
		Lobby government and development partners for increased refugee healthcare funding	% increase in resources for refugee healthcare funding	80%?	MoH, DLG, OPM, Partners
		Advocate for a joint financing mechanism combining donor contributions with government to ensure a unified and predictable funding pool to support transition of refugee health services	na	na	
		Advocate for high-level government support to prioritize resource allocation for refuge healthcare	% increase in resources for refugee healthcare funding	90%	OPM, MoFPED, MOH, Partners
		Seek out for new international funding sources, including global health partnerships	% increase in resources for refugee healthcare funding	50%	MoH, DLG, OPM
		Advocate for refugee health insurance scheme to facilitate access to services during the transition phase.	# of healthcare insurance schemes for refugees established	13	MoH, DLG, OPM Partners,
Improve health infrastructure to	Upgrading and Equipping	Construct and upgrade health facilities	# of health facilities constructed and or upgraded	TBD	MoH, DLG, Partners.

increase access to quality and equitable healthcare services for refugees and host communities		Maintenance of the assent inventory on quarterly basis by facilities	# facilities maintaining the inventory	TBD	DLG, Partners.
		Equip health facilities with essential medical equipment according to level of service delivery.	# of health facilities equipped by type of equipment's	TBD	MoH, DLG, Partners,
		Conduct infrastructure audits to ensure infrastructure upgrades are maintained during transition	#of infrastructure audit carried out.	40	MoH, MoWT, DLG,
Strengthen human resource capacity for improved healthcare delivery, and better health outcomes for refugees and host communities	Timely recruitment, deployment and retention of health workers	Advocate for expedited clearance, recruitment and deployment processes	# of staff recruited by cadre by gender by refugee hosting district in the health sector	TBD	MoPS, MoH, MoFPED, OPM
		Facilitate integration of partner supported refugee health workers into the national health workforce through affirmative action	# of health care staff integrated	TBD	MoPS, MoH, MoFPED, OPM
		Advocate for the recruitment of qualified refugee health professionals into the national workforce where possible.	# of qualified professional refugees recruited by gender and qualifications recruited	TBD	MoPS, MoH, MoFPED, OPM
	Conduct professional development	Conduct Training needs assessment among refugee healthcare workers to identify skill gaps	Refugees Training needs assessment report	1	MoH, DLG
		Develop a targeted capacity building plan to address identified skill gaps and enhance service delivery during transition.	Report on Capacity building plan	1	MoH, DLG
		Conduct tailored training of healthcare workers to address refugee health needs and transition demands.	# of health staff trained	TBD	MoH, DLG
		Train and deploy refugee and host community CHWs to raise awareness for transition and deliver basic health services in the settlements and host communities.	# of CHWs trained by gender and training area	TBD	DLG, NGOs
		Conduct support supervision, mentorship and coaching to support the transition process.	# of support supervision carried out during transition	40	MoH, DLG, Partners
	Improving welfare for staff	Provide decent accommodation	# of staff houses built for health workers	TBD	MoH, DLG, Partners
Enhance access to essential medicines		Assess the existing supply chain to identify key gaps, bottlenecks, and inefficiencies.	Assessment report on supply chain management in health	1	MoH, DLG, Partners,

and medical supplies for improved patient care and health outcomes for refugees and host communities	Strengthening Supply Chain Systems	Develop a procurement and distribution plan for sustainable supply of medicines and other commodities for refugee healthcare	Procurement plan developed for medicines in refugee hosting districts	2	MoH, DLG, Partners,
		Secure agreements with reliable prequalified suppliers for better coordination and ensuring steady flow of essential commodities.	# of supply contracts signed with prequalified suppliers by type and quantity of goods to supply	TBD	MoH, DLG
	Digitalizing inventory tracking and monitoring	Establish an inventory tracking software or system for efficient inventory tracking and distribution.	An inventory tracking software or system established.	1	MoH, DLG, Partners,
		Train staff in digital inventory management, demand forecasting, and efficient distribution	# of staff trained in digital inventory management	TBD	MoH, DLG,
		Train staff in IMAT and SPARS Supervision, Performance Assessment, and Recognition Strategy (SPARS) to increase health workers' ability to manage medicines through on- the-job training	# of staff trained in IMAT and SPARS	39	DLG, UNHCR, Partners
Strengthen governance and management systems to enhance coordination, accountability, and resource utilization for efficient and effective healthcare delivery	Develop Conflict Sensitivity and Inclusion Measures to Support Cohesion	Train all stakeholders on conflict-sensitive approaches to ensure fair and inclusive transition planning and implementation.	# of stakeholders trained on conflict-sensitive approaches	TBD	MoLG, OPM, MoH, DLG, Partners
		Conduct joint community-building activities, such as sports, cultural events, and festivals, to strengthen relationships between host and refugee communities.	# community activities involving refugees and host communities carried out by type	26	OPM, DLGs/UNHCR
		Develop grievance and dispute resolution mechanisms to address any conflicts that arise during the transition.	A dispute Grievance mechanism plan developed.	1	MoLG, OPM, MoH, DLG, Partners
		Promote inclusive programming that targets the needs of vulnerable groups (e.g., women, youth, persons with disabilities) in refugee and host communities.	# of programs implemented by type that target vulnerable group	13	OPM/UNHCR/DLGs
	Leadership capacity building	Orientate the established coordination structures on their roles and responsibilities to streamline decision making processes at various levels.	# of established coordination structures oriented on their roles and responsibilities	17	MoFPED, MoLG, DLG, Partners, NGOs.
		Conduct leadership and management training for technical staff, Political leaders, Local leaders, Religious, Founders	# of staff trained on leadership and management	TBD	DLG, Partners, NGOs.

		Refugees, Cultural leaders... etc. in various leadership skills, governance, planning, and resource management, community mobilization, mediation, advocacy and land acquisition and management.	# of political leaders trained on leadership and management # of religious leaders trained on leadership and management # of culture leaders trained on leadership and management		
	Enhancing Stakeholder collaboration for enhanced coordination and optimal resource utilization	Assess coordination mechanisms to guide the review of MoH guidelines for refugee health services to ensure effective participation of all relevant stakeholders in planning and management of refugee healthcare services ensuring a unified approach to service delivery	Assessment Report on the coordination mechanisms finalized to guide the review of MoH guidelines for refugee health services	1	MOH, MoFPED, Partners, DLG
		Support district level coordination structures such as the Extended District Health Team, the District Refugee Oversight Committee to ensure their functionality	# of district level coordination structures supported to undertake coordination activities	39	DLG, Partners, MoH
		Create coordination platforms to promote governance practices and trust and, ensure continuous feedback at all levels.	# of coordination platforms at the settlement level created.	13	OPM, DLG, Partners, UNHCR,
		Support regular coordination meetings bringing together various stakeholders to review implementation progress at various levels.	# of stakeholders' coordination review meetings	TBD	MoLG, OPM, MoH, DLG, Partners, NGOs
	Use of data driven approaches for decision making and planning	Implement robust M&E systems to track progress, assess impact, and adjust strategies based on evidence for better outcomes.	M&E system established	1	MOH, DLGs, MoLG, OPM
		Strengthen capacity in data management, ensuring linkage of refugee health related data with national health systems for comprehensive planning, monitoring and resource allocation	# of staff trained in data management	TBD	MoH, DLG, Partners.

7 REFERENCES

1) MoH Annual Health Sector Performance Report 2023/24
2) MoH Strategic Plan 2020/21 - 2024/25
3) MoH Health Sector Integrated Refugee Response Plan (2019-2024)
4) MoH Health Financing Strategy 2015/2016 - 2024/2025
5) National population and housing census, UBOS 2014
6) MoH Second National Health Policy 2010/11 - 2019/20
7) Uganda Demographic and Health Survey, UBOS 2016
8) UNFPA, Annual Report, 2023

ANNEX

ANNEX I: STAFFING GAP ANALYSIS MATRIX

Table 6: Public HR Gaps in RHDs

	Staffing		Number	Unit cost	Months	UGX	USD
						-	-
1	Doctors	Kyangwali	3	2,500,000	12	90,000,000	25,714
		Kiryandongo	1	2,500,000	12	30,000,000	8,571
						-	-
	Sub Total (Doctors)		**4**	**5,000,000**		**120,000,000**	**34,285**
2	Clinical Officers	Palorinya	1	1,500,000	12	18,000,000	5,143
		Oruchinga	1	1,500,000	12	18,000,000	5,143
		Rwamwanja	4	1,500,000	12	72,000,000	20,571
		Kyangwali	11	1,500,000	12	198,000,000	56,571
		Kiryandongo	12	1,500,000	12	216,000,000	61,714
		Nakivale	5	1,500,000	12	90,000,000	25,714
	Sub Total (Clinical Officers)		**34**	**9,000,000**		**612,000,000**	**174,856**
3	Nurses	Palorinya	6	1,000,000	12	72,000,000	20,571
		Kyaka	10	1,000,000	12	120,000,000	34,286
		Nakivale	10	1,000,000	12	120,000,000	34,286
		Kiryandongo	31	1,000,000	12	372,000,000	106,286
		Rwamwaja	11	1,000,000	12	132,000,000	37,714
		Kyangwali	23	1,000,000	12	276,000,000	78,857
		Oruchinga	3	1,000,000	12	36,000,000	10,286

	Staffing		Number	Unit cost	Months	UGX	USD
	Sub Total (Nurses)		**94**	**7,000,000**		**1,128,000,000**	**322,286**
4	Midwives	Palorinya	2	1,000,000	12	24,000,000	6,857
		Kyaka II	13	1,000,000	12	156,000,000	44,571
		Nakivale	4	1,000,000	12	48,000,000	13,714
		Kiryandongo	17	1,000,000	12	204,000,000	58,286
		Kyangwali	19	1,000,000	12	228,000,000	65,143
		Rwamwanja	5	1,000,000	12	60,000,000	17,143
	Sub Total (Midwives)		**60**	**6,000,000**		**720,000,000**	**205,714**
5	Laboratory technician	Nakivale	1	1,000,000	12	12,000,000	3,429
		Kiryandongo	4	1,000,000	12	48,000,000	13,714
		Palorinya	2	1,000,000	12	24,000,000	6,857
		Rwamwanja	5	1,000,000	12	60,000,000	17,143
		Kyangwali	6	1,000,000	12	72,000,000	20,571
	Sub Total (Laboratory technician)		**18**	**5,000,000**		**216,000,000**	**61,714**
6	Pharmacist	Rwamwanja	1	1,000,000	12	12,000,000	3,429
		Kiryandongo	1	1,000,000	12	12,000,000	3,429
	Sub Total (Pharmacist)		**2**	**2,000,000**		**24,000,000**	**6,858**
7	Nutritionist	Kyagwali	5	1,000,000	12	60,000,000	17,143
		Kyaka II	5	1,000,000	12	60,000,000	17,143
		Kiryandongo	2	1,000,000	12	24,000,000	17,143
		Palorinya	3	1,000,000	12	36,000,000	10,286
	Sub Total (Nutritionist)		**15**	**4,000,000**		**180,000,000**	**61,715**
8	Anesthetic Officer	Rwamwanja	1	1,000,000	12	12,000,000	3,429
		Nakivale	1	1,000,000	12	12,000,000	3,429

	Staffing		Number	Unit cost	Months	UGX	USD
		Kyagwali	2	1,000,000	12	24,000,000	6,857
		Imvepi & Rhino	2	1,000,000	12	24,000,000	6,857
	Sub Total (Anaesthetic Officer)		**6**	**4,000,000**		**72,000,000**	**20,572**
9	Radiographer	Rwamwanja	1	1,000,000	12	12,000,000	3,429
		Kiryandongo	2	1,000,000	12	24,000,000	6,857
		Nakivale	1	1,000,000	12	12,000,000	3,429
		Imvepi and Rhino	1	1,000,000	12	12,000,000	3,429
	Sub Total (Radiographer)		**5**	**4,000,000**		**60,000,000**	**17,144**
10	Data clerks	Nakivale	1	1,000,000	12	12,000,000	3,429
		Rwamwanja	7	1,000,000	12	84,000,000	24,000
		Kyaka	9	1,000,000	12	108,000,000	30,857
		Kyangwali	1	1,000,000	12	12,000,000	3,429
		Kiryandongo	5	1,000,000	12	60,000,000	17,143
	Sub Total (Data clerk)		**23**	**5,000,000**		**276,000,000**	**78,858**
11	Health Inspector	Kyangwali	1	1,000,000	12	12,000,000	3,429
		Kiryandongo	2	1,000,000	12	24,000,000	6,857
						-	-
	Sub Total (Health Inspector)		**3**	**2,000,000**		**36,000,000**	**10,286**
12	Stores Assistant	Kiryandongo	2	1,000,000	12	24,000,000	6,857
		Nakivale	1	1,000,000	12	12,000,000	3,429
		Kyangwali	2	1,000,000	12	24,000,000	6,857
	Sub Total (Stores Assistant)		**5**	**3,000,000**		**60,000,000**	**17,143**
13	Dental officer	Nakivale	1			-	-

	Staffing		Number	Unit cost	Months	UGX	USD
	Sub Total (Dental officer)		**1**	**-**	**-**	**-**	**-**
14	Counsellors	Nakivale	1			-	-
		Oruchinga	1			-	-
		Rwamwanja	1			-	-
		Kyaka II	2			-	-
	Sub Total (Counsellors)		**5**	**-**	**-**	**-**	**-**
15	Ophthalmia	Nakivale	1			-	-
	Sub Total (Ophthalmia)		**1**	**-**	**-**	**-**	**-**
16	Support Staff	Palorinya	6	500,000	12	36,000,000	10,286
		Oruchinga	6	500,000	12	36,000,000	10,286
		Rwamwanja	13	500,000	12	78,000,000	22,286
		Kyaka	22	500,000	13	143,000,000	40,857
		Kyangwali	29	500,000	12	174,000,000	49,714
		Kiryandongo	34	500,000	12	204,000,000	58,286
		Nakivale	18	500,000	12	108,000,000	30,857
	Sub Total (Support Staff)		**128**	**3,500,000**		**779,000,000**	**222,572**
Overall Total			**404**	**59,500,000**		**4,283,000,000**	**1,234,003**

ANNEX II: INFRASTRUCTURE GAP ANALYSIS MATRIX

Table 7: Public Health Infrastructure Gaps in RHDs

No.	Item	Location	Qty (Gaps)	comment
Infrastructure				
1.	Accommodation for staff	Lamwo (5 units per block)	4	Paula H/C -2, Awich H/C -2
		Moyo (5 units per block)	43	itula-5, parolinya -5, ibowa-5, ibakwe-5, idiwa-5, lulu-5, kali-3, belle5, belameling-5,
		Palorinya settlement (5 units per block) staff	2	accommodation at COVID management facility Basecamp
		Adjumani (5 units per block)	5	
		Kiryandongo (5 units per block)	7	Panyadoli HC III -4, nyakadoti HC II -2 Panyadoli Hills
		Kyangwali (5 units per block)	22	Rwenyawawa - 6, Nguruwe -3, Malembo C 1 maratatu B - -6 and kasonga -2, kwangwali -4
		Imvepi (1 block of staff accommodation for 5 staff)	25	Imvepi HCII -10, Yinga HCIII -10, & Imvepi zone3 HC 5
		Rhino Camp (1 block of staff accommodation for 5 staff)	21	Ocea HC 3, Olujobu HC 2, Omugo 3 HC 5, Ofua 3 HC 5, Omugo HCIV 3 and Rhino HCIV 3
		Lobule (1 block of staff accommodation for 5 staff)	10	Lurujo HC 3, Kuluba HC 2, Pijoke HC 3 & Lobule HC 2 (40 staff not accomodated in HF)
		Kyaka (5 units per block)	9	Bujumbuli H/C III - 6, mukondo -3
		Nakivale (5 units per block)	9	Nakivale-2, Juru-1, Kibengo-1, Rubondo-2, Ruhoko-1, Rwekubo-2
		Oruchinga (5 units per block)	2	Nshungyezi-1 and Rulongo-1
		Matanda (5 units per block)	2	Matanda HC III
		Nyakabande (5 units per block)	2	Nyakabande HC III
		Ntoroko(5 units per block)	2	Ntoroko HC III
		Rwamwanja (5 units per block)	10	Rwamwanja HC III-4, kempango-2, mahega -2, Ntenugi-2
	New complete Health facilities	Palorinya	2	Idiwa, Lulu,
		Rhino Camp (Omugo 2, Ofua 3)	2	Omugo 2, Ofua 3
		Imvepi (Imvepi zone 3 HC)	1	Ivempi Zone 3 HC
		Rwamwanja	2	Ntenungi HC II, Mahani HC II
		Kyaka II	2	Itambabiniga, Bwiriza

No.	Item	Location	Qty (Gaps)	comment
		Nakivale	1	Ruhoko
		IPD in Zombo	1	Zombo
		Point of entry isolation unit	1	Zombo
		Maternity ward	1	Zombo
		Imvepi	1	medicines store in imvepi
		Kyangwali	1	Maratatu
	Expansion of existing health facilities	Bidibidi (isolation units)	5	iyetie koro, swinga, yayari, jomorog, kombe, yoyo, igamara, bolomoni, ayiro, okubani
		Nutrition unit in Rwamwanja	1	Rwamwanja HC III
		Rwamwaja (OPD and paediatric ward, ART clinic, Medicine warehouse, IPD)	7	Rwamwanja HC III(OPD, Paediatric ward, ART clinic, medicine ware house), Kempango-IPD and Mehega-IPD & Maternity unit
		Oruchinga (IPD, Renovation & expansion of Maternity unit, isolation ward, mortuary)	4	IPD-Nshungezi HC III, Renovation & expansion of maternity unit-Nshungezi HCIII, Isolation ward-Nshungezi HC III & Mortuary-Nshungezi HC III
		Ntoroko (IPD, isolation ward and maternity unit)	3	Ntoroko HC III
		Palorinya	1	Kitchen for COVID 19 management facility
		Adjumani (Maternity Block in Pagirinya)	3	Pagirinya HC, Nyumazi and Mungula
		Parolinya (maternity	3	Belameling
		Bidibid (Nutrition unit)	1	Bidibidi
		Expansion of medicines store in Bidibidi	1	Bidibidi
		Rhino (6 IPDs)	6	Olujobu HC, Oduobu HC, Siripi HC, Ocea HC, Omugo 2, Ofua 3
		Nutrition unit Lamwo	2	Paula H/C -2, Awich H/C -2
		Nutrtion Unit Arua (Rhino, Imvepi, Koboko)	13	Olujobu HC, Oduobu HC, Siripi HC, Ocea HC, Omugo 2, Uriama HCIII; Ocia HCIII, Lobule, Pijoke, Lurujo, Yinga, Imvepi HCIII, Imvepi Z3 HCII
		Rhino (Waiting sheds - siripi, Oduobu and Omugo)	3	Siripi, Oduobo, Omugo HFs
		Imvepi & Rhino	1	Medicines warehouse

No.	Item	Location	Qty (Gaps)	comment
		Parolinya (OPDs)	4	Palorinya HC III, Ibowa HC II , Belameling HC III AND Ibakwe HC II
		Parolinya (isolation units)	5	ibakwe, blemilin, luru, idiwa, bele
		Parolinya (Inpatient wards)	3	Belameling HC III, Palorinya HC III, Belle HC III, Idiwa HC III, Luru HC III.
		Koboko (1 OPD blocks)	1	Lurujo
		Imvepi (1 IPD blocks)	1	zone 3 HC
		Koboko (1 IPD blocks)	1	Kuluba
		Kyangwali (laboratory)	1	Malembo
		Kiryandongo (maternity)	2	Panyadoli Hills & Nyakadote
		kyangwali surgical ward	1	Kwangwali H/C
		malembo B OPD	1	malembo B OPD
		kyangwali maternity ward	1	Kwangwali H/C
		kywangwali nutrition unit	1	Kwangwali H/C
		Kyangwali (maternity)	2	Nuguru, Malembo B
		Kyangwali (OPD)	1	Kituti govt HF
		Kyangwali (TB ward)	1	Kyangwali
		Rwenyawawa (1 ART clinic)	2	Rwenyewewa, kituti
		Kyaka (Waiting shed - Bujumbuli)	3	Waiting sheds-Bujibuli HC III, Mukondo HC III & Bwiriza HC,
		Kyaka (ART clinic)	1	Bujumbuli H/C III
		Kyaka (Bujumbuli) Maternity ward	1	Bujumbuli H/C III
		Rwamwanja (ART Clinic)	1	Rwamwanja HC III
		Kyaka OPD	1	Bujubuli HC III
		Kyaka IPD	1	Mukondo HC III
		Kyakya (bujumbili - EPI shelter)	1	Bujumbuli H/C III
		Kyakya (bujumbili - surgical ward)	1	Bujumbuli H/C III
		Rwamwanja (medicine warehouse)	1	Rwamwanja HC III

No.	Item	Location	Qty (Gaps)	comment
		Nakivale (2 waiting sheds)	2	Ruhoko, Misyera
		Nakivale (Maternity Ward)	1	Nakivale H/C
3.	Renovation	Bidibidi	1	Okubani HC
		Parolinya (Premature Ward)	1	Moyo hospital
		Parolinya (Maternity wards)	2	Parolinya H/C III and Tula)
		Kyaka (Maternity Ward)	1	Bujumbuli H/C III
		Kyangwali (Nutrition Ward)		Rwenyawawa
		Rhino & Imvepi(Partition of ITC Ofua 3 and Yinga HCIII)	2	Ofua 3 and Yinga HCIII
		Nakivale (stabilization block - Kibengo)	1	Kibengo H/C
		kyangwali health centre iv (painting and partitioning and expansion of OPD)	2	Kyangwali H/C
		Nakivale (5 staff blocks)	3	Juru, Kibengo, Nakivale
		Nakivale (HIV Clinic - Nakivale)	1	
		Oruchinga (IPD)	1	Oruchinga HC III
		Oruchinga (OPD)	1	Oruchinga HC III
		Oruchinga (IPD)	1	Rulongo
4.	Construction of semi-permanent health centre	Imvepi in Zone 4	1	Imvepi zone 4 - Jakisa
		Nakivale (Qurantine unit/ETU)	1	Complete treatment unit
		Rwamwanja (semi-permanent facilities at mahani and Kikuhura, Quarantine unit)	3	Complete facility at the two output and 1-QIC unit
		Kisoro (IQC) and construction of semi-permanent screening sheds at Cyanika and Bunaguna PoE	3	Kisoro, transit center and PoE
		Imvepi & Rhino - IQC	3	Imvepi & Rhino
		Ntoroko (IQC/isolation units)	1	1 Isolation unit at PoE/transit center
		Matanda (IQC/Isolation unit)	1	1 Isolation unit at PoE/transit center

No.	Item	Location	Qty (Gaps)	comment
		Parolinya (Semi-permanent facilities - OPD)	10	
		Palabek (Semi-permanent facilities - OPD)	3	(3 OPD, 3 IPDs, 3 Maternity
		Bidibidi (semi-permanent facilities - OPD)	2	Twajiji, Aivu
5.	Solar lighting in health facilities	Rhino & Imvepi	6	Imvepi HCII, Ocea HCII, Siripi HCIII, Imvepi zone 3 HC, Omugo 2, Ofua 3
		Nakivale	5	Nakivale HC III, Rukoho HC, Rubondo HC II, Kibengo HC II., Juru HC II
		Ntoroko	1	Ntoroko HC III
		Matanda	1	Matanda HC III
		Oruchinga	2	Nshungyezi HC III and Rulongo HC II
		kIisoro	1	Nyakabande HC III
		Rwamwanja	6	Rwamwanja HC III, Kyempago HC III, Mahega, Ntegungi, Mahani, Kikurura
		Kyaka II	4	Bujibuli HC III, Mukondo HC III, Bwriza HC III and Itambabiniga HC
6.	Connection to the power Grid	Lobule (Lobule, Pijoke, Kuluba, Lurujo)	4	Lobule, Pijoke, Kuluba, Lurujo
		Bidibidi	1	Bidibidi HC
7.	Fencing of health facilities	Imvepi & Rhino	6	Imvepi T29, T79, Zone 3 HC, Ofua 3, Ofua 4/5, Ofua 6
		Bidibidi	5	(luzira, yoyo, igamara, bolomoni, ayiro
		Kyaka II (4 facilities)	4	4 out post needs fencing for safaty
		Rwamwanja (3)	3	Mahani HC II, Ntenungi HC III and Kikurura HC
		Palorinya	7	all health facilities in Palorinya
		Kyaka (Bujumbli)	1	Done
		Kyangwali	3	Maratatu B, Nguruwe, Kasonga
8.	Water Source for health facilities	Lobule	1	Lobule HCIII
		Bidibidi	12	Okubani, Ayivu, Bolomoni, Igamara, Yoyo, Jomorogo, Kombge, Luzira, Iyete, Swinga, Yayari, Koro,

No.	Item	Location	Qty (Gaps)	comment
		Rwamwanja	3	Mahega-Installation of a water harvesting system at the health centre, Kikuhurura & Ntenungi - Procure 10,000l Tank
		Nakivale	1	Installation of water harvesting system at Rwekubo HC IV
9.	Demolition	Imvepi & Rhino	3	Siripi HC, Olujobu, Oduobu
10.	Placenta Pits	Imvepi & Rhino	3	Imvepi zone 3 HC, Ofua 3, Imvepi HCII
		Kyaka II	1	Mukondo HC III
		Nakivale	2	Rwekubo HC IV & Nakivale HC III
		Rwamwanja	2	Rwamwanja HC III & Kyempango HC III
11.	Incinerators	kiryandongo	1	Panyandoli
		Rwamwanja	2	1-Kikuhurura & 1-Ntenungi
		Oruchinga	0	
		Nakivale	2	1-Rwekubo HC IV, 1-Nakinale
		Kyaka II	5	1 for (Bwiriza, Kakoni, Itambabiniga and Sweswe Health out posts) and 1-Bujibuli
		Bidibidi	7	Yayari, Swinga, Koro, Iyete, Jomorogo, Okubani, Ayivu,
		Lamwo	2	
12.	Latrine construction	Kyaka II	13	Bujibuli-3, Mukondo-3, Each out post 1 at least (7)
		Rwamwanja	10	2-Rwamwanja HC III, 2-Kyempango, 2-Mahega, 2-Kikuhurura and 2-Ntenungi
		Nakivale	5	1-Nakivale HC III, 1-Rubondo, 2-Rwekubo, 1-Juru
		Palorinya	1	Liquid waste management facility for COVID 19 facility at Basecamp
		Parolinya	6	Plolinya, itula , ibakwe, belemeling, idiwa
		Bidibidi	6	Bidibidi, Yangani, Okubani, Kombge, Igamara, Bolomoni
		Imvepi	20	Yinga HC, Imvepi HC, Zone 2 tank 29, Point I HC, Zone 3 HC
		Palorinya	5	Belle, Ibakwe, kali, HKF, belemeling
		Kiryandongo	10	Panyadoli HCIII 10

No.	Item	Location	Qty (Gaps)	comment
		Rhino	8	(Oduobu 04, Ofua VI 02, Ofua IV/V 02, Ofua III 02, Omugo I 10, Omugo III 02).
		Koboko (20 stances)	20	Lurujo HC, Kuluba HC, Lobule, Pijoke & Koboko Hosp
13.	Bathing shelters	Rhino	10	(Siripi 02, Omugo I 2, Omugo III 02, Ofua IV/V 02, Oduobu 02)
		Palorinya	7	kali, idiwa, luru, belle, itula, palorinya, ibakwe
		Imvepi	10	Tank 29, Point I, Zone 3, Imvepi HC & Yinga
		Nakivale	4	Four stance patient bething shelters (2-juru and 2-kibengo)
		Rwamwanja	9	4- Rwamwanja HC III (Two-four stance for patients and 2- for staff), 2-Kyempango (1-bathing shelters for patients and 1 for staffs at their residences). 2-Mehega (1-bathing shelters for patients and 1 for staffs at their residences), Ntenungi HC II (1 washing station with 10 stance)
		Kyaka II	2	2-Bujibuli HC III (One for patient and one for staff),

ANNEX III: EQUIPMENT GAP ANALYSIS MATRIX

Equipment	Location	Number	Estimated cost	Total cost (UGX)	USD
coordination vehicles					
	Ivempi	2	136462260	272,924,520	77,978
	Rhino	2	136462260	272,924,520	77,978
	Obongi	1	136462260	136,462,260	38,989
	Adjumani	1	136462261	136,462,261	38,989
	Kyaka	2	136462260	272,924,520	77,978
	Nakivale	2	136462260	272,924,520	77,978
Ambulances					
	Burial van - Arua	1	154808040	154,808,040	44,231
	Kyangwali	2	154808040	309,616,080	88,462
	Moyo	2	154808040	309,616,080	88,462
	Arua (Rhino, Ivempi)	2	154808040	309,616,080	88,462
	Koboko	1	154808040	154,808,040	44,231
	Nakivale	2	154808040	309,616,080	88,462
	Lamwo	1	154808040	154,808,040	44,231
	Kiryandongo	1	154808040	154,808,040	44,231
	Yumbe	2	154808040	309,616,080	88,462
	Kyegegwa	1	154808040	154,808,040	44,231
	Adjumani	2	154808040	309,616,080	88,462
	Kamwenge	1	154808040	154,808,040	44,231
Motorcycles					
	Kyangwali	12	7500000	90,000,000	25,714
	Moyo	12	7500000	90,000,000	25,714
	Arua (Rhino, Ivempi)	12	7500000	90,000,000	25,714
	Nakivale	12	7500000	90,000,000	25,714
	Lamwo	12	7500000	90,000,000	25,714
	Kiryandongo	12	7500000	90,000,000	25,714
	Yumbe	12	7500000	90,000,000	25,714
	Kyegegwa	12	7500000	90,000,000	25,714

	Adjumani	12	7500000	90,000,000	25,714
	Kamwenge	12	7500000	90,000,000	25,714
Ultrasound scan					
	Bidibidi	1	30000000	30,000,000	8,571
	Kyangwali	1	30000000	30,000,000	8,571
	Nakivale	1	30000000	30,000,000	8,571
Hospital beds					
	Bidibidi	50	950000	47,500,000	13,571
	Ivempi	50	950000	47,500,000	13,571
	Rhino	100	950000	95,000,000	27,143
Cold Chain Fridges					
	Kyangwali	3	35000000	105,000,000	30,000
	Yumbe	5	35000000	175,000,000	50,000
	Moyo	3	35000000	105,000,000	30,000
	Lamwo	1	35000000	35,000,000	10,000
	Kyaka	2	35000000	70,000,000	20,000
	Arua	3	35000000	105,000,000	30,000
Cold chain boxes					
	Adjumani	4	600000	2,400,000	686
	Bidibidi	8	600000	4,800,000	1,371
	Parabek	4	600000	2,400,000	686
	Kyaka	4	600000	2,400,000	686
	Kiryandondo	4	600000	2,400,000	686
	Kyangwali	4	600000	2,400,000	686
	Rwamwanja	4	600000	2,400,000	686
	Nakivale	16	600000	9,600,000	2,743
	Oruchinga	4	600000	2,400,000	686
Vaccines Carriers					
	Adjumani	8	150000	1,200,000	343
	Bidibidi	16	150000	2,400,000	686
	Parabek	8	150000	1,200,000	343
	Kiryandongo	8	150000	1,200,000	343

	Arua	17	150000	2,550,000	729
	Kyangwali	8	150000	1,200,000	343
	Kyaka	8	150000	1,200,000	343
	Rwamwanja	8	150000	1,200,000	343
	Nakivale	8	150000	1,200,000	343
	Oruchinga	8	150000	1,200,000	343
Computers					
	Adjumani	11	3000000	33,000,000	9,429
	Nakivale	8	3000000	24,000,000	6,857
	Oruchinga	3	3000000	9,000,000	2,571
	Imvepi	4	3000000	12,000,000	3,429
	Kyaka	12	3000000	36,000,000	10,286
	Rwamwanja	6	3000000	18,000,000	5,143
	kyangwali	5	3000000	15,000,000	4,286
	Rhino	15	3000000	45,000,000	12,857
	Parabek	5	3000000	15,000,000	4,286
	Kiryandongo	4	3000000	12,000,000	3,429
	Bidibidi	10	3000000	30,000,000	8,571
Oxygen concentrator					
	Adjumani	0	4332900	-	-
	Parolinya	0	4332900	-	-
	Oruchinga	0	4332900	-	-
	Nakivale	0	4332900	-	-
	Rwamwanja	0	4332900	-	-
	Kyaka II	0	4332900	-	-
	kyangwali	0	4332900	-	-
	Kiryandongo	0	4332900	-	-
	Rhino	0	4332900	-	-
	Ivempi	0	4332900	-	-
CD4 machine					
	Adjumani	1	42000000	42,000,000	12,000
	Parolinya	1	42000000	42,000,000	12,000

CBC Machine					
	kyangwali	2	35000000	70,000,000	20,000
	Kyaka II	1	35000000	35,000,000	10,000
	Oruchinga	1	35000000	35,000,000	10,000
	Rwamwanja	1	35000000	35,000,000	10,000
	Imvepi	1	35000000	35,000,000	10,000
	kiryandongo	1	35000000	35,000,000	10,000
	Parolinya	1	35000000	35,000,000	10,000
	Nakivale	1	35000000	35,000,000	10,000
Chemistry Anaylzer					
	Kyaka II	1	10000000	10,000,000	2,857
	Rwamwanja	1	10000000	10,000,000	2,857
	Nakivale	2	10000000	20,000,000	5,714
	kyangwali	2	10000000	20,000,000	5,714
	Parolinya	1	10000000	10,000,000	2,857
Viral Load counter					
	Nakivale	1	40000000	40,000,000	11,429
	Kyaka II	1	40000000	40,000,000	11,429
	Rwamwanja	1	40000000	40,000,000	11,429
	Parolinya	1	40000000	40,000,000	11,429
Resuscitation Equipment (ample bags, bulb syringes, Stethoscpoes)	Parolinya	10	200000	2,000,000	571
	Nakivale/oruchinga	10	200000	2,000,000	571
	Kyaka II	5	200000	1,000,000	286
	Rwamwanja	5	200000	1,000,000	286
	Imvepi	3	200000	600,000	171
	Rhino	7	200000	1,400,000	400
Incubators	Imvepi	3	7000000	21,000,000	6,000
	Rwamwanja	4	7000000	28,000,000	8,000
	Kyaka II	4	7000000	28,000,000	8,000

	Nakivale	4	7000000	28,000,000	8,000
	Rhino	7	7000000	49,000,000	14,000
	Parolinya	4	7000000	28,000,000	8,000
	kyangwali	1	7000000	7,000,000	2,000
Hemocue machines					
	Arua (Imvepi, Rhino Camp)	3	2870000	8,610,000	2,460
	Lobule	1	2870000	2,870,000	820
	Bidibidi	3	2870000	8,610,000	2,460
	Palabek	2	2870000	5,740,000	1,640
	Adjumani	3	2870000	8,610,000	2,460
	Palorinya	3	2870000	8,610,000	2,460
	Kiryandongo	2	2870000	5,740,000	1,640
	Kyaka II	3	2870000	8,610,000	2,460
	Kyangwali	3	2870000	8,610,000	2,460
	Rwamwanja	2	2870000	5,740,000	1,640
	Nakivale	3	2870000	8,610,000	2,460
	Oruchinga	1	2870000	2,870,000	820
Height boards					
	Kyangwali	6	520000	3,120,000	891
	Moyo	4	520000	2,080,000	594
	Arua (Rhino, Ivempi)	5	520000	2,600,000	743
	Koboko	1	520000	520,000	149
	Nakivale	6	520000	3,120,000	891
	Lamwo	5	520000	2,600,000	743
	Kiryandongo	3	520000	1,560,000	446
	Yumbe	8	520000	4,160,000	1,189
	Kyegegwa	4	520000	2,080,000	594
	Adjumani	7	520000	3,640,000	1,040
	Kamwenge	3	520000	1,560,000	446
Electronic weighing scales					
	Kyangwali	12	430000	5,160,000	1,474

	Moyo	8	430000	3,440,000	983
	Arua (Rhino, Ivempi)	10	430000	4,300,000	1,229
	Koboko	2	430000	860,000	246
	Nakivale	12	430000	5,160,000	1,474
	Lamwo	10	430000	4,300,000	1,229
	Kiryandongo	6	430000	2,580,000	737
	Yumbe	16	430000	6,880,000	1,966
	Kyegegwa	8	430000	3,440,000	983
	Adjumani	14	430000	6,020,000	1,720
	Kamwenge	6	430000	2,580,000	737
				7,201,907,321	**2,057,688**
				63,985,555,856	**18,281,587**