Practical Guidance on Operationalizing Improvement of Service Delivery in both Central and Local Government Health Facilities

April 2025

Foreword

The Government of Uganda is steadfast in its commitment to ensuring equitable access to high-quality health services for all citizens. In recent years, the growing burden of both communicable and non-communicable diseases has increasingly strained our health system, underscoring the need for a transformative approach to health service delivery.

This Practical Guide on Integration marks a significant step forward in consolidating services such as HIV/AIDS, TB, Hepatitis, Hypertension, and Diabetes into a unified, patient-centered model of care, while ensuring appropriate referral to specialized services when needed. Policies and frameworks like the Essential Minimum Health Care Package and the Uganda Clinical Guidelines (UCG) have long advocated for the integration of preventive, curative, and rehabilitative services within our Primary Health Care system, all with the goal of achieving Universal Health Coverage. I strongly encourage all health workers to adopt and implement this guide, as it will play a pivotal role in optimizing the available resources, reducing duplication and fragmented care, improving patient outcomes, and enhancing the continuity of care nationwide.

I commend all health workers, district and facility leaders, as well as our development and implementing partners, for their invaluable support in driving this shift in service delivery. This guide offers a practical framework that will empower healthcare providers at all levels to implement service integration with clarity and confidence.

Let this document stand not only as a guide but also as a testament to our shared commitment to providing care that is accessible, efficient, and delivered with dignity for every Ugandan.

_____ Hon. Dr. Jane Ruth Aceng Ocero Minister of Health Republic of Uganda

Acknowledgements

The development of the Practical Guidance on Operationalizing the Improvement of Service Delivery in both central and local government health facilities has been the result of a collaborative effort involving numerous stakeholders and contributors.

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This guide reflects our shared commitment to building a resilient, sustainable, and high-quality health system, with integrated service delivery at its core. Let it serve as a living tool for continuous improvement, patient-centered care, and advancing integrated service delivery for all Ugandans.

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Introduction

1. Purpose of the Practical Guide

This document provides guidance for health care workers, health services managers and implementing partners (IPs) on the operationalization of integrated services, including HIV, Tuberculosis (TB), Hepatitis, and Non-Communicable Diseases (NCDs), among other disease programs within Primary Health Care (PHC). The aim is to optimize service delivery, enhance patient satisfaction and outcomes, and foster a holistic approach to healthcare.

2. Scope

This practical guide applies to all public and private-not-for-profit healthcare facilities under the Uganda Ministry of Health (MOH) jurisdiction. It covers service integration and the systems that support it.

3.Target Audience

The target audience for this practical guide are policy makers, health care workers, health services managers, health services supervisors, and implementing partners (IPs) who plan and provide health services for both acute and chronic conditions.

4. Objectives

This practical guide aims to:

Provide practical guidance on operationalizing the 7th of Feb 2025 health services integration circular from the Ministry of Health

Establish a patient-centered service delivery model that consolidates care into a seamless, one-stop experience, moving beyond traditional disease-focused approaches

Improve access to quality prevention, diagnosis, treatment, and management of communicable and non-communicable diseases.

Optimize available resources including health workforce, space utilization, PHC funds and other resources.

Strengthen referral systems within the health system and from the community, including access to specialized care.

Improve data management, reporting and surveillance such as mortality audits, and outbreaks detection and response.

While this practical guide provides a framework for integration, it may not address every specific circumstance encountered in primary health care settings. Facilities are encouraged to adapt the guide to meet local needs and comply with relevant regulations and standards. Additionally, the use of quality improvement, continuous monitoring and evaluation will be necessary to refine these procedures based on feedback and changing healthcare dynamics.

5. Implementation Procedures

a) Leadership and Planning:

Standard 1: Ensuring that all leaders and managers at districts and health facilities have in place an action plan to fully integrate HIV/ AIDS, TB, Hepatitis B, Hypertension (HTN), and Diabetes services into the routine outpatient and chronic care services in hospitals and lower-level facilities.

District health offices and health facility managers must establish an action plan that includes support supervision and monitoring the integration of standalone services into routine outpatient and chronic care clinics at hospitals and lower-level health facilities in the district.

Facility directors, medical superintendents, and in-charges are responsible for planning and organizing the implementation of both acute and chronic care services.

The action plan should include orientation of health workers on the recommendations made in the integration circular from MoH and the contents of this practical guide.

All health facility-in-charges should ensure effective supervision of health workers to promote accountability and productivity while enforcing measures to address perennial absenteeism.

District leadership and health facility managers must create a flexible enabling environment for adaptive change management where health providers focus on holistic patient-centered care and make adaptations to meet client needs, including referrals to specialist services where needed.

Patients should be informed about the change in care models and guided through the client flow to access integrated services.

b) Integration of HIV/AIDS, TB, DM/HTN, Hepatitis, and other Chronic Disease Services in a clinic setting

Standard 2: Ensuring establishment or identification of clinic space for integrated services to manage Acute and Chronic conditions. This space will be equipped to effectively serve as the primary point of care for patients with acute and chronic care needs.

Implementation Process for clinic space and reorganization:

Facility Structure:

Integrated services will be provided through the outpatient settings of the health facility.

Based on the set-up of the health facility, the Outpatient Department (OPD) setting may function as a care point for both acute and chronic care conditions (mixed model) OR the OPD settings may be different e.g., the General OPD may provide acute care services while the existing standalone HIV/DM/Hypertension clinics are transformed into Chronic Care Clinics handling chronic conditions.

Facilities should identify space for management of chronic disease conditions like HIV/AIDS, hypertension, diabetes, hepatitis, TB and others.

For example, standalone HIV clinics or DM/hypertension clinics with adequate space should be converted into Chronic Care clinics where all patients with chronic conditions are cared for

Clinics that have already been managing HIV patients with other disease conditions in OPD should continue with this best practice of integration and embrace also patients without HIV to access services in the same clinic space if adequate.

The management of these conditions should be on the same day of the visit and by the same healthcare workers for patients with co-morbidities.

Facilities should streamline longitudinal follow-up, counseling, tracking, and monitoring for all chronic diseases.

Facility directors, medical superintendents, and in-charges are responsible for planning and organizing the implementation of both acute and chronic care services.

Chronic Care Model:

All patients attending General OPD or Chronic Care Clinics at PHC facilities should be screened and managed through patient-centered approaches for the care of acute and chronic illnesses. This will include managing acute and other chronic illnesses e.g., HIV, TB, Hepatitis, and NCDs per MOH guidelines in a one stop center.

Implementation Process 1- Clinical assessment and care:

For all patients seeking outpatient care at facilities, the starting point will be the reception at the General OPD except for patients already in routine care who go directly to the Chronic Care Clinic. There should be designated registration and triage at either the general or chronic care clinics.

Initial Triage Assessment: At the triage station, all patients undergo a rapid triage assessment to determine urgency based on vital signs and symptoms. Patients are categorized as:

Emergency: Immediate stabilization and referral to higher-level care, if necessary, using the ambulance system.

Urgent: Prompt consultation and intervention for stabilization in the resuscitation/treatment room and then direction to the respective ward or clinic.

Routine: Management within scheduled service delivery, including chronic care services

Infection Control: Isolation/separation of patients with infectious diseases and general infection prevention and control (IPC) measures should be always adhered to at all service delivery points.

Comprehensive Patient Assessment: Conduct a thorough medical history, clinical examination, and necessary laboratory tests as per the Uganda National Clinical Guidelines (UCG)/ disease-specific guidelines.

Screening for Multiple Conditions: Eligible patients presenting for any service should be screened for HIV, TB, Hepatitis, and NCDs to ensure early detection and improved patient outcomes

Linkage to Care: Newly diagnosed patients should be linked to treatment service points for further assessment and treatment from the outpatient's unit. Such patients will be received regardless of the clinic day.

Individualized Treatment Plans: Clinicians should develop individualized treatment plans that address multiple coexisting conditions, referring to disease-specific treatment guidelines.

Medication Prescriptions and refills: Clinicians and pharmacy staff should ensure proper prescription management to prevent drug interactions and enhance adherence. Multi-month dispensing (MMD) should be extended to other non-HIV disease conditions whenever practical. For patients with comorbidities, appointment dates and medicine refills should be aligned and on the same visit.

Routine Follow-Up and Monitoring: Clinicians should schedule regular follow-up appointments to assess progress, response to treatment to provide appropriate support and make necessary adjustments.

Health Education, Self-Management, Adherence Support and Counseling: Providers should educate patients on lifestyle modifications, medication adherence, and early symptom recognition with the aim of improving treatment literacy around chronic care and self-management.

Multidisciplinary Team Approach: For patients with complications or special needs, ensure thorough consultations and facilitate collaboration with relevant team members, including specialist consultants, dietitians, and community health workers.

Ensure patient data is documented using the Nationally approved client cards and reporting systems

Referrals: Internal referrals may be conducted in settings where capacity exists but the existing national system of interfacility referrals will be used to refer from one facility to a higher-level facility.

Suggested Clinic Flow

Implementation Process 2: Service delivery approaches fostering efficiency and quality of care

Implement Continuous Quality Improvement (CQI) initiatives that include but are not limited to: client satisfaction surveys, mortality audits, data quality audits, data utilization, and service quality assessments. Every death should be reviewed by the facility team and notified.

Utilize the latest versions of clinical guidelines and job aids including the UCG, Consolidated HIV, TB guidelines and other relevant references, to ensure adherence to best practices.

Ensure the integration of additional care services within existing differentiated service delivery models (DSDM), including community models. All community-level activities such as outreaches, home visits, campaigns, community sensitization and mobilization must be implemented in an integrated manner.

Appointment and tracking system: Stable chronic patients should be managed on appointment. The facility should therefore establish a robust appointment and tracking system. This system should allow for new patients and walk-ins who missed their previously scheduled clinic visits to be attended to.

Patient support groups: Support the establishment of patient support groups for chronic disease management including prevention.

Community Tracking: utilize community health workers to support patient follow-up and adherence to treatment.

Health commodities

Standard 3: An uninterrupted supply of essential medicines, diagnostics, and commodities for HIV, TB, Hepatitis, and NCDs must be maintained.

Integrated quantification

Conduct regular demand quantification for medicines and diagnostics for patients in care/ expected by a multidisciplinary team.

Use data-driven procurement to prevent shortages and overstocking.

Ordering

Place timely and accurate orders for all commodities (including Essential Medicines and Health Supplies (EMHS), program and laboratory commodities) based on the warehouse (JMS/NMS) order and delivery schedule, using facility consumption data to ensure continuous availability.

Stock tracking and Inventory Management

Implement a stock management system (electronic or manual, including updated stock cards) for real-time tracking. Health facilities should maintain a one-stock card policy per item.

Update stock-keeping records (stock cards and/or electronic systems) for all commodities after each transaction

Conduct monthly physical stock-taking to identify and rectify discrepancies early.

Dispensing

Dispensing of commodities should be handled in a designated and spacious space (preferably at the OPD pharmacy) where clients receive their medication with appropriate instructions for proper use

Standardize dispensing protocols across all integrated services.

Use a First Expiry, First Out (FEFO) approach to minimize wastage.

Ensure proper labeling and patient counseling to enhance adherence.

Maintain clear documentation of dispensed medications for monitoring consumption and auditing purposes.

Fill in dispensing logs for all medicines dispensed

Stock redistribution

Strengthen coordination with warehouses and facility stores.

Implement contingency plans for emergency stock replenishment during shortages.

Rational Medicines use

Assess patients comprehensively including medicines history

Conduct relevant investigations

Adhere to disease treatment guidelines

Document prescriptions clearly and accurately

Review patients routinely for potential drug interaction/resistance.

Medicines Therapeutics Committees (MTCs) should oversee and coordinate efforts to report and address drug-related patient safety concerns.

Health information system

Standard 4: Functionalizing the National Integrated Health Management Information Systems (HMIS) for improving continuity of care, reducing duplication, reporting and ensuring data-driven decision-making

The National Health Management Information System (HMIS) enables seamless data capture, real-time access, and efficient information sharing across healthcare providers, reducing data redundancy and ensuring that patient records are comprehensive and up to date to inform patient and program management.

Context: The implementation of the National Health Management Information System (HMIS) for both paper-based and electronic systems is not unified (siloed) requiring the use of different HMIS tools for different points of care and disease areas within health facilities to capture, store, report and utilize data for decision-making.

Intervention: To fully integrate all HMIS tools and processes (both paper-based and electronic) into a unified health management information system at both the national and subnational levels including health facilities.

Recommendations:

Data capture and documentation: The health facility in charges shall provide oversight to ensure that all integrated services provided are documented using standardized paper-based or electronic HMIS tools available.

In the meantime, respective paper-based HMIS tools for the various disease conditions shall be used to capture clinical data at HCIIs, HCIIIs, IVs levels. Where the Electronic Medical Records (EMR) Systems (i.e. eAFYA, Clinic Master and Uganda EMR) exist at these levels, they shall be fully utilized to capture, store, report and utilize data for decision-making.

Health facilities at the level of general hospitals and above that have already been digitized (have existing local area network, ICT hardware and EMR installed) shall use EMR Systems (i.e. eAFYA, Clinic Master and Uganda EMR) to capture, store, report and utilize data for decision making. Otherwise, the non-digitized health facilities shall use the respective paper-based HMIS tools.

Health facilities that have both Uganda EMR and eAFYA deployed, shall use both EMRs at the Outpatient Department (OPD) to capture, store, report and utilize data for decision-making. Health facilities with technical support available shall migrate both EMRs onto one computer that shall be deployed at the point of service.

Reporting: Facilities shall continue to submit standard routine reports (daily, weekly, monthly, quarterly etc.) for the various disease conditions as per scheduled reporting frequency through the already existing mechanisms.

Performance monitoring and evaluation:

Data analysis and use: In addition to disease-specific analysis, facilities shall conduct routine integrated data analyses and review meetings to facilitate decision-making, planning and patient management. By analyzing this data, healthcare providers shall monitor treatment effectiveness, improve care coordination, and optimize resource allocation.

Joint performance review meetings should be conducted to provide feedback and inform improvement actions.

Data storage, filing, archiving and retrieval:

Facilities should ensure that the patient data for paper-based systems are safely stored, secure and accessible in an integrated manner (in one place) and following the established procedures for data access.

Continuous onsite Training and Support: Comprehensive integrated training for healthcare staff in using integrated electronic and manual information systems is required. This training shall be conducted periodically and reinforced through refresher sessions as needed. The health information assistants and data managers at facilities shall build the capacity of the users through training and mentorship

Data Quality Assurance: To ensure completeness, accuracy, and timeliness of data, facilities shall implement integrated routine data harmonization and quality assurance (DQA) measures. This includes data validation exercises, cross-checking reports by supervisors and a multidisciplinary team, and corrective actions for discrepancies identified during periodic reviews as part of report preparation and submission in the respective reporting systems.

Unique identification of patients: Facilities shall continue implementing unique patient identifiers in the respective systems to ensure accurate tracking, reduce duplication, and improve continuity of care. This shall be implemented into both electronic and manual record-keeping systems to maintain consistent and reliable patient data.

Human Resources

Standard 5: Prioritizing Human Resource Optimization to support Integrated service delivery

Staffing Requirements: Effective integration of acute and chronic care requires a multidisciplinary team, including primary care physicians, nurses, pharmacists, clinical officers, counselors, biostatisticians, sample transporters, laboratory personnel, radiology specialists and other staff.

Prioritizing Recruitment of Critical staff: Where wage is available, health care managers must prioritize the recruitment of critical health workers as per the services offered by the facility and patient load.

Training and Capacity Development: Continuous training and professional development are crucial for building staff competency in integrated care management. This will be achieved through a comprehensive strategy encompassing needs assessment, targeted training, mentorship, and ongoing support.

Responsibilities: The MOH, Regional Referral Hospital (RRH) teams, and District Health Management Teams (DHMTs) will collaborate on planning, resource mobilization, budgeting, and implementation of training and capacity building activities for relevant personnel.

Needs Assessment: The MOH will conduct a comprehensive training needs assessment at each level of care to identify specific gaps in integrated care delivery. This assessment will inform the development of targeted training programs.

Training Roadmap: The MOH has developed a training and capacity development roadmap/matrix to ensure continuous capacity building for all primary care providers, including community health workers. This roadmap will guide training initiatives.

Training Content and Delivery: The integrated training package will be delivered in a modular format, addressing all chronic conditions and integrating relevant acute care protocols for effective learning.

Training methods: Several strategies will be used to provide continuous support:

Facility-Based Mentorship: Regular facility-based sessions will focus on best practices for managing chronic diseases and acute care, providing practical, hands-on training.

Online Refreshers: Zoom and Echo sessions will provide accessible and flexible refresher training and orientation.

Continuing Education: Staff are encouraged to pursue relevant continuing medical education (CME) in integrated care, including chronic disease management and acute care protocols. To this end, health facility leaders should develop schedules for routine CME.

Performance Evaluation: A robust performance evaluation system is essential to maintain high standards of integrated care. This system will include the following components:

Patient Satisfaction Surveys: Feedback will be collected from patients regarding their experiences with integrated care services. Client satisfaction will be triangulated with data on the national client satisfaction dashboard to inform improvement strategies.

Quality Metrics: Key performance indicators (KPIs) will be monitored, including readmission rates, treatment adherence, health outcomes for chronic conditions and system indicators such as staff absenteeism and staff practices on providing comprehensive integrated care, among others.

Staff Feedback Mechanisms: Avenues should be created for staff to provide input on the integration process, identifying challenges and suggesting improvements.

Health Outcomes: Analyzing patient outcomes, including hospitalization rates, complication rates, and chronic disease management, to determine the impact of integration on health.

Laboratory systems and diagnostic services

Standard 6: Integration of Laboratory Systems, Networks and Diagnostic Services

The Ministry of Health through the Department of National Health Laboratory and Diagnostic Services (NHLDS) established a robust laboratory network that ensures quality-assured diagnostic services, sample transportation and results return, medical lab equipment, supply chain and waste management. Integration of this laboratory network creates a streamlined, efficient system providing all primary diagnostic services needed for disease prevention, care and treatment, disease surveillance and outbreak investigation without requiring patients to go to different laboratory facilities for specific tests. Such a network focuses on providing timely quality-assured laboratory diagnosis using common specimen collection and transportation, reporting and diagnostic platforms, equipment and waste management systems that can be used across diseases.

Context: Laboratory testing points have expanded beyond the main designated laboratories, but some of these additional points may not be adequate for the required services. Various facilities have diverse laboratory structures, such as mini labs in Outpatient Departments (OPD), Maternal and Child Health (MCH) clinics, and wards, each with different capacities. Side labs at higher-level health facilities perform real-time tests, but their capacities vary. Extensive task-shifting to other cadres helps alleviate the burden on professional laboratory staff, yet the limited capacity for Point of Care (POC) testing affects the timely delivery of test results. Multitasking burdens on existing staff pose challenges to consistent operations. The unintegrated system of equipment maintenance and calibration, complexities in logistics and stock management, and non-standardized

quantification methods further complicate operations. There is a fragmented distribution of External Quality Assessment (EQA) panels, focusing on only one disease at a time. Root cause assessments for EQA performance often focus on only one EQA scheme. Supervision and mentorship primarily focus on disease-specific rather than integrated approaches. Untrained Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs) on integrated approaches for various diseases, exacerbate the issue. Siloed logistical processes in sample transportation and cold chain capacity, coupled with unclear roles and responsibilities for hub coordinators and lab staff, affect the performance of the hub system.

Guidance

Disease diagnosis: All health facilities should increase the capacity of their side labs and utilize trained health workers to conduct integrated rapid diagnostic tests (RDTs) and point-of-care (POC) tests at both the patient's location and side laboratories. This will apply for both outpatient (OPD) and inpatient settings. The main laboratories at all health facilities will primarily process automated tests but will also provide extended point-of-care testing to support confirmation or troubleshooting as needed.

Human Resource: The health facility Directors, City Health Officers, DHOs and Municipal Council Health Officers will prioritize strengthening the laboratory HR component for all cadres (in both numbers and skill set) by securing the wage bill and ensuring operationalization of the approved laboratory scheme of service at all levels of health care. Existing laboratory human resources will multitask to ensure the provision of integrated laboratory services while leveraging support from IP-supported staff.

Training and mentorships: All health facilities should use an integrated approach to conduct laboratory-based training activities, for example Strengthening Laboratory Management Toward Accreditation (SLMTA), Laboratory Quality Management System (LQMS), Lab SPARS, biosafety and biosecurity etc., post-mentorship training, and support supervision. This should be done for all laboratory cadres and non-laboratory health workers, targeting the diagnosis of multiple diseases including TB, malaria, HIV, hepatitis, NCDs among others.

Equipment management: All health facilities should work with regional equipment maintenance workshops in collaboration with the National Equipment Calibration Laboratory at NHLDS to conduct integrated planned periodic equipment maintenance, servicing, calibration and biosafety cabinet certification.

Supply chain: Laboratory managers should make timely and appropriate orders for commodities and monitor the utilization of laboratory logistics and supplies through periodic reviews and support the training of health facility teams in stock management using integrated, evidence-based quantification methods and procurement plans.

Quality Assurance: All health facilities should participate in the External Quality Assessment (EQA) schemes for various disease programs for all laboratories and POC testing sites as per the National EQA calendar provided by the NHLDS, and the districts should monitor the EQA performance for all laboratories and POC testing sites within their catchment areas and further conduct integrated corrective action for the poorly performing laboratories and POC testing sites.

Sample transportation and referral: Peripheral health facilities should refer all sample types which they cannot perform, to laboratory hubs using the sample transport bike rider. The laboratory hubs should process and test these samples, print all test results and additionally refer those samples requiring specialized testing, including outbreak samples under one health approach, to regional and national specialized testing laboratories. The laboratory hubs and peripheral health facilities should ensure the tracking of motorbikes and all sample types to maintain traceability and chain of custody.

Monitoring and reporting: All health facility in-charges should ensure utilization of the Health Laboratory Information System (HLIMS) and Electronic Medical Records (EMRs) to support laboratory data management and reporting to the national databases and/or dashboards. To streamline workflows and reduce downstream workload, all laboratory test requests originating from

points of care, whether directed to side laboratories, main laboratories or referral laboratories, should be submitted electronically. In addition, all health facility in-charges should regularly monitor their respective health facility performance logging onto the national dashboards and come up with continuous quality improvement plans.

Community level Services

Standard 7: Reorganization of community systems for Integration

Integrating chronic care and treatment services such as HIV services into routine integrated community activities can help to increase access, reduce stigma and improve health outcomes for all.

Context: Focus on disease-specific siloed rather than integrated community approaches, untrained Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs) on various diseases as well as disease- specific training for community actors is the current issue.

Interventions:

All health facilities will align the delivery and planning for community health services to the integrated package for the implementation of integrated community health services. To fully provide integrated community services, the following key actions will be undertaken to facilitate the process.

1. Integration of all health services during community outreaches.

a) Co-location of services: Health facilities should offer HIV services alongside other health services, such as maternal and child health, tuberculosis, or sexual and reproductive health during the planned integrated outreaches.

b) Differentiated service delivery models at community: Health facilities shall build capacity of community health workers such as the VHTs and CHEWs and PLHIV volunteer networks to support integrated community service delivery, including counselling, testing, adherence support to treatment and community-based tracking for chronic care patients.

2. Community led initiatives

Community- based organizations and volunteer networks: Health facilities shall continuously identify/ map and build capacity of community-based organizations to provide integrated health services, advocacy and support.

3. Reducing stigma and improving adherence to treatment: Integrated service delivery provides an equitable platform for access to health services as care is not tagged to a disease. It requires high levels of confidentiality among the services providers.

Health education and awareness:

a) Client literacy; Health facilities shall provide an integrated health education package to all the clients receiving community health services. The community actors should provide accurate up-to-date information about transmission, treatment and prevention routinely.

b) Peer support groups: Health facilities shall work with exclusively voluntary peer groups such as, PLHIV networks to provide psycho-social support and reduce feelings of isolation. Facility managers should ensure that PLHIV networks and other peer support groups are engaged in the implementation of integration to create buy-in.

4. Data capture and documentation for integrated community activities

The health facility in- charges shall provide oversight to ensure that all integrated services provided are documented for all community services using standardized paper-based or electronic HMIS tools available.

Primary Health Care resources

Standard 8: Utilization of Primary Health Care (PHC) resources

Where wage provisions exist, PHC grants should be leveraged to recruit critical, essential health workforce positions that are currently missing. Additionally, PHC funds should be strategically utilized to enhance service delivery by addressing key gaps in disease prevention outreach—such as immunization, nutrition and family planning awareness, and health commodity distribution—as well as supporting laboratory hub operations for sample referral and minor equipment maintenance.

Waste Management

Standard 9: Integrated Waste Management

Effective waste management is a critical component of quality health service delivery and must be prioritized in health facility planning and budgeting processes. Facilities should allocate dedicated resources to ensure proper segregation, collection, and disposal of medical and general waste. This includes provision of adequate and appropriate Personal Protective Equipment (PPE) for waste handlers, investment in infrastructure and supplies for safe waste handling, and building the capacity of all relevant staff through training in proper waste management practices. Integrating waste management into routine operations not only safeguards the health of patients and staff but also protects the environment and supports regulatory compliance.

Equipment Maintenance

Standard 10: Integrated maintenance of laboratory and other hospital equipment

All available and functional medical equipment should be actively utilized to support service delivery and should not remain idle or stored away unnecessarily. Optimal use of existing equipment maximizes investments and improves patient care. Health facilities are encouraged to work closely with the Regional Equipment Maintenance Workshops located at Regional Referral Hospitals to coordinate the servicing and repair of major equipment. Additionally, health facility leadership should take responsibility for planning the timely disposal of obsolete or non-repairable equipment, in accordance with national guidelines, to ensure a safe and efficient working environment and prevent unnecessary clutter or misuse of space.

Frequently Asked Questions (FAQs)

Implementation process for NGOs, specialized clinics and centers of excellence (COEs)

What is the guidance for specialized clinics at HIV centers of excellence?

The specialized clinics at identified HIV centers of excellence, such as JCRC, IDI Clinic, Mildmay Hospital, CAF, Baylor Clinic, TASO centers, MUJHU, MJAP, and AHF, will continue to provide standalone HIV/TB services with integration for other chronic illnesses within HIV care.

What about non-HIV Centers of Excellence?

The non-HIV COEs, i.e., Uganda Heart Institute, Uganda Cancer Institute, ULI, specialized MDR TB centers are beyond the scope of this practical guide and will be provided in the broader Integration framework.

How will the CSOs and CHWs work together?

Refer to the community health strategy

What should I do if I need further information or guidance?

Utilize available support resource persons by contacting the Ministry of Health secretariat, 0800-100-066, or the Infectious Diseases Institute (IDI) call center toll free line 0800-200-055.